

# Ask the Experts

In this and future issues of *MPM*, we ask a panel of experts to comment on a pressing issue of the day. Let us know if you have suggestions regarding experts you would like to hear from or questions you would like to see addressed.

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***Should the federal government negotiate directly with pharmaceutical companies? What would be the consequences on overall health outcomes if they are permitted?***

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**Ruben J. King-Shaw, Jr.**  
*Chairman and Chief Executive Officer  
Mansa Equity Partners, Inc.*

No. Private health plans have established over the years information systems and knowledgeable and experienced personnel to manage the complex pricing, utilization, benefit design, and rebate formula that characterize the pharmaceutical industry. The federal government would need years to recruit and/or train sufficient staff—and would have to acquire new information systems—before it could effectively negotiate with pharmaceutical companies. Moreover, such capabilities would require additional funding for the Centers for Medicare and Medicaid Services (CMS), which is chronically understaffed and underfunded to perform its current set of responsibilities.

As we have seen in most current applications of so-called “evidence-based medicine,” government agencies tend to prefer the lower cost, established, branded drugs and generic drug items. This often creates a bias against newer, more cost-effective items. In addition, the federal government could only achieve substantial savings

by implementing a restrictive formulary or preferred drug list. While private plans must respond to physician and patient preferences and allow flexibility and choice within formularies, the federal government would be less pressured to do so. Hence, physician choice and patient preferences would likely suffer in federal government negotiations with pharmaceutical companies.



**Benjamin Zycher, PhD**  
*Senior Fellow  
Manhattan Institute for Policy Research*

The latest scheme to steal from the future to buy votes today is reflected in the various proposals to mandate direct negotiations between the federal government and the pharmaceutical producers over the prices of medicines offered in the Medicare Part D drug program.

Now, the federal behemoth indeed could garner big discounts on Medicare drugs, as it does for veterans’ and other drug programs. And that sounds great, particularly for the winners in this particular game of wealth redistribution by government. On the other hand, if government can bestow goodies upon some today, it also can smile upon others tomorrow; everyone is a potential loser when government plays Robin Hood.

More narrowly: There are no free lunches, so “cheap” drugs will carry a cost. Recent research shows that substantial reductions in drug prices automatically yield lower returns to investments in the research and development of new and improved medicines. Those investments will decline. Even small annual price reductions would yield large adverse effects over time: a loss of about 200 drugs over a 20-year period. The result in terms of life expectancies would be a decline of about 5 million expected life-years annually; even a very low assumption about the value of an expected life-year results in an economic cost of \$500 billion per year, far more than the entire US market for pharmaceuticals.

Moreover, government has interest groups rather than customers, and thus powerful incen-

tives to pursue budget savings at the expense of patient well-being; that is why the veterans' drug formularies (lists of approved drugs) are only about half as large as those of the private Part D formularies.

Maybe cheap drugs wouldn't be such a great deal after all.

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**Vincent A. Galletta, MS, RPH**  
*Manager, Long-term Care Operations*  
*Buffalo Pharmacies Institutional*

At this time, we should not change the Medicare Part D system for price negotiation. Cost of the program is lower than initial projections. We are only in year 2 of the benefit. The current system should be given more time. The financial dealings between CMS, the private drug plans (PDPs), the pharmacy benefit managers (PBMs), and the manufacturers is supposedly transparent. CMS and the Congressional Budget Office (CBO) should be able to track and audit rebates and costs to ensure that CMS and beneficiaries are truly receiving the best price. If inappropriate financial dealings are found, a change should be considered. Health outcomes are dependent more on medication therapy management (MTM), formulary availability, and plan selection. Giving the pharmacist a greater role in the above can impact outcomes.



**Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD**  
*Editor-in-Chief, Medicare Patient Management*  
*Founding Executive Director*  
*Health Policy Institute, University of the Sciences in Philadelphia*

The answer is a resounding NO. The reason revolves around the consequences on overall health outcomes if this is permitted. To see those effects one needs look no further than what is currently going on with Medicare physician services. Because of the way that Medicare calculates physician reimbursement, 2008 payments will be cut by 10%. According to an American Medical Association (AMA) survey, this will result in:

- 60% of doctors limiting the number of new Medicare patients they accept
- More than two-thirds deferring the purchase of needed information technology in 2008
- 50% reducing their staff

- 14% no longer treating patients

Now let's fast forward some 15 or 20 years after the federal government has begun negotiating—or rather setting—prices (as they do in every aspect of health care because of their dominant size). As a result of the federal involvement, we would see exactly what is now happening with physician services. Instead of 60% of physicians limiting their care to the elderly population, we would have 60% fewer pharmaceuticals available. If 66% of pharmaceutical companies defer their purchase of technology and 50% reduce staff, where would pharmaceutical innovation be left? I can tell you—pharmaceutical innovation would be exactly where physician practice innovation is today—in a very sorry state. Despite the innovation that we have seen in other industries (for example, FedEx's technology that allows us to track packages as they cross the country, knowing exactly where they are), many of us today waste time trying to find our patient's paper chart during our hospital rounds.

Part of the reason that we are even debating this issue is that we are constantly locked in a “short-sighted politically driven zero-sum game” instead of working as an interdisciplinary team focused on improving healthcare outcomes. Even the current physician debate for increased reimbursement falls into this shortsightedness. Rather than argue for appropriate reimbursement on the ground of quality outcomes, the AMA and others argue that the cost of reversing future physician reimbursement cuts should be offset by making payments to private Medicare Advantage plans (which currently are 12% higher on average than traditional Medicare payments) equal to reimbursements for traditional Medicare. AMA further points to the fact that in its survey, fewer than 1 in 5 doctors said that the additional payments to Medicare Advantage plans should continue. Everyone constantly misses the point!

We need to stop bashing our teammates who are working to improve quality through integrated systems of care and instead start working together to improve our healthcare system for the long haul. Clearly extending Medicare's control over the one aspect of health care in which the US dominates in innovation and quality—pharmaceuticals—will have the same consequences that our current reimbursement of physician services is having—a catastrophic tipping point. Health care must focus on quality outcomes first and foremost, and that requires necessary resources and incentives.

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