Why Medicare (Unlike Medicaid and the Veterans Health Administration) Cannot Negotiate Prescription Drug Prices

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Introduction & Background

The national conversation around health care reform has been approached from many angles, but the general consensus is this: the United States is spending more on health care, and getting less in return, than any other comparable country.¹ There are many reasons why this is the case, and health policy experts have been trying to get to the bottom of this problem for years. One case they make for astronomical health care costs is the rising price of prescription drugs.² Both Democrats and Republicans have emerged as critics of this issue, placing the blame on the pharmaceutical industry and their powerful lobby.³ In a Congressional hearing last February, Senator Sherrod Brown (D-Ohio) challenged pharmaceutical executives, telling them, “We cannot continue to give Big Pharma the blank check that you have had to pay for high-priced prescription drugs.”⁴ Senator Cassidy (R-La.) argues that the burden should not be placed on the government to pay for these expensive drugs, since the cost eventually falls on taxpayers. He says “if the taxpayer is paying that money… it is almost as if the taxpayer has ‘stupid’ written on their face, which they should not. That is unfair.”⁵

However, legislators discount the role they have had in this crisis. Nearly one third of prescription drug spending is through the Medicare Part D prescription drug benefit,⁶ but

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⁵ *Drug Pricing in America*, 51.
Medicare is restricted from negotiating drug prices, allowing manufacturers to essentially fill out the “blank check” that Brown references. The prescription drug cost debate has been centered around this restriction and giving the United States government the power to directly intervene on behalf of insurers to lower costs for Medicare Part D patients, a proposal that over eighty percent of Americans support but has been met with fierce opposition from pharmaceutical companies.\(^7\)

Both policymakers and health policy experts who bemoan the cost of prescription drugs cite other government health care systems, such as Medicaid and the Veterans Health Administration, as examples of the possibilities available to Medicare if they could just remove the noninterference clause. But they rarely take an analytical view at why those systems were able to obtain lower drug prices in the first place.\(^8\) Because of the fragmented nature of our health care system, those disparate plans were easily obscured in the fog of government bureaucracy, and many are unable or unwilling to ask the question we need to answer to solve this puzzle: what are the politics that gave Medicaid and the VHA the ability to negotiate for lower drug prices in the early 1990s, while restricting Medicare from doing the same just over a decade later?

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To discover the politics around why Medicaid and the VHA were granted permission to negotiate, while Medicare was left out, and why nothing has been done to rectify this, I will look at each of the three laws and their stories. After uncovering each of their stories, I will examine the factors that led to these bills’ success. Through a careful analysis of the influence that institutions, individuals, ideas, and interests had on these bills, we will discover the real reason Medicaid and the VHA are able to obtain lower drug prices while Medicare continues to drive politicians crazy.

**Medicaid and the Drug Rebate Program**

Medicaid is a joint federal and state health insurance program that primarily supports low-income people and can also act as a supplement for Medicare recipients when their medical expenses are not fully covered. Under the Medicaid drug rebate program, enacted in 1990 under the Omnibus Budget Reconciliation Act, Medicaid “pays a net price that is consistent with the lowest or best price that manufacturers charge other payers for the drug.” Drug manufacturers do this by providing direct rebates to state Medicaid programs that the Secretary of Health and Human Services negotiates with the companies, on behalf of the states. The companies that complied would be guaranteed coverage under the state Medicaid prescription drug programs.

A great deal of the success of the rebate program can be owed to Senator David Pryor (D-Ark). Without Pryor’s persistent interest in the pharmaceutical industry, the rebate program may have never been established. He was elected to the United States Senate in 1978, after serving as

