View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by IssueLab

Celebrating Pork

The Dubious Success of the Medicare Drug Benefit

Dean Baker

March 2007

Center for Economic and Policy Research
1611 Connecticut Avenue, NW, Suite 400
Washington, D.C. 20009
202-293-5380
www.cepr.net

Contents

About the Author

Dean Baker is a co-director at the Center for Economic and Policy Research in Washington, D.C.

Acknowledgements

We are grateful to the Retirement Research Foundation for financial support of CEPR's research on Medicare. The views presented here do not necessarily reflect those of the Foundation.

Liz Chimienti and Rebecca Ray provided helpful comments on an earlier draft of this paper.

Executive Summary

Recent news accounts have touted the fact that the Medicare prescription drug benefit is now expected to cost somewhat less than previously had been projected. This has been taken as evidence of the success of the program and used as an argument against taking steps to reform the program in ways that would lower cost.

This paper examines the factors that have led to the downward revisions in the projected cost of the drug benefit. It also notes the potential cost savings from designing a more efficient drug benefit.

It notes that:

- The main reason that the cost projections have been revised downward is that prescription drug costs are rising less rapidly than originally had been projected. While there have been efforts to claim that the Medicare drug program is responsible for the lower rate of growth in drug costs, in fact the rate of growth in spending had already slowed sharply from 15.4 percent in 2000 to just 8.0 percent in 2005, the last year before the beginning of the program. While the rate of growth slowed further to 7.7 percent in 2006, this slowdown merely continued the trend of the prior five years. The main reason for the slower growth in drug prices is the well-documented stagnation in the drug development process.

- The other reason that the program is projected to cost less than originally had been anticipated is that fewer people are expected to enroll in the program. The Congressional Budget Office (CBO) now projects that ultimate enrollment in the program will be 10 percent lower than it had anticipated originally. As a first approximation, a 10 percent decline in enrollment will lead to a 10 percent reduction in costs.

- The decision to have the program administered by private insurers rather than through the existing Medicare system was projected by CBO to add nearly $5 billion a year to the cost of the program's administrative costs. This projection seems to have been born out by projections from the Center for Medicare and Medicaid Services, which show that administrative costs for health care jumped by 10.3 percent in 2006. If administrative costs had risen at the same rate as in 2005, it would have saved the country $9.6 billion on its health care bill.

- The insurance companies operating within the Medicare system are paying close to 70 percent more for drugs than the Veterans Administration or countries that negotiate drug prices directly with the pharmaceutical industry.

Under a system such as the VA health care system, patients can still obtain drugs that are not on the formula. They simply need a special request from their physician.Even if some beneficiaries occasionally have to buy a drug outside the Medicare program, the savings from negotiated prices on other drugs would almost certainly offset paying a higher price on a single drug. Since the whole program is completely voluntary, it is almost inconceivable that anyone will ever be denied a drug to which they would have had access otherwise.

The potential savings from an efficient drug benefit are more than $30 billion a year. This sum is more than ten times as large as the amount of money at stake in other important policy debates such as increased subsidies for student loans or the extension of the State Children's Health Insurance Program. Therefore the gains from reducing waste in the Medicare drug benefit merit attention.

Introduction

Proponents of the 2003 Medicare Modernization Act have touted the fact that recent reports indicate that the program is costing the government less than projected. It is certainly good news that the program is costing less than expected, but even with the latest projections, the cost of the program is still far higher than necessary. Furthermore, not all of the reasons that the cost is less than previously projected are good news.

This paper briefly outlines the main reasons that the program is costing less than previously had been projected. It then points out how the program could be redesigned to substantially reduces costs from the currently projected levels. Finally, it compares the amount of waste in the Medicare program with the cost of other programs that have been recent topics of public debate. While waste should be eliminated wherever possible, the energy devoted to reducing or eliminating waste should be proportional to the amount of waste involved. In the case of the Medicare drug benefit, the amount of waste in the program is very large relative to the cost of many other important public programs.

