GAO Report Illuminates Insurer Influence On Drug Discounts

by Christopher Ody, Craig Garthwaite and Paul Greenberg

Law360 (September 20, 2019, 3:49 PM EDT)


Christopher Ody


Craig Garthwaite


Paul Greenberg

Policymakers of all political persuasions frequently express concern about the level of U.S. health care spending, which now approaches 20% of the gross domestic product. Perhaps more concerning, U.S. aggregate health outcomes are in many ways worse than other developed countries (though it is unclear how much of that is the responsibility of the health care system).

This naturally leads us to wonder: Are we getting good bang for our proverbial buck on health care spending? Concerns about spending have led to a variety of policy proposals that range from market-based interventions to single payer coverage under Medicare for all.

There is perhaps no area of health care that attracts more attention than prescription drugs — which account for approximately 15% of health care spending but a far greater share of policy proposals. Many have called for federal negotiations with drug manufacturers in the Medicare Part D program, the drug insurance program for the elderly.

What is often lost in that discussion is that drug prices already are negotiated in the Medicare Part D program.[1] Crucially, however, these negotiations do not directly include the federal government. Instead, they take place between drug manufacturers

and private insurers that compete to offer drug benefits to seniors through the Medicare Part D program.

Medicare receives data on the drug prices paid by Part D insurers, but because of their sensitive competitive nature, releases little information about proprietary discounts. Thus, a recent report by the United States Government Accountability Office on Part D prices provides novel insights concerning the variability of negotiated discounts across drugs and insurers.[2]

The remainder of this article proceeds in two steps. First, we provide a basic explanation for how prices for drugs are negotiated in the Medicare Part D program, and contrast this with price negotiations in Medicaid, the U.S. insurance program for the poor. Then we discuss some of the implications of the GAO report.

Drug Pricing in the United States

Medicare Part D beneficiaries do not directly purchase drugs from manufacturers. Instead, a number of intermediaries play important roles. Simplifying considerably, when a beneficiary fills a prescription at a pharmacy, the beneficiary's insurer reimburses the pharmacy for the drug at a price that is benchmarked against some (high) sticker price.

For branded drugs, a drug manufacturer and the insurer negotiate separately over a "rebate" that the drug manufacturer will pay to the insurer. Manufacturers offer rebates to incentivize insurers to drive volume to their drugs rather than competitor drugs. Insurers negotiate with drug manufacturers over rebates in both Medicare Part D and private insurance markets.

What determines how these dynamics play out within the Part D program? Negotiations are complex, but economic theory points to some factors that are likely to come into play. Most importantly, the price should not be higher than the amount that beneficiaries "on average" value having access to the drug; if it were, the insurer would better serve beneficiaries by lowering premiums and not covering the drug.

For drugs with close substitutes, beneficiaries may value access to one or another drug in the therapeutic class, but do not care so much which specific drug is covered. In such cases, insurers may be able to extract large price concessions. Thus, competitive forces among drug manufacturers can play an important role in determining prices.

There are concerns that unfettered competition could lead to exclusion of high value drugs that treat vulnerable populations. For example, some patients have sufficiently high drug costs that insurers inevitably lose money on them. Covering drugs that predominantly attract these patients is necessarily a money-losing endeavor. Medicare requires insurers to cover all drugs in six "protected classes" and at least two drugs in every drug class. Past research suggests that these restrictions worsen the bargaining position of insurers and lead to smaller price concessions for drugs.

How does Medicare benefit from these negotiations? Rebates lower insurer costs, decreasing federal subsidies to these firms, and lowering costs to Medicare. Thus, while Medicare does not directly receive or negotiate rebates, it reaps the benefits of such negotiations by private insurers.

Arguments that the federal government should play a more active role in negotiating prices often point to Medicaid drug prices. Medicaid "negotiates" by statutorily demanding that it receive a "best price" guarantee, meaning that Medicaid must receive a rebate at least as large as the rebate offered to any private insurer. Some Medicaid systems then negotiate supplemental rebates on top of this best price. Tautologically then, Medicaid has "negotiated" the best rebate. Estimates suggest that Medicaid rebates on branded drugs could average as high as 57%,[3] with rebates for specific drugs sometimes approaching 100%. By contrast, for Medicare Part D, these rebates average approximately 18%.

Economists have identified a number of problems with the Medicaid negotiation model, the most important of which is that getting the biggest discount is not the same as getting the best deal. For example, drug manufacturers may give Medicaid the "best rebate" by cutting rebates to everyone else, rather than raising rebates to Medicaid. This means that a portion of the lower prices that are made available to Medicaid is subsidized by higher prices in the rest of the market.

Extending Medicaid's "best price" guarantee to Medicare would incentivize drug manufacturer to raise prices on those who are privately insured. In addition, drugs such as generics may provide high value, and yet have relatively low rebates because of low "sticker prices." Because of dynamics such as these, Medicaid's focus on the "biggest rebates" may come at the expense of determining which drugs provide good value.

GAO Report

The recent GAO report is unique because of the granularity of rebate data that it contains. Below, we present a bar chart of rebates by prescription therapeutic class and by (anonymized) Part D private insurer, with each class or insurer representing a single bar. To provide some additional context, we also plot cross-country branded drug price data from another recent study.[4] While the GAO report includes a sample of branded and generic drugs, in the Part D program, the vast majority of all rebates are associated with branded drugs.[5]

The GAO report suggests that there is wide variation in rebating across plans, with some plans receiving rebates in excess of 30% of branded drug spending, and other plans receiving rebates as low as 5% (note that the data do not allow us to compare rebates for individual drugs across plans).