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a U.S. representative and as governor of Arkansas. Pryor’s focus was always on the elderly. As Senator Donald Riegle (D-Mich.) recalled to Pryor during a subcommittee hearing, “My mind goes back 24 years to when we were serving together in the House of Representatives and the great concern you had about what was going on in the lives of senior citizens at the time… this is not a new interest of yours. This is an interest that stretches back at least two and a half decades.” Pryor announced his attention to take on the drug industry in December 1988, according to the Congressional Quarterly. Pryor noted, “I frankly think there’s a lot of greed out there… [The drug companies] say they need to spend all this money on research and I just don’t buy that.” In 1989, Pryor became Chairman of the Senate Special Committee on Aging, where he “investigated the pricing practices for prescription drugs. … His efforts helped change the pricing behavior of pharmaceutical companies.” While Pryor and his Aging Committee began investigating pricing practices in August 1989, they realized that while Medicaid and Medicare were not providing adequate prescription drug care to their patients, there was one organization that was: the Veterans Health Administration. They asked a similar question to the one I am addressing in this paper: “How can the Medicaid and Medicare programs achieve the efficiencies in purchasing pharmaceuticals that the Department of Veterans Affairs has already realized?”

In a follow up report the next January, the committee declared that “it isn’t just the eldest

Note that at this time, the VHA was a part of a purchasing program that allowed for discounts on prescription drugs. See later in this paper for further.
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Americans who are suffering. State Medicaid programs that serve the poorest Americans have struggled through this decade – by chopping and chiseling at their drug coverage.” As a result of these reports, Pryor introduced multiple bills addressing the high cost of drugs, S. 2605 and S. 3029.

S. 2605, the Pharmaceutical Access and Prudent Purchasing Act, was introduced in May 1990. According to Pryor, it “saves money by requiring manufacturers to bargain over the price of their drugs.” The bill would create a National Pharmacy and Therapeutics Committee to “continuously review and evaluate… the relative safety and efficacy, and the comparability, of covered outpatient drugs approved for marketing in the United States.” Once the drugs had been grouped into similar categories, drug manufacturers would compete to offer the lowest price for their drug to state Medicaid programs. Whichever manufacturer was able to negotiate the lowest price would be able to sell their “preferred” drugs to that state almost exclusively. Pharmaceutical companies, anticipating a bill like this after the Aging Committee’s reports, immediately went full throttle on opposing the legislation. Industry executive Paul Freiman called S. 2605 everything from “cumbersome and complex” to “scientifically unsound” and even “unconstitutional.” Pharmaceutical companies began proposing their own solutions in order to avoid being forced into compliance if Pryor’s legislation were to succeed.

As a “response to the industry alternatives,” Pryor introduced a less extreme bill, S. 3029: the Medicaid Anti-Discriminatory Drug Price and Patient Benefit Restoration Act, in

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September. The Act introduced the idea that drug manufacturers simply pay Medicaid the “best price” that they offer any other purchaser, by providing a rebate directly to Medicaid for as much as the difference between their price and the best price. Pryor knew that this was the best strategy to defeating the drug lobby, because the term “best price” was taken directly from plans that some companies had offered up. Those companies were the ones who offered similar prices across their markets, guaranteeing that even their “best price” would not be much of a discount. By accepting their proposal, Pryor guaranteed that later pushback would not be as strident. Even though the bill did much to address the concerns raised from S. 2605, and demobilized a wing of the pharmaceutical industry, it still was not enough. As Pryor declared in a September committee hearing on the two bills, “We have all seen an extraordinary, well-financed campaign by [the Pharmaceutical Manufacturers Association] and its member drug companies to roll onto Capitol Hill in an attempt to defeat both of these pieces of legislation. I do not mind a good fight. In fact, I enjoy a good fight.”

Pryor got his fight and then some: neither of those bills made it out of the Senate. But he was not done. Pryor saw his chance a few months later, as Congress negotiated with the White House to pass a budget for the 1991 fiscal year. President Bush was facing a serious cost containment issue. At the 1988 Republican National Convention, President Bush promised that he would not establish any new taxes as a way to generate revenue. However, like many

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20 Medicaid Prescription Drug Pricing, 4.
23 Medicaid Prescription Drug Pricing, 4.
campaign promises, that did one did not end up coming true. As the White House struggled to find ways to tighten the 1991 budget without instituting taxes, Bush turned to the government health care programs to look for potential places to cut costs. They identified prescription drug prices as something they could cut down on without actually reducing coverage, by simply getting companies to charge the government less for their drugs. The topic of cost containment through prescription drug pricing reform started at the Andrews Air Force budget negotiation session in the summer of 1990.\textsuperscript{25} However, the Office of Management and Budget’s proposals to allow pharmacists to substitute similar drugs without doctor oversight in what they called “therapeutic substitution” had been met with strong opposition not just from the drug industry but from consumer groups that would generally applaud lower costs.\textsuperscript{26}