Reasons for Savings in the Medicare Drug Benefit

Recent news accounts have extolled the fact that updated projections show the Medicare prescription drug benefit costing less than had previously been projected.[1] Both the Centers for Medicare and Medicaid Services (CMS) and the Congressional Budget Office (CBO) have indicated that they intend to lower their projections for spending on Medicare Part D. While lower spending on the program will reduce the federal budget, the reasons for lower spending are not necessarily good news for the public.

The first reason that spending is now projected to be lower than had been projected in the past is that drug costs are not rising as rapidly as had previously been expected. Spending on prescription drugs is estimated to have increased by 7.7 percent in 2006 and is projected to increase by 8.0 percent in 2007.[2] This rate of growth is considerably lower than had earlier been projected. In 2004, CBO projected that per capita prescription drug spending for Medicare beneficiaries would rise by 12.1 percent annually from 2000 to 2006 and by 9.0 percent from 2006-2012.[3] With annual population growth of approximately 1.0 percent, the 2004 CBO projections implied that overall prescription drug costs would rise at an annual rate of approximately 13 percent from 2000 to 2006 and by 10 percent from 2006-2012.[4] Clearly, the new CMS projections for the rate of increase in prescription drug spending are substantially lower than had previously been projected.

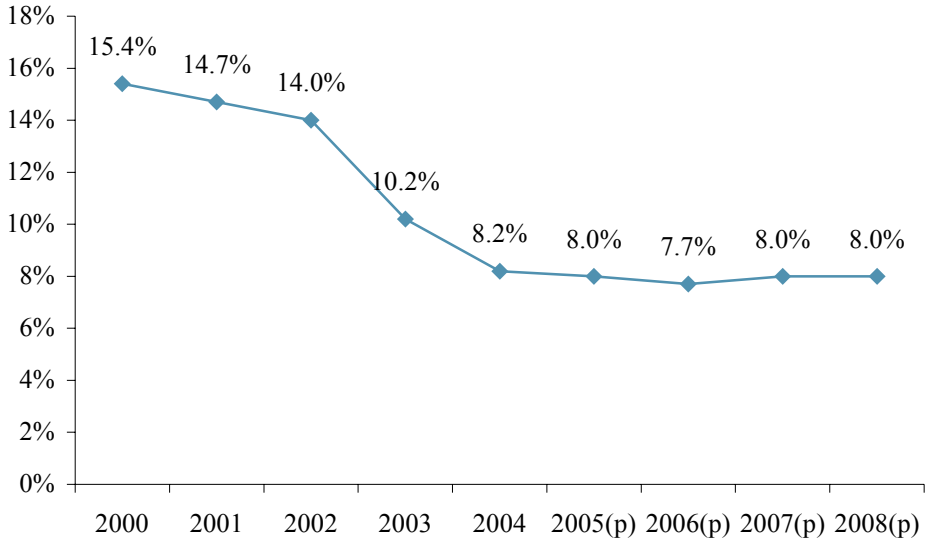
However, it is questionable whether the slower rate of cost growth can be attributed to the Medicare prescription drug benefit. The rate of growth in spending on prescription drugs had already been

---

[1] E.g. see Lee 2007.
[2] CMS 2007: Table 2.
[3] CBO 2004a, Endnote 11.
[4] The Medicare population is projected to increase more rapidly than the total population over this period. Since older people spend far more on prescription drugs than younger people, the 2004 CBO projected increase in per capita spending actually implies a more rapid rise in national spending on prescription drugs than indicated in this discussion.

slowing before the benefit came into existence last year. Table 1 shows the rate of growth of spending on prescription drugs since 2000.

FIGURE 1
Rate of Growth of Spending on Prescription Drugs



Source: CMS 2007: Table 2.

