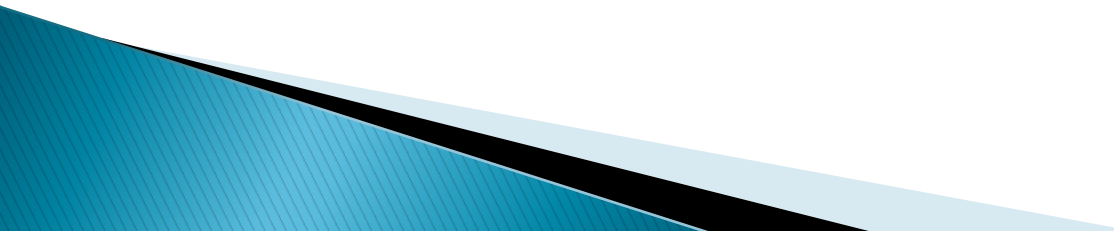


Framework for Negotiation in Part D of Medicare: Incentives and Reinsurance

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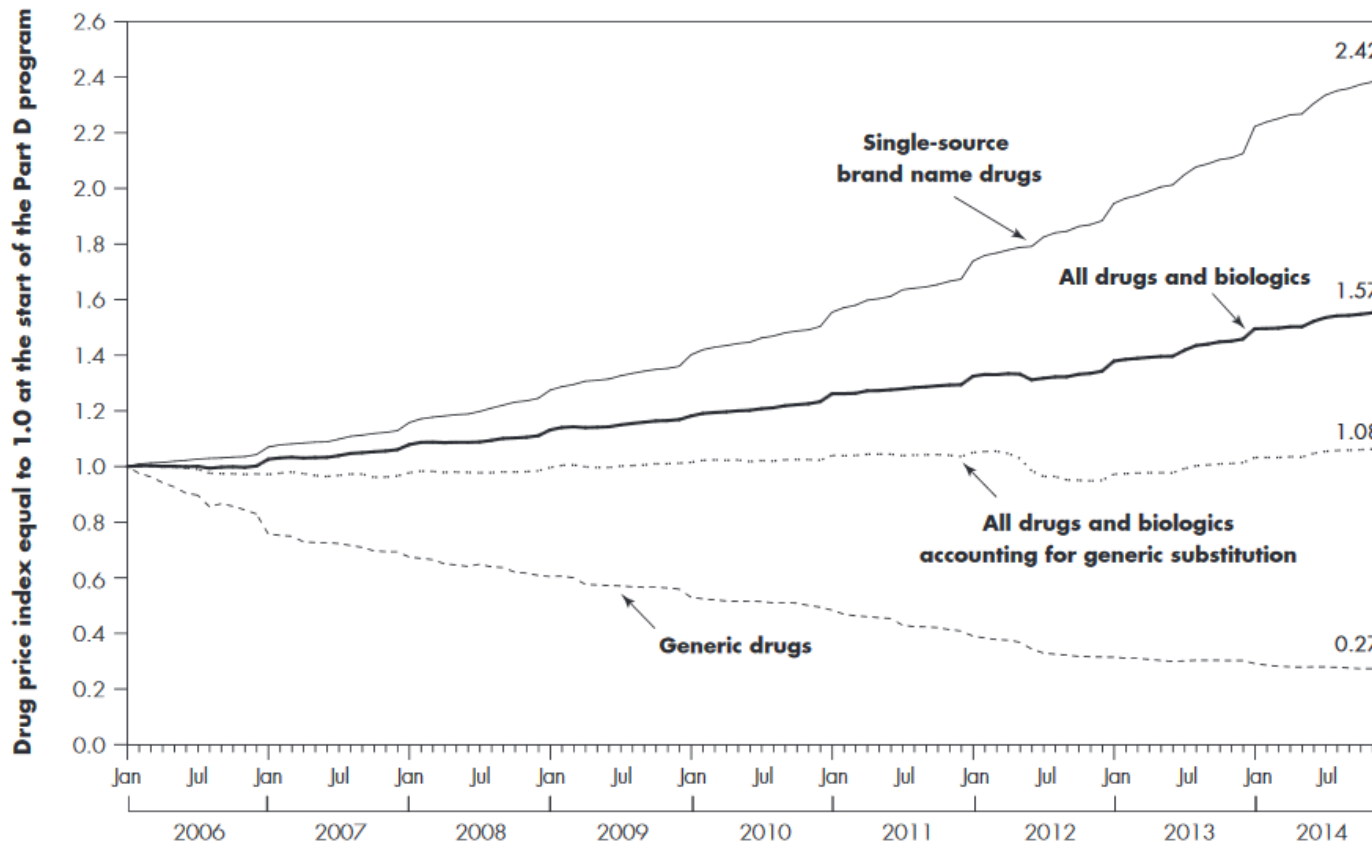
Outline

