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.

- **Single-source brand name drugs**
- **All drugs and biologics**
- **Generic drugs**

**Note:** Chain weighted Fisher price indexes.

**Source:** Acumen LLC analysis for MedPAC.
Reinsurance Risk Sharing

- Consumer subsidy: patients pay 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; \( \alpha \)–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
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