As can be seen, spending growth had slowed sharply from 2000 to 2005, falling from a 15.4 percent increase in 2000 to a 8.0 percent rate of growth in 2005. While the rate of growth of spending fell further to 7.7 percent in 2006, the year the benefit was first put in place, the falloff in the rate of growth from 2005 to 2006 is relatively modest and just continues a downward path from the prior five years. It is possible that the introduction of the benefit contributed to this 0.3 percentage point slowing in the rate of spending growth between 2005 and 2006, but virtually all of the decline in the rate of growth of spending preceded the introduction of the benefit. Therefore, at best the prescription drug benefit can only account for a very small portion of the slower growth in spending on prescription drugs.

The most plausible alternative explanation for the slower growth in spending is the failure of the pharmaceutical industry to develop important new drugs over this period. The number of new drugs approved that the Food and Drug Administration (FDA) considers to be qualitative improvements over existing drugs ("priority" reviews) has remained constant or even declined slightly over the last five years, even as the industry claims to have increased research spending at double-digit rates. The number of priority approvals peaked at 29 in 1996 and then fell back to an average of just 12 per year from 2001 to 2003, although it did increase to 25 in 2004, the most recent year for which data is available.[5] The stagnation of the drug development process has been the topic of recent studies by both the FDA and Government Accountability Office.[6]

The stagnation in the drug development process can explain slower spending growth, since new drugs were the primary factor fueling higher spending growth. While the industry had been

[5] The number and ratings of new drug approvals each year can be found in FDA 2005.
[6] FDA 2004, GAO 2006. See also Baker 2007.

increasing prices for existing drugs somewhat more rapidly than the overall rate of inflation (the CPI for drugs rose at an average annual rate of 3.8 percent from 2000 to 2006, while the overall CPI rose at a 2.7 percent annual rate), the main reason for the rapid run-up in drug prices has been the introduction of new, and ostensibly better, drugs. The prices for newly developed drugs are set far higher than prices for existing drugs. If the industry is not developing many new drugs, then it is not surprising that spending on prescription drugs has not been rising rapidly.

It is not especially good news that the pharmaceutical industry is having difficulty developing new drugs, although the industry's failure has led to a slower rate of growth in spending on prescription drugs. However, this slowdown cannot in any obvious way be attributed to the Medicare prescription drug benefit.

The other reason that the Medicare drug benefit is now expected to cost less than had previously been projected is that fewer people are expected to enroll in the program than had previously been projected. CBO has now projected that enrollment will eventually reach 78 percent of the eligible population. It had previously projected that enrollment would be 87 percent of the eligible population.[7] Other things equal, if enrollment is 10 percent lower than projected, it would be expected that costs would also be 10 percent lower.

This reduction in projected spending is also not obviously a positive development. Enrollment is lower than expect because fewer people believe that they will benefit from the program than CBO had originally anticipated. This does save the federal government money, but it means that the program is helping fewer people than had originally been expected. If people felt that the Medicare drug benefit was better, then the enrollment would be closer to CBO's original projection, although the cost would also be higher.

To summarize, the main reasons that the Medicare prescription drug benefit is now expected to cost less than had previously been projected are the stagnation in the drug development process and lower than anticipated enrollment. While the insurers operating within Part D may be performing better than expected, this is clearly a secondary factor.

[7] CBO 2007: 77.

The Inefficiency in the Design of the Medicare Prescription Drug Benefit

The Medicare drug benefit designed by Congress in the 2003 Medicare Modernization Act created a program that is unnecessarily costly. This bill raised costs in two ways. First, it prohibited Medicare from offering its own drug benefit as an add-on to the standard Medicare program, requiring that beneficiaries receive the program through private insurers. According to the Congressional Budget Office, this increased the gross cost (before premiums and state contributions) of the program by more than 10 percent in its first years of existence, or just under $5 billion a year.[8] In fact, the recent projections from CMS seem to confirm CBO's projections of excess administrative costs. The administrative costs incurred by the government and private insurers jumped by 10.3 percent in 2006, following an increase of just 4.2 percent in 2005. While the growth in administrative costs is erratic, if the administrative costs in 2006 had increased at the 2005 rate, the savings in 2006 would have been $9.6 billion.