The Pharmaceutical Manufacturers Association, under the guidance of President Gerald J. Mossinghoff, did their best to conflate the OMB plan with Pryor’s bills. They put forth a paper called “Leading Organizations Speak Out in Opposition to Restricted Drug List/Therapeutic Substitution.”\textsuperscript{27} Although Mossinghoff claimed they meant to say “and/or,” the damage was done. With so many groups, such as the American Medical Association, the American Diabetes Association, the Epilepsy Foundation, the American Society of Health-System Pharmacists and the American Society for Clinical Pathology, assumed to be in opposition, Pryor had to find a way forward.

The White House was still interested in pursuing cost containment measures. By the end of September, a new plan based off of S. 3029 was proposed, using the idea of best prices and setting minimums and maximums on rebate amounts.\textsuperscript{28} Although some drug companies were

\textsuperscript{25} Medicaid Prescription Drug Pricing, 46.
\textsuperscript{26} Medicaid Prescription Drug Pricing, 46.
\textsuperscript{27} Medicaid Prescription Drug Pricing, 47.
\textsuperscript{28} Berman, 48.
unhappy, the ones who had introduced the idea of best prices in the beginning were mollified. This time, the opposition came from Congress itself. While the rebate program had been worked out, President Bush went back on his campaign promise of “no new taxes” in order to prioritize reduced spending. The House was furious, and in a “stunning defeat,” rejected the budget in protest.  

After that failure, each chamber of Congress worked to pass their own budget, intending to settle differences in the budget reconciliation process. Because reconciliation only requires a simple majority in the Senate (no filibusters are allowed), it makes legislation easier to pass. In budget reconciliation, each Congressional committee writes its own budget bill, adjusting expenditures and cutting costs. Once that is done, each committee’s bills are combined into one big bill: the omnibus bill. Congress can use this loophole to tack on legislation that may be only tangentially related to this budget in what is known as “the express train.” Because the bill encompasses so many different issues, debate on any one issue is limited, and more controversial measures can ride through without much pushback.

On November 5, 1990, the Omnibus Budget Reconciliation Act by President George H.W. Bush. The House of Representatives passed their version of the bill 227 – 203. Although not entirely a party line vote, 227 Democrats voted for OBRA-90 while 163 Republicans voted against it. In the Senate’s version, it passed 54 – 46, with about an equal number of Democrats

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32 Gilman, 122.

and Republicans for and against it. After the House and Senate each passed their own version of OBRA-90, the House Ways and Means Committee, the House Energy and Commerce Committee, and Senate Finance went into conference. The private nature of the conference means that reporters and constituents are kept in the dark on the negotiations that occur; it also means that lobbyists are not able to utilize their lobby as well in this final stage. Even after the more important parts of the bill had been decided on, the conferees stayed to work out the final details of the rebate program.

The Medicaid drug rebate program had a lot on its side: a senator who cared deeply about the issue, a provision that pitted drug companies against each other, and the timing of an omnibus bill to slide in the program. Although special interest groups negotiated with Congress about the specifics of the bill, for the most part it was a simple political struggle with all of the typical key players. In the end, the program was not “what Senator Pryor would like, it is not all that patients would like, it is certainly not what the research-based pharmaceutical industry would like – but it is, as it stands, something that most of us can and should support.”

The Veterans Health Administration and Minimum Discounts

The Veterans Health Administration, a subsidiary of the Department of Veterans Affairs that manages health care for United States military veterans, has a similar arrangement to Medicaid for its patients. Through the 1992 Veterans Health Care Act and the section 340B drug

36 Senator Orrin Hatch, quoted in Berman, 50.
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discounts, the VHA was able to buy medications at steep discounts and dominate the market by deciding which drugs will make it onto its national formulary.