- ▶ The Problem
 - ▶ Market Power and Nearly Complete Insurance
 - Monopoly Insurance Subsidized Consumption (MISC)
 - Reinsurance—applies after consumer pays \$4950
 - Double insurance
 - Consumers subsidized in cost sharing
 - Plan subsidized
 - ▶ Towards a Negotiated Value Based Pricing
 - ▶ Observations
- 

Price Trends

**FIGURE
14-5**

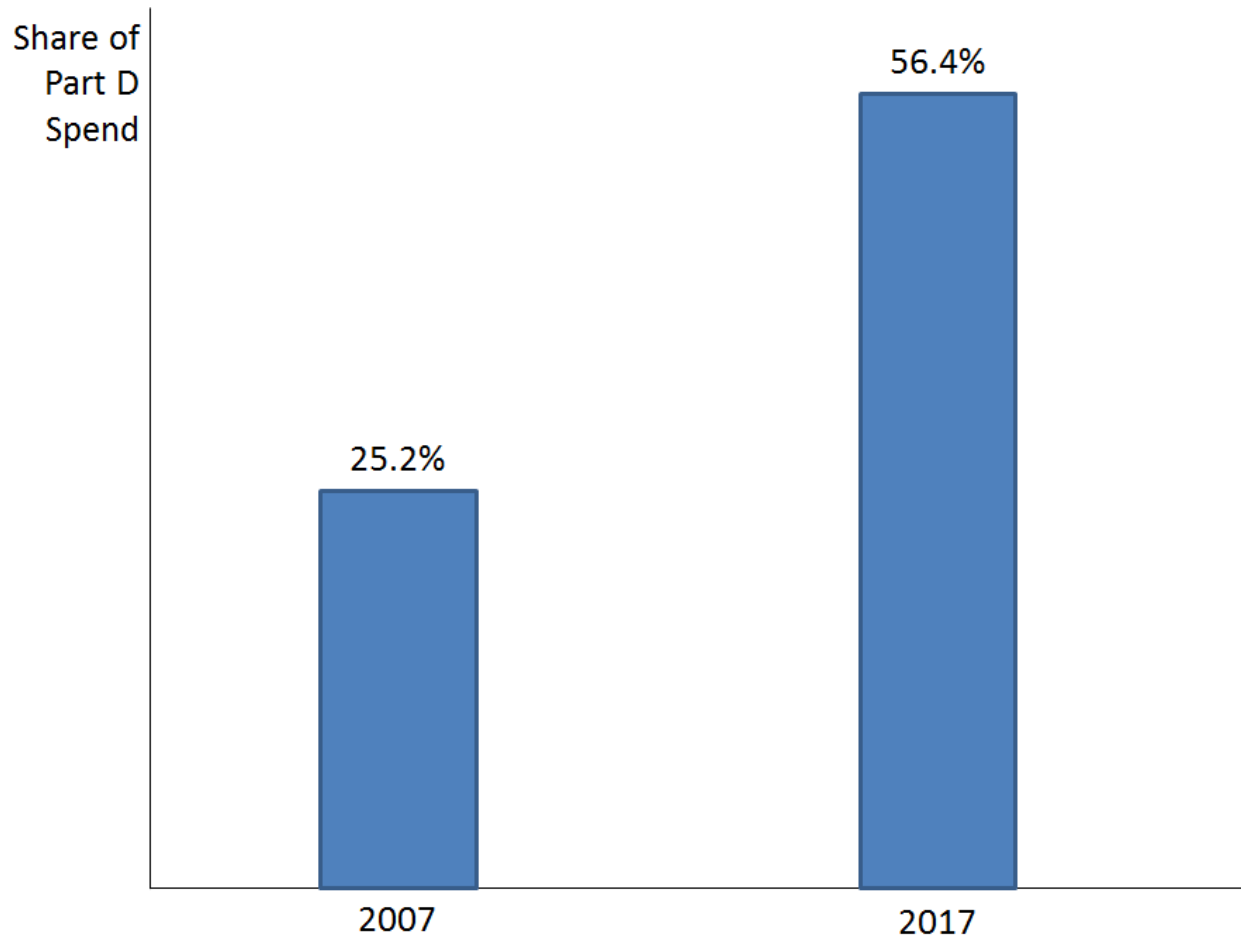
**Price increases for brand-name drugs are overwhelming
the effects of using lower priced generics**



Note: Chain-weighted Fisher price indexes.

