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Blowin' in January's Winds

Under what is called the "noninterference" provision of the Medicare Modernization Act (MMA), the Bush Administration prohibited Medicare Part D officials from negotiating discounted prices with pharmaceutical manufacturers. Instead, the Administration wanted to rely on private sector negotiations conducted by PBMs and health plans. This approach has been anathema to Democrats. Incoming Speaker of the House Nancy Pelosi has said that in her first 100 hours as Speaker she will make sure that legislation reversing the Bush Administration's position will be introduced in Congress.

Allowing Medicare to negotiate drug prices with the manufacturers won't be the first time Uncle Sam has been at the bargaining table with Big Pharma. The Department of Veterans Affairs (VA) negotiates its drug prices. Moreover, the Federal Supply Schedule (FSS) which covers the Department of Defense, the Public Health Service, and the Bureau of Prisons is based on negotiated drug prices.

When leveraging its high volume, the federal government appears to be an effective negotiator. For example, the Congressional Budget Office (CBO) found that the VA obtains discounts of 58% off Average Wholesale Price (AWP) for brand name drugs and that the FSS garners an average of 47% off AWP.

What about the Part D discounts achieved under President Bush's private sector approach? A study by the U.S. House of Representatives Government Reform Committee found that average drug prices under Medicare Part D's 10 leading private plans are higher than the VA and FSS negotiated prices by 84% and even exceed Costco's average prices by 3%.

Turning percentages into dollars, the CBO's "high estimate" (most conservative) is that Medicare (and the U.S. taxpayers) could achieve savings exceeding President Bush's private approach of over $332 billion in seven years if Medicare were allowed to negotiate with the pharmaceutical companies. That's about 24% of the $1.4 trillion in private sector drug spending expected over the next seven years as projected from 2006 Kaiser Foundation data.

So unleashing Medicare's buying power should be good, if not great news, right? If only life were so simple. The likelihood of lower Medicare Part D drug prices may be matched by the likelihood of Big Pharma attempting to recover this "lost" revenue from the private sector. In familiar terms-cost shifting. The Pharmaceutical Care Management Association (the national PBM lobbying organization) has warned clearly if not ominously: "Requiring the federal government to directly negotiate drug prices will take away drug choices for seniors and require massive cost shifting to consumers and employers in the private marketplace."

If Big Pharma's track record in recovering "lost" revenues due to price-capped sales in Western Europe and Canada is any predictor, we probably can expect the drug companies to make strenuous efforts to get back each and every of the $332 billion dollars to be given up in Medicare Part D negotiations.

If we assume that one way or the other Big Pharma is not going to forfeit the $332 billion, the question then becomes who pays how much? If Medicare does not negotiate drug prices, presumably Medicare (U.S. taxpayers) will pay the $332 billion in higher Part D prices. This will be done through the Medicare payroll tax, which is currently 2.90% of pay split equally between the employer and employee. If Medicare negotiations do take place and turn out as expected, and if Big Pharma is able to shift the $332 billion to the private sector, employers will pay about two-thirds of that and employees one-third (if current overall private sector cost sharing averages stay the same).

Is there a villain here? No. It's more likely that it's just business (Big Pharma) acting in its self interest. But what is good for Big Pharma is not necessarily good for corporate benefits budgets and the wallets of employees.

Employers can begin to take steps now to protect themselves and their employees from this possible $332 billion cost shifting "tax". Readily available and effective action steps include:

- Redouble employee education to maximize use of generics and to align plan member utilization with medical necessity and pharmacological efficacy
- Sharpen drug plan design to be consistent with employee education efforts
- Provide better financial incentives and oversight for chronic condition drugs and supplies to maximize patient adherence to physician treatment recommendations
- Proactively analyze medical and drug claim data for specialty drug use. Install plan design defenses against unrestricted consumption. Educate employees about value proposition dilemmas with many specialty drugs.
- Master the intricacies of PBM pricing and be vigilant in the search for the best net, net deals

Taking these actions make sense in today's high-cost prescription drug environment. These actions make even more sense with the prospect of Big Pharma aggressively in search of lost revenue.

HSAs Today

Continuing our series of Questions and Answers about HSAs that are practical but less publicized.

Question: Will an employer's payment of the administrative fees of employees' HSA accounts make the HSAs ERISA-covered plans?

Answer: No. The DOL has stated that the mere fact of an employer paying the HSA's administrative fees will not render the HSA an ERISA-covered plan. The DOL's reason is that since an employer can establish an HSA for employees and make contributions to the HSA without the HSA becoming an ERISA-covered plan, employer payment of administrative fees should not do so either.