Some of the differences in rebates may be driven by the composition of drugs purchased, such as certain plans doing more to encourage adoption of lower-priced generic drugs with lower — or no — rebates in place of higher-priced, higher-rebate brand drugs. However, differences in the buyer power of different insurers likely also plays a role as larger insurers get better deals than smaller ones.

The differences in rebates are large compared to the 12.4% margin that Part D insurers earn on average.[6] One would not expect an insurer to be able to compete with another insurer with input costs that are 25% lower. Thus, the wide dispersion suggests either that with time, the low rebate insurers should either be exiting the Part D market or that these insurers are pursuing very different business strategies and are competing on dimensions other than just price or drug coverage.

For example, some plans are offered in conjunction with medical (i.e., hospital and physician) benefits, which could improve the bargaining position of drug manufacturers offering products that help control medical spending.

Consider this chart organizing discounts by country, Part D insurer and Part D therapeutic class.[7]

Interestingly, the plans receiving the lowest rebates may have better options that they are not currently exploiting. Elsewhere in the report, GAO separates Part D insurers by whether they negotiate rebates themselves or instead use a pharmacy benefit manager to negotiate with drug manufacturers on their behalf.

The results suggest that large insurers tend to negotiate rebates for themselves. The smaller insurers typically rely on a PBM, and ultimately those PBMs negotiate similar rebates for the small insurers to the rebates that the large insurers would have negotiated for themselves. Thus, favorable drug prices appear to be something that insurers can, to some extent, purchase by hiring a PBM — though it is unclear whether the costs of the PBM services justify the savings available to these smaller PBMs.

The cross-therapeutic class variation in rebates is even more dramatic than the cross-insurer variation in rebates. For example, rebates average 56% of branded spending for gastrointestinal drugs, which is comparable to the average Medicaid rebate. Interestingly, the two therapeutic classes with minimal rebating are immunological and antineoplastic. As Medicare regulations require insurers to cover all drugs in these classes, it likely leaves insurers with only toothless threats in negotiations over prices of drugs in these categories.

Perhaps unsurprisingly, the Part D rebates are not as large as those found in the Medicaid program or the discounts received in other jurisdictions. Peer countries vary in their procurement mechanisms. Some countries are more aggressive at excluding drugs that they do not deem to be cost effective, and use this as a credible threat in negotiations. This is at odds with the Medicare program's history of covering most treatments.

Other countries use approaches similar to that of Medicaid and demand that their prices internationally be at least as good as some other benchmark prices. Given the substantial role of U.S. drug demand in driving innovation and pricing, such a change to the Part D program could have difficult to anticipate and potentially unintended adverse consequences.

We conclude that negotiations of prescription drug prices are complex, involving both a number of different actors and a number of different prices. While it is true that Medicare does not directly negotiate with drug manufacturers, this does not mean that Medicare or its enrollees are paying list prices for drugs. Instead, Medicare outsources the job of negotiating to private insurers that then negotiate drug prices as they compete for enrollees.

Christopher Ody is a manager at Analysis Group Inc. Craig Garthwaite is a professor at Northwestern University's Kellogg School of Management and an Analysis Group affiliate. Paul Greenberg is a managing principal at Analysis Group.

Endnotes

1 There are also calls for active price negotiation by the government for physician-administered drugs, which are reimbursed under Medicare Part B. Part B's incentives are structured differently than Part D's, and are not covered in the GAO report.

2 GAO, "Medicare Part D: Use of Pharmacy Benefit Managers and Efforts to Manage Drug Expenditures and Utilization," United States Government Accountability Office, GAO-19-498, July 2019. [cited on September 13, 2019]. Available from: https://www.gao.gov/assets/710/700259.pdf.

3 Chown, Jillian, David Dranove, Craig Garthwaite, and Jordan Keener. The Opportunities and Limitations of Monopsony Power in Healthcare: Evidence from the United States and Canada. No. w26122. National Bureau of Economic Research, 2019.

4 Kang, So-Yeon, Michael J. DiStefano, Mariana P. Socal, and Gerard F. Anderson. "Using External Reference Pricing In Medicare Part D To Reduce Drug Price Differentials With Other Countries." Health Affairs 38, no. 5 (2019): 804-811.

5 For consistency with the cross country data, we inflate the GAO rebates to account for the fact that the GAO includes generics but that generics do not receive rebates.

6 The Medicare Payment Advisory Commission, "Status Report on Part D," Report to The Congress: Medicare Patment Policy, March 2016. [cited on September 18, 2019]. Available from: http://www.medpac.gov/docs/default-source/reports/chapter-13-status-report-on-part-d-march-2016-report-.pdf

7 Cross-County data is from Kang, et al. (2019) and Chown, et al. (2019). Cross-therapeutic class and cross-insurer data is from the GAO-19-498. The country-level data is for all branded drugs. The GAO report limits to 920 high spend and high utilization branded and generic drugs. The reported Part D therapeutic classes do not encompass all drugs. Furthermore, the 17 reported insurers are only a sample of Part D insurers. For these reasons, the average Part D rebate is not equal to the average of the reported rebates by therapeutic class or by insurer.