While the Medicare drug benefit would have imposed additional administrative expenses for the government even if it was simply appended to the traditional Medicare program, these costs likely would have been largely or completely offset by lower private sector costs. Instead, the inefficient design of the benefit led to a net increase in administrative expenses for the economy as a whole.

The second reason that the program costs more than necessary is that Congress explicitly prohibited Medicare from using the collective buying power of nearly 40 million beneficiaries to force down prescription drug prices. The volume of drugs purchased by Medicare beneficiaries is considerably larger than the drugs purchased through governmental systems such as those in place in Canada and Australia. Therefore, it is reasonable to assume that Medicare could have been able to secure prices that are comparable to those paid by the Canadian or Australian governments, or the Veteran's Administration in the United States, had it been given the authority to negotiate drug prices on behalf of beneficiaries.[9]

CBO had projected that the private insurers operating within Medicare Part D would be able to negotiate discounts that averaged approximately 15 percent of the retail prices examined in its international comparison. This means that if a low cost country (Australia) paid prices that averaged 50 percent of U.S. prices, then Medicare would have been able to save more than 40 percent off the price paid by private insurers, if it negotiated as effectively as the Australian government (50 percent = 58.8 percent of 85 percent).

The combined savings to the government and beneficiaries from having Medicare offer the drug benefit as an add-on to the traditional program, and to negotiate directly with the pharmaceutical industry, would be close to $30 billion in 2008.[10] Even this figure is somewhat conservative since

---

[8] CBO 2004a. This number is based on the amount of annual administrative expenses attributable to marketing and profits as described on p. 17 and also in Table 3.

[9] In a comparison of international drug pricing, CBO found that foreign countries paid an average of 35 to 55 percent less than patients in the United States (CBO 2004b). A study by the Commerce Department found similar price differences (USDOC 2005).

[10] This calculation is derived from CBO's projection of $52 billion in gross spending for 2008 (CBO 2007: 77). Assuming that two-thirds of drug costs are paid by the government and one-third by beneficiaries, then total spending

more beneficiaries would enroll in the program if it offered drugs at lower prices. While higher enrollment raises the cost for the government, it does lead to larger savings for beneficiaries and therefore larger combined savings to the government and beneficiaries.

Since any negotiations between the drug industry and Medicare could lead to some drugs being left off of a preferred list of drugs, or formulary, it is worth addressing some confusion about the implications of this outcome. First, most private insurers have formularies that exclude certain drugs. While beneficiaries can try to select insurers that cover the drugs they need, both the list of drugs on the formulary and their needs can change over the course of a year, leaving the possibility that they will need a drug not on the formulary. So the problem of beneficiaries needing a drug not included on a formulary already exists in the current system.

Second, in the case of the Veteran's Administration, the fact that a drug is not on the formulary does not mean that a patient cannot get it through the VA system. The system simply requires that the patient's doctor indicate that it is necessary for the patient to get a specific drug rather than the closest substitute available on the formula. In most cases, the VA still pays less for drugs not included on its formulary than private insurers pay under Medicare Part D.

It is also important to remember that even in an extreme case where a beneficiary needs a drug and is unable to purchase it through a Medicare drug benefit, she is still likely to have a lower drug bill than under the current system. If a beneficiary saves 40 percent for all the drugs that she currently uses, except one, and then is forced to buy that drug out of her pocket, it is likely that she will still be paying less in total for prescription drugs. While there could be extreme cases, in which some beneficiaries actually end up paying more in a system where Medicare negotiates prices, public policy is rarely designed solely to prevent extreme cases. Clearly the overwhelming majority of beneficiaries would have much lower drug costs if Medicare directly negotiated prices with the pharmaceutical industry, although it is theoretically possible that some beneficiaries could pay more than they do under the current system.

This raises one final point. The Medicare drug benefit is completely voluntary. No one is forced to sign up for it. If an eligible beneficiary believes that he will pay less on his own or through an insurance plan that is independent of Medicare, then he would always have the right to refuse the benefit. It is a very peculiar approach to public policy to require the government and the beneficiaries of an optional program all pay more money than necessary, just because there is a possibility that some individual would end up paying higher prices if they remained in Part D and the program had a formulary.