Representative Gillespie V. “Sonny” Montgomery (D-Miss.) was the main sponsor of H.R. 5193. Before beginning his political career, Montgomery was a Major General in the Mississippi National Guard and served in World War II and the Korean War. A popular Congressman, Montgomery served in the House of Representatives for thirty years, thirteen of those as chairman of the House Veterans’ Affairs Committee. In his obituaries, the New York Times called him “a staunch voice for the military and the needs of veterans,” and the Mississippi Meridian Star reported that he was “affectionately known as ‘Mr. Veteran’ on Capitol Hill.” The Veterans Health Care Act, while important, was only one bill Montgomery sponsored on the issue of veterans’ care. Two of his most notable achievements were expanding the GI Bill to provide more educational opportunities to veterans and cosponsoring the 1988 Department of Veterans Affairs Act which established the VA as a cabinet level department. As a conservative Democrat and an old friend of President Bush, Montgomery was the perfect

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42 Hevesi.
person to bridge the divide not only between Republicans and Democrats, but between the White House and Capitol Hill.

Some members of Congress noticed that the price of prescription drugs in the Veterans Health Administration system had been increasing as a side effect of the Medicaid drug rebate program. After it had passed in OBRA-90, manufacturers raised the prices for organizations like the VHA to avoid triggering the “best price” requirement from the Medicaid drug rebate program. As Senator Ron Wyden (D-Ore.) recalled, “Almost as soon as the ink was dry on the 1990 law, Congress began to hear from hundreds of drug customers that drug manufacturers were canceling or raising the best prices they had previously enjoyed.” Veterans organizations, including Disabled Veterans of America, Paralyzed Veterans of America, Veterans of Foreign Wars, and American Veterans (AMVETS) testified in favor of prescription drug pricing reform. Pryor lamented the drug companies that were cutting their losses “on the backs of our Nation’s soldiers and veterans… rather than slightly trim excessive profits or cut back on huge marketing budgets.”

Montgomery introduced his first attempt to remedy the effects of the Medicaid rebate with H.R. 2890, but after taking over a year to pass the House, it did not make it to the Senate. The bill, which would have mandated that manufacturers roll back their prices to pre-OBRA-90 levels, was immediately attacked by Mossinghoff and the PMA as “a far more radical and

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45 Prescription Drug Rebate Program, iii (table of contents).
46 Quoted in Berman, 13.
47 Actions, https://www.congress.gov/bill/102nd-congress/house-bill/2890/actions?q=%7B%22search%22%3A%5B%22%5C%22%5C%22H_R.+2890%5C%22%22%5D%7D&r=1&s=10.
intrusive disruption of the free-market system than was caused by the Medicaid rebate program.”

But Montgomery was persistent.

Prescription drugs prices were not the only topic of conversation surrounding veterans’ care in the early 1990s. As the Persian Gulf War ended, the oil fires in Kuwait and various environmental risks led to an increased concern in the health for the Americans who had served. In response to the war and its health impacts on soldiers, Montgomery and others in Congress begin to push for the need to improve veterans’ health care. There was also an increased awareness around sexual harassment in the military, which President Bush called “abhorrent.”

In May 1992, Montgomery introduced H.R. 5193, known as the Veterans Health Care Act. The bill’s primary purposes were in response to the above concerns, as well as improving long term care options for disabled veterans. What was inconspicuously present in the bill was a provision to address prescription drug prices. Although a clear win for Montgomery and veterans, even President Bush neglected to mention the measure in his signing statement.

Section 601 of the Veterans Health Care Act established section 340B in the Public Health Service Act which requires manufacturers to provide discounts to “eligible entities” (i.e., the Veterans Health Administration and other small government health programs). The VHCA

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51 George Bush.

avoided a clash with the Medicaid program by excluding the Veterans Health Administration prices from the ones calculated into Medicaid’s “best price” provision.\(^{53}\)

H.R. 5193 was passed in a Democratically controlled Congress, and signed into law by Republican president George H.W. Bush on November 4, 1992, near the end of his second term in office.\(^{54}\) In the House of Representatives, where H.R. 5193 originated, it had eight Democratic and five Republican cosponsors.\(^{55}\) On the day that the Veterans Health Care Act passed the House, Congressman Butler Derrick (D-S.C.) applauded the bill and Montgomery’s efforts, declaring that the prohibitive cost of prescription drugs was “scuttling the American dream.”\(^{56}\) The bill, facing no opposition, passed by a simple voice vote in both chambers.\(^{57}\)

