How Do Commercial Insurance Plans Fare Under Proposed Prescription Drug Price Regulation?

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The 2 leading current proposals to control prescription drug pricing in the US, H.R. 3 and H.R. 5260, propose new negotiation authority for the Secretary of Health and Human Services to establish prices for selected high-expenditure drugs. These policies seek to benefit Medicare beneficiaries, taxpayers, commercial insurers, and their beneficiaries and are expected to save patients, payers, and taxpayers half a trillion dollars over the next decade.1

While the prospect of federal price negotiation of drugs for all US payers has been discussed for decades,2 the current debate in the US Congress has raised the possibility of a policy design that would be limited to Medicare only. Such a policy design has led to concerns regarding direct harm, namely that passage of a Medicare-only policy will cause pharmaceutical companies to increase the prices of drugs paid by commercial insurers and their beneficiaries. This unintended consequence is colloquially termed cost shifting.

Cost shifting occurs when a private firm acts to offset losses in revenue from regulations that establish lower prices in Medicare by increasing drug prices on nonregulated payers. While this might have some intuitive appeal, the contention in the US prescription drug market is inconsistent with standard economic models of profit-maximizing firms.3 According to theory, pharmaceutical companies set the price of their products at the point which maximizes their profits, given the demand that they face and the marginal costs of production, which are generally accepted to be very low compared with current prices. Price regulation that applies to Medicare only splits demand for a drug into 2 purchasing streams: the first, the purchaser for which regulation has made them more price sensitive (Medicare), and the second, the purchaser with the same price sensitivity as before the regulation (commercial plans). As a result, the price charged by the profit-maximizing pharmaceutical company for their drug to Medicare is expected to fall, but this change should not have any effect on the price charged for the drug to commercial plans and their beneficiaries because their demand remains unchanged.

This theory stands in stark contrast to the legions of private insurance executives who assert that cost shifting is the norm necessitated by underpayments from federal programs. The economic theory has been largely supported by empirical evidence drawn from the actual experiences of hospitals in the face of their own reductions in price paid by Medicare.4 Therefore, economists and many policy makers tend to view with skepticism industry claims of inevitable, large-scale cost shifting for existing drugs.3

However, there are 2 reasons pharmaceutical companies may respond to increased price regulation in Medicare by raising drug prices charged to commercial plans and their beneficiaries. Both are related to the types of cost-shifting behavior which pharmaceutical companies could be posited to pursue in reaction to a Medicare-only negotiation policy: one related to drugs that are already available for use and the other related to new drugs that have yet to launch in the US market.

First, the drugs targeted for price negotiation are sold by pharmaceutical companies acting as monopolists, not hospitals that frequently operate in relatively competitive markets.2 The market for drugs is markedly different compared with that for hospital services: current Medicare law prohibits price from being considered in the decision to cover a new drug. The proposed legislation also focuses on high-priced drugs that have little or no therapeutic competition. Many of these drugs are administered intravenously by clinicians, and therefore patients are unable or reluctant to switch.

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Moreover, while out-of-pocket costs can sometimes be high, the bulk of the price for most people is covered by insurance. Although insurers and intermediaries, such as pharmacy benefit managers, can restrict access through prior authorization and other utilization management tools, they may be reluctant to do so for the management of diseases with limited therapeutic options. As a result, a pricing change in Medicare-only would not meaningfully alter these companies’ current pricing incentives. Demand will remain strong for these products, even if prices go up and consequently commercial plans will continue to face a seller with monopoly pricing power for many drugs. Only the government can serve as a counterbalance to the monopoly pricing power of pharmaceutical companies.

Second, even in the presence of high price levels, pharmaceutical companies selling drugs without competitors raise prices higher over time. Price increases for many drugs each year exceed the general inflation rate or the growth in labor and material costs. Such behavior is inconsistent with the notion that prices are optimized for profit maximization at the outset. Approval of supplemental indications, additional information about the benefits associated with treatment, and potential increases in manufacturing costs also do not appear to explain these price increases after launch. One alternative explanation is that companies pursue a pricing strategy that is not the full profit-maximizing monopoly price at launch to ensure greater market adoption and minimize concerns over public opinion and political backlash. If new regulations were to threaten profits and potentially compromise their standing with shareholders and Wall Street analysts, pharmaceutical companies may well accelerate price increases.

This leads us to the second type of price response to Medicare-only negotiation that relates to setting the prices of new drugs. Pharmaceutical companies strongly prefer to launch new drugs in the US first, where they fetch the highest prices and are the most profitable. We do not believe Medicare-only negotiation would cause the companies to raise the launch prices of new drugs in European Union member countries to make up for the Medicare revenue shortfall. Pharmaceutical companies have dismissed this as a possibility, reaffirming that there is no direct relationship between US drug prices and foreign prices. However, pharmaceutical companies could raise launch prices on commercial insurers in the US, since commercial payers do not enjoy state-sanctioned abilities to reject excessive prices and have to answer to the fears of employers and consumers. The pharmaceutical industry has pursued powerful promotional campaigns aimed at stoking public fears of rationing access to counter any prospect of reform.

In sum, the US system of paying for prescription drugs puts virtually no limits on the prices that pharmaceutical companies can charge for drugs that face little competition. Companies have built their business models around the assumption that these rules will remain unchanged. Yet, in a democracy, the rules by which companies operate can and do change if and when maintaining the status quo becomes untenable for enough engaged citizenry. Only time will tell if this is the tipping point when policy makers pursue reforms ensuring value-based pricing for prescription drugs. When they do, it seems prudent to extend prices negotiated by Medicare to the private sector. This will ensure there are no other ATMs out there for the pharmaceutical industry to exploit in the US.

ARTICLE INFORMATION


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REFERENCES