

A Dangerous Medicare Proposal

By Tomas J. Philipson

Medicare Part D, the prescription-drug benefit program for seniors, has cost the federal government considerably less than was initially estimated. It's also overwhelmingly popular among beneficiaries. But in Washington, Part D is now a prime target for overhaul. In the heat of debate over the debt ceiling, President Obama and a group of lawmakers led by Rep. Henry Waxman (D., Calif.) and Sen. Jay Rockefeller (D., W.V.), have proposed lowering the deficit by eliminating one of the very things about Part D that makes it such a success.

That thing is competition. Part D works—and stands out among federal entitlement programs—because it harnesses market forces to save money for the government and beneficiaries. Drug companies compete for the right to sell their drugs to the private insurers who participate in the program. Those private insurers, in turn, compete to offer their plans to the Medicare enrollees.

The result is a program that was supposed to cost \$551 billion between 2004 and 2013, but actually is on tar-

get to cost just \$375 billion, 32% less than the Congressional Budget Office's original estimate. The competitive bidding process—aided, in part, by patent expiration of brand drugs—drives down the costs to both the beneficiaries and the taxpayers.

Price controls on Part D drugs would cripple medical innovation and undermine a successful federal entitlement program.

To grasp how successful Part D has been, consider this: While health-care costs for the average American almost inevitably go up year after year, Part D enrollees have seen their payments decline each year. This year, seniors are paying \$30 per month, on average, for their drug plans. They were expected to pay \$53. By any measure, this is a remarkable accomplishment for a government entitlement program.

Yet the president and his allies in the House have proposed implement-

ing precisely the kind of price controls in Part D that make other parts of Medicare so inefficient. Specifically, they want to force drug makers in the Part D program to give the government the same rebates that they are forced to offer under Medicaid. (That's about 23% off the average market price for brand-name drugs and about 13% for generic drugs.)

Advocates of this plan believe it will drive down the cost of care. They are wrong, for two main reasons.

First, because the rebates would be based on prices outside the program, drug companies would have no incentive to discount prices for other consumers. This would have the most impact on breakthrough drugs, as they could enter the market more easily at higher prices. Because the Part D price controls would be tied to prices in the private market, offering more favorable prices in the private market would be less attractive to drug companies because it would lower prices paid in Part D.

So the government could actually end up costing non-Medicare consumers millions in inflated drug prices in the private market. This is one of the hidden evils of price controls: It affects consumers who aren't even involved in the program.

Second, what matters to patients is the cost of better health, not drug spending per se. Having no drug to treat a condition makes patients worse off, even if they don't buy any drugs.

Some policy analysts dismiss the argument that medical innovation is driven by profits. But the facts tell the opposite story. Lack of potential profits is exactly the reason why diseases that afflict poor countries receive few R&D dollars.

Venture capital funding for the biotech that kick-off research for new drugs is completely contingent on strong signs of profitability in terms of intellectual property, disease prevalence and reimbursement. The government's proposed price controls will ultimately cause some of this funding to dry up entirely.

This is the rerun of a much too familiar story: The more a government gets involved in paying for care, the

more it will use its power as a big buyer to force down prices to providers. This has already happened in other parts of Medicare and many European countries. Indeed, one can argue that individual European governments act rationally in holding down prices because the global profits that support innovation come from the U.S. market.

For the U.S., this story will not end as happily. By threatening the worldwide profitability for their patented drugs, price controls put drug companies on a collision course with basic intellectual property policy.

Intellectual property laws like patents are designed to enable innovators to mark up prices enough to cover their R&D costs—roughly \$1 billion per medicine developed—and make a normal profit for their shareholders. Their earnings encourage innovation and help fuel the next round of research.

Price controls undermine this system. Although no sensible policy maker would propose abolishing patents, price controls essentially have the same economic effect. So while bashing drug-company profits may make for good political theater, the price controls that result from such rhetoric leave future patients to die because of stunted innovation.

We can do better. The key to continued American medical innovation is means-testing entitlement programs. Actual market pricing for the rich will result in better incentives for biopharmaceutical research, with more valuable innovations commanding higher prices. Lower prices for the poor will increase their consumption of drugs, which is also good for innovation.

It turns out that in addition to its competitive structure, Part D also has the strength of being relatively more means-tested than other parts of Medicare. The bottom line is that Part D's model works and it should be extended into other parts of Medicare—not vice versa.

Mr. Philipson is a professor of public policy at the University of Chicago. He is also a partner at Precision Health Economics, which consults private and public payers, as well as manufacturers.

THE WALL STREET JOURNAL

Published since 1889 by DOW JONES & COMPANY

Robert Thomson
Editor in Chief

Rupert Murdoch
Chairman

Gerard Baker, Deputy Editor in Chief

DOW JONES MANAGEMENT:
Todd Larsen, President
Kevin F. Halpin, Chief Financial Officer
Mark H. Jackson, General Counsel
Gregory Giangrande, Chief Human Resources Officer

DEPUTY MANAGING EDITORS:
Michael W. Miller, Senior Deputy; Rebecca Blumenstein; Deborah Brewster; Alex M. Freedman; Alan Murray; Matthew J. Murray; F. James Pensiero; Ann Podd; Elyse Tanouye

OPERATING EXECUTIVES:
Allisa Bowen, Digital
Christine Brendle, Asia
Edwin A. Finn, Jr., Barron's
Andrew Langhoff, Europe
Joe Lanza, Financial Markets
Scott D. Schulman, Corporate Markets

Neal Lipschutz, Newsires Managing Editor
Kevin Delaney, Managing Editor, WSJ.com

Paul A. Glogot, Editor of the Editorial Page
Daniel Henninger, Deputy Editor, Editorial Page

VICE PRESIDENTS:
Dean A. Del Vecchio, Chief Information Officer;
Jennifer Jehu, Senior Vice President, Marketing;
Kelly Leach, Senior Vice President, Strategy;
Bethany Sherman, Chief Communications Officer;
Ian Weston, Senior Vice President, Special Projects;
Joseph J. Cantamessa, Security;
Howard Hoffman, Communications

WALL STREET JOURNAL MANAGEMENT:
Michael F. Rooney, Chief Revenue Officer;
Lynne K. Brennan, Circulation; Joseph B. Vincent, Operations; Sandra Baez, Advertising Operations;
Daniel J. Bernard, Digital Product Chief; Chris Collins, Advertising; Larry L. Hoffman, Production;
Jim Richardson, Brand & Research; Andrew Sippel, Marketing

EDITORIAL AND CORPORATE HEADQUARTERS:
1211 Avenue of the Americas, New York, N.Y., 10036; Telephone (212) 416-2000.
Subscription Services: Call 1-800-JOURNAL, <http://services.wsj.com>

DOW JONES
A NEWS CORPORATION COMPANY