### The Medicare Modernization Act and the Noninterference Clause

Medicare, the federal health insurance plan for the elderly and people with disabilities or end-stage renal disease, was established in 1966 in a much more limited scope than today. In 2003, Congress passed the Medicare Modernization Act to expand the benefits Medicare offers. One key part of the bill was the creation of Medicare Part D, which authorized an optional prescription drug program to help Medicare recipients pay for their medications by enrolling them in a prescription drug plan, or PDP. Although it would make sense that a large organization like Medicare would be able to negotiate on behalf of the PDPs, using its collective market power to obtain discounts on drugs for its beneficiaries, in fact, the opposite is true. Senator Bill,  


Cassidy (R-La.) says that “one of the fundamental problems… [is that] Medicare has a very limited ability to negotiate.”\(^58\) This is due to the noninterference clause in the MMA that states that “in order to promote competition… the Secretary [of Health and Human Services] may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and may not… institute a price structure for the reimbursement of covered part D drugs.”\(^59\)

In the 2002 primaries, Republicans gained back control of the Senate, after losing it the previous year when Senator James M. Jeffords (R-Vt.) switched parties to become an independent.\(^60\) Not only was this a success for Republicans, it was a success for the pharmaceutical industry. Representative Richard A. Gephardt (D-Mo.), the House Minority Leader, guessed that “the pharmaceutical companies probably spent more than $60 million across the country.”\(^61\) Following their wins, Congressional Republicans went to work on writing what would eventually become the Medicare Prescription Drug, Improvement, and Modernization Act.

Unlike the other two bills, there was not one member of Congress who was responsible for this bill. Also, unlike the other two bills, this one did not have strong bipartisan support in its creation. In Congress, Senate Majority Leader Bill Frist (R-Tenn.) was a “chief negotiator”\(^62\) and Representative Billy Tauzin (R-La.) was “an architect.”\(^63\) The bill was introduced by Speaker of

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\(^{58}\) Drug Pricing in America, 51.
\(^{61}\) Nagourney.
the House Dennis J. Hastert (R-Ill.) in June 2003 with the prestigious title of H.R. 1, an indication of its priority.  

At the time the House was ready to vote on the final bill, on a Friday in November, the margin for success was small. Republican leaders put every effort they had into passing the bill: they “violated parliamentary procedure” by keeping the voting machines open far longer than they were supposed to, and “twisted arms” to convince Congressmembers of both parties to change their votes.”65 Finally, the Secretary of Health and Human Services, Tommy Thompson, “defying House custom, moved onto the floor and the leaders roused President Bush to make another half-dozen calls to convince a handful of their colleagues to change their votes.”66 The back and forth lasted nearly until 6am the next Saturday morning, but it passed 220 – 215. It was not even a strictly party line vote: 207 House Republicans and 19 Democrats voted for the MMA.67

Once in the Senate, it passed 54 – 44, with senators and presidential candidates John Kerry (D-Mass.) and Joe Lieberman (D-Conn.) skipping the vote to rejoin their campaigns once they learned it would pass with or without their votes.68 Forty-three Senate Republicans and eleven Democrats supported the MMA.69 The vote was not about G.O.P. solidarity or conservative ideology. It was a win for the health care industry and not the people needing the

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67 Oliver, 321.
care. Proponents of the law “insist that the prohibition on price negotiations had nothing to do with catering to special interests – that it was a matter of principle, of preserving incentives to innovate,” but the money speaks for itself. According to CBS, Big Pharma “invested more than $10 million in campaign contributions during the last election and has been a source of lucrative employment opportunities for congressmen when they leave office.”

**Analysis**

The stories of these three bills do not provide a conclusive answer to why Medicaid and the VA enjoy much lower prices than Medicare. However, it does give us some starting points to see where Medicare diverged from those two and maybe teach us some lessons for the prospects of future reform.