Source: Acumen LLC analysis for MedPAC.

Reinsurance Share of Part D Spend

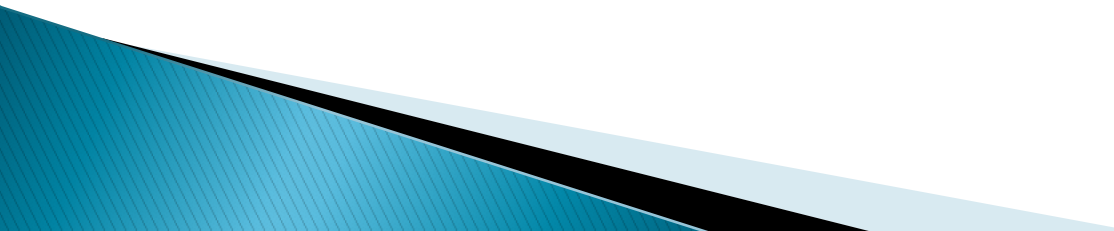


Source: MedPac 2017 March
Report to Congress

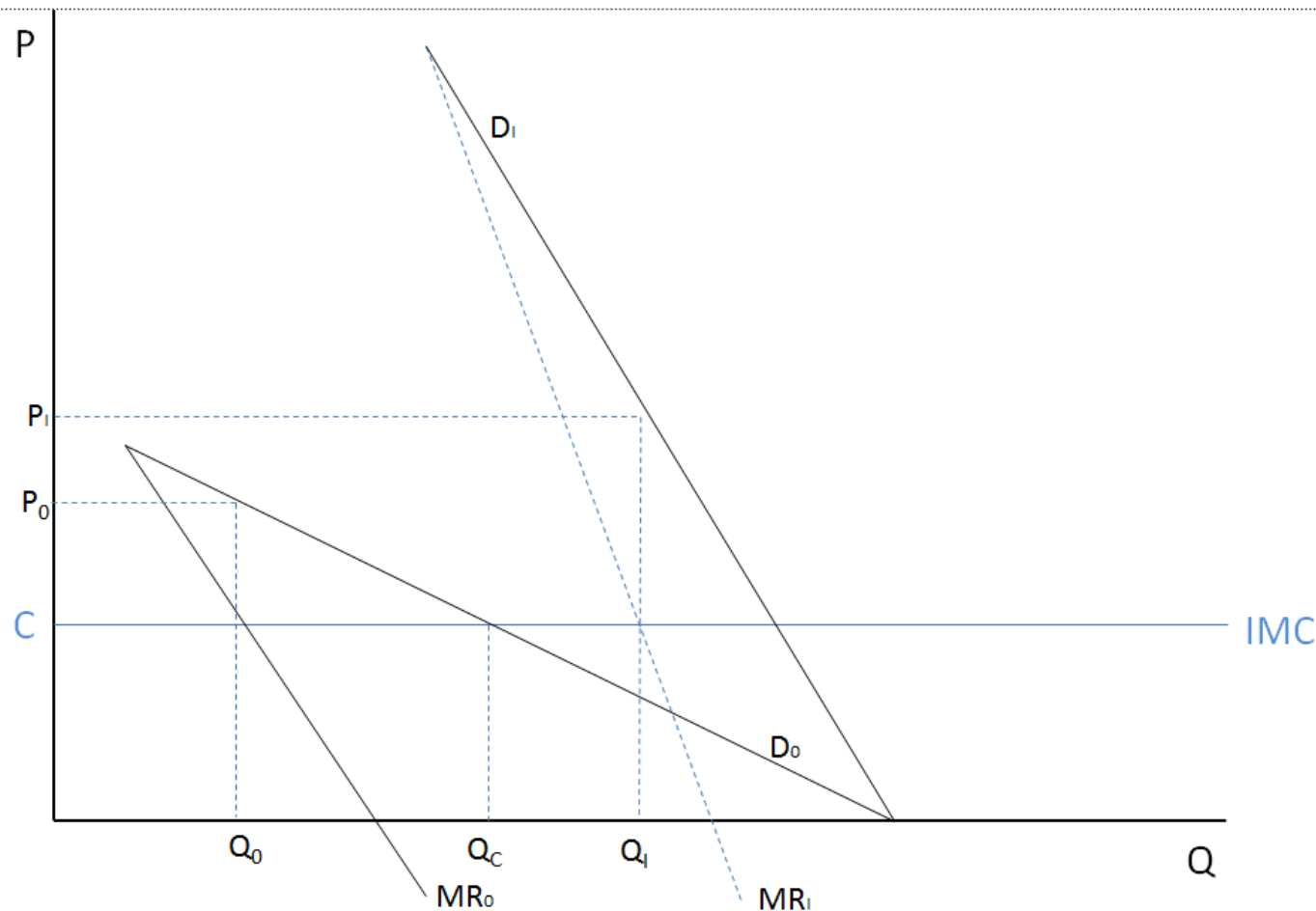
Reinsurance Risk Sharing

- ▶ Consumer subsidy: patients pays 5%
 - ▶ Plan subsidy: plans pay 15%
 - ▶ Federal Government pays 80% of “cost”
-
- ▶ 65% of reinsurance benefit spending was for high cost drugs (OIG, 2017)

Incentive Distortions for Plans

- ▶ Reinsurance subsidy by government, allocation rules, rebates from pharmaceutical manufacturers
 - ▶ Incentives for formulary placement of high cost drugs
 - ▶ Incentives to negotiate are dampened
 - ▶ Market power and double insurance
- 

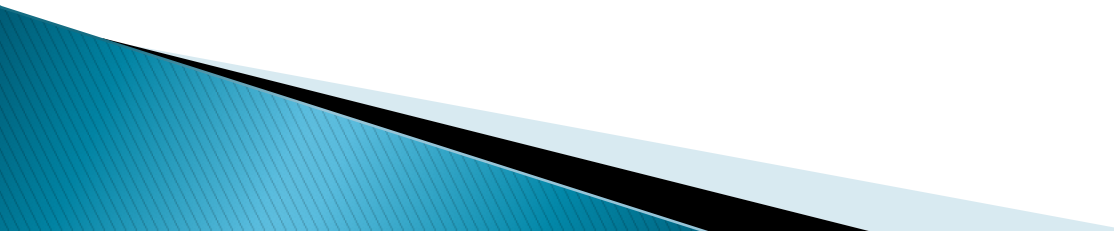
Market Power and Nearly Complete Insurance: MISCs



Profitability and R&D

- ▶ Strong evidence suggesting positive relation
 - New drugs (Acemoglu and Linn, 2004; Dubois et al, 2014; Yin, 2008)
 - Higher R&D spending (Scherer 1996, 2001)
- ▶ Evidence that relationship is subject to diminishing returns
- ▶ Many new drugs use existing mechanisms and occasionally “novel” (Dranove et al, 2015)

Towards Negotiated Value Based Purchasing for MISCs

- ▶ Targeted and Temporary Negotiated Prices
 - ▶ Target high cost drugs w/market power selling in the reinsurance benefit
 - Modest number
 - ▶ Constrain negotiations to prices that yield economic profits