The Omnibus Budget Reconciliation Act, the Veterans Health Care Act, and the Medicare Modernization Act all had some measure of bipartisan support, even if the prescription drug pricing sections of them did not. They were all signed by Republican presidents, and all three had a mixture of Republican and Democratic support in Congress, albeit some more than others. However, the country has grown increasingly polarized since the 1990s, allowing less opportunities for good faith bipartisan collaboration. Even though all three bills were bipartisan, to an extent, it was Democrats who championed Medicaid and veterans, and a Republicans who initiated the Medicare plan.

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71 Krugman, “A Serious Drug Problem.”
72 Singer, “Under the Influence.”
The Medicare Modernization Act has the distinct honor of being the only one passed during a unified conservative government. In November 2002, Republicans took back control of the Senate, creating “a political alignment not seen since the 1950s: Republicans were now in charge of the White House, the House of Representatives, and the Senate.”\(^{74}\)

Although prescription drug pricing may have reemerged as a bipartisan issue, Democrats are the ones who stand to gain from their outspoken support for marginalized constituencies. It is part of their “brand.” While individual Republicans may get behind programs to support the poor and veterans out of the goodness of their hearts, they have less political motivation to spearhead legislation that would increase government involvement and support.

This dichotomy is clear in the final hours of the vote on the Medicare Modernization Act. At 3am when the vote opened, “the Medicare Part D bill appeared set to fail, this time 215 – 219. But then [Representative Ernest Istook (R-Oкла.)] switched his vote from no to yes, and with the margin slightly narrowed the vote was held open for two hours.”\(^{75}\) Two of the no votes were Congressmen Butch Otter (R-Idaho) and Trent Franks (R-Ariz). Although they were likely against the bill based on their personal opinions, the pressure of their party and the knowledge that their base would not punish them for the vote led them to switch their votes.

Another important influence was clearly the pharmaceutical industry. In all three bills, Big Pharma played a key role, but in very different ways. For the first two bills, the Pharmaceutical Manufacturers Association and other companies successfully lobbied against more radical ideas and negotiated with Congress to mitigate the impact of legislation on their


\(^{75}\) Eric Revell, “Medicare’s Prescription Drug Coverage Became Law Under George W. Bush On This Date,” Countable, last modified December 8, 2019, [https://www.countable.us/articles/39245-medicare-s-prescription-drug-coverage-law-george-w-bush-date](https://www.countable.us/articles/39245-medicare-s-prescription-drug-coverage-law-george-w-bush-date).
profits. To some degree, they were successful, preventing extreme cost controls from making it through Congress. But the drug manufacturers ran into problems in the 90s that they were careful not to replicate again.

In 1990, when the Medicaid rebate program was being considered, the PMA used confusion over the many proposals that Pryor and others offered to sow doubt into the hearts of consumer groups that would have otherwise supported his actions. But by the time the final language of the rebate program in OBRA-90 was written, Pryor used their own strategy against them. By changing the rebate program to be set by “best price” and not some other metric, he divided pharmaceutical manufacturers into two categories: ones that would suffer, and ones that would not. Some drug companies, such as Merck and Pfizer, used relatively even pricing models in all their markets, while others, like Upjohn and Schering, had deep discounts, and would therefore suffer more under a “best price” model.76 So Merck, Pfizer, and others, had less of an incentive to waste their lobbying dollars on this plan.

Another problem was that with Democrats in control, especially these Democrats, the Pharmaceutical Manufacturers Association had to rely on traditional lobbying techniques that were eventually unsuccessful. In the 1990s, the PMA used their lobby to advertise against the programs, meet with lawmakers to convince them to oppose the measures and consider their alternatives, and persuade other groups to rally with them. Of course, they targeted members on both sides of the aisle, and were relatively successful in stopping some of the more drastic measures from becoming law. But Mossinghoff, who was the president of the PMA at the time,

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was a Republican and a former Reagan administration employee. He simply did not have
enough sway with the Democratic majority on Capitol Hill to stop either the Medicaid drug
rebate program or the Veterans Health Administration discounts.

By 2003, the lobby had learned its lesson. It reorganized with the drug research industry
as PhRMA, but its name was not the only thing that had changed. PhRMA took advantage of
the new Republican majority in Congress by not only lobbying them, but by bribing them with
cushy jobs after leaving Congress. There were more than a few Congressmen who worked on the
MMA and later became lobbyists for the pharmaceutical industry. Billy Tauzin, credited with
the success of the noninterference clause in particular, left Congress just a few years later to
become PhRMA’s new president. Additionally, Thomas Scully, the Medicare administrator at
the time, was able “to negotiate for a future health industry lobbying job at the very same time he
was pushing the drug bill.” With everyone they had on the inside, PhRMA not only had
influence but impetus to push through as much industry-friendly legislation as they could.

Neither the Medicaid prescription drug rebates, the Veterans Health Administration
discounts, or the Medicare noninterference clause were passed as independent pieces of
legislation. The bills that were the predecessors to the Medicaid prescription drug rebates died in
the Senate, after committee hearings revealed the strong opposition the pharmaceutical industry

https://www.washingtonpost.com/archive/business/1984/12/13/patent-chief-quits-to-head-drug-lobby/ab5d5b142d2d/
78 The Pharmaceutical Manufacturers Association, or PMA, later became the Pharmaceutical Researchers and
Manufacturers of America, or PhRMA.
79 Singer, “Under the Influence.”
80 Chris Macke, “Ex-Rep. is Still Costing Taxpayers Billions in Prescription Fees,” The Hill, February 15, 2018,
81 Krugman, “A Serious Drug Problem.”
had to the program. It was only under the cover of a large budget bill and the magic of reconciliation that lawmakers ironed out a solution. The veterans’ discount program, the least controversial legislation out of the three, was not viable as its own bill; Montgomery included it in the bigger picture of veterans’ health care. It is unclear if the noninterference clause would have passed as its own bill. The uproar from constituents would likely have been louder, especially given how loud it has been in the years following the bill, but perhaps Big Pharma would have come out on top regardless. What is clear is that each of these programs, while only small parts of the legislation they were a part of, have had, and will continue to have, a big impact on prescription drug patients in the United States.

In the end, despite their many differences, the Medicaid rebates, the veterans’ 340B discounts, and the Medicare noninterference clause have one thing in common: they have all been codified into law. All three pieces of legislation have been cemented into the policy trap of the United States healthcare system, satisfying just enough constituencies that balk at reform but not thoroughly solving the problem. Although Democrats remain unsatisfied with what the Medicaid drug rebate program has achieved, and the pharmaceutical industry would be happy to see it go away, the last time it was contested was in 1995, when Senate Republicans attempted to shut the program down while working on a Medicaid reform bill. However, Senator Pryor introduced an amendment to preserve the program as one of his last moves on Capitol Hill. By calling a voice vote, Pryor “maneuvered his amendment through the Senate [Finance] Committee,” letting supportive Republicans spare their political capital in exchange for saving his program. And while Big Pharma did its best to propose alternatives to the Veterans Health Care Act before it was passed, they understand the political fire they would be under if they

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proposed repealing benefits for veterans. Although Democrats “began introducing bills to free the government to use its vast purchasing power to negotiate better deals even before former President George W. Bush signed the Part D Law,” they have never been successful. Even with Barack Obama as president, a candidate who had vowed to repeal the noninterference clause, even using the talking point in a campaign ad, the power of the drug industry was too immense (see Figure 1).

![Figure 1: The effects of pharmaceutical lobbying on Congress, 2003-2016](https://www.opensecrets.org/news/2016/10/lobbyists-campaign-cash-help-drug-industry-stymie-bid-to-restrain-medicare-prescription-costs/)

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Conclusion

I believe that as the costs of prescription drugs become more and more outrageous, proponents of spending reform will need to reevaluate the risks associated with this fight. As the stories of struggling Americans continue to make headlines and impacted constituencies organize, the issue will only become more urgent. And while the repeal of the noninterference clause is a necessary component of solving this crisis, lawmakers will need to establish a system so that Medicare has the buying power it needs to negotiate with drug companies, while ensuring that other systems like Medicaid and the VHA are not adversely impacted. By taking a critical look at each of these systems and the political forces involved in passing them, legislators may be able to finally find a solution to the prescription drug cost crisis that they can actually pass.