 - ▶ Cover drugs and specify a default price (operative if negotiations fail or performance is subpar)
- 

Value Based Pricing

- ▶ Builds on the economics of prizes and two-part pricing

- ▶ $P_t = P_{0t} + b_t(q)$

Where t indexes time, P —full per unit price; P_0 default price; q —quality or outcome schedule of bonus payments; b —per unit bonus payment

- Default and bonus payment depend on year
- ▶ Default payment approaches
 - Using experiences of other countries (as is often done in Europe)
 - Ad hoc rate setting
 - Linked to development costs in industry
 - $P_0 = \alpha C$;
 - Where C —expected development costs for a drug in a particular therapeutic class; α —percentage of costs (development costs) covered by the default payment
- ▶ Negotiations would focus on $b(q)$ that consists of the amount of the bonus and the criteria for payments

Concluding Comments

- ▶ Markets work much of the time in Part D
 - ▶ Focus on distorted incentives and market failure where negotiated prices likely to improve welfare
 - Negotiated prices would be temporary
 - ▶ Negotiation structure creates incentives to bargain and constrains government to prices that generate economic profit in expectation
 - ▶ Meaningful savings and rewards targeted at highest health impact drugs would likely result
 - ▶ Negotiated arrangement could be incorporated into scheme with large bonus and prices near marginal cost
- 