---

would be $78 billion. If $5 billion of this spending is due to excessive administrative costs, then Part D beneficiaries spend approximately $73 billion on drugs. If prices could be reduced by 40 percent, the savings on drug prices would be $29.2 billion. Including the $5 billion in savings on administrative costs, total savings would be $34.2 billion. Of course, if the program were more efficient, then more seniors would enroll, making the total savings to the government and beneficiaries even larger.

[10] This calculation is derived from CBO's projection of $52 billion in gross spending for 2008 (CBO 2007: 77). Assuming that two-thirds of drug costs are paid by the government and one-third by beneficiaries, then total spending would be $78 billion. If $5 billion of this spending is due to excessive administrative costs, then Part D beneficiaries spend approximately $73 billion on drugs. If prices could be reduced by 40 percent, the savings on drug prices would be $29.2 billion. Including the $5 billion in savings on administrative costs, total savings would be $34.2 billion. Of course, if the program were more efficient, then more seniors would enroll, making the total savings to the government and beneficiaries even larger.

The Relative Size of the Waste in the Medicare Drug Benefit

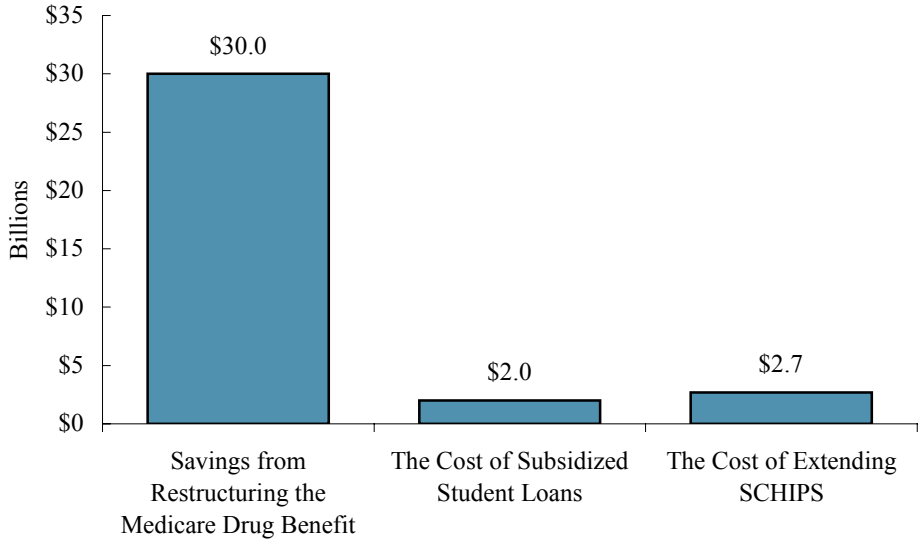
Several commentators have suggested that reducing the cost of the Medicare drug benefit should not be a priority, since it is working better than expected.[11] The willingness to ignore the waste in the benefit might be reasonable, if the waste in the Medicare drug benefit was small. However, this is not the case.

The excess cost of the Medicate drug benefit is quite large relative to other issues that have been important topics of public debate. For example, the House of Representatives recently passed a bill that reduced the interest rate charged on some government-guaranteed student loans. The bill phased in the reduction of the interest rate over 5 years, because it was believed that the government did not have the money (approximately $2 billion a year) to pay for the lower interest rates immediately.[12]

Another major debate is taking place over the extension of the State Children's Health Insurance Program (SCHIP). President Bush has proposed a funding level for the program that averages $2.7 billion less each year than the level that governors have argued is necessary to meet their coverage targets.[13]

In both cases, the potential savings from the restructuring the Medicare drug benefit is more than 10 times larger than the sums at issue in the funding of these programs, as shown in Figure 1.

FIGURE 2
The Relative Size of Waste in the Medicare Drug Benefit



Source: see text.

[11] "An Election on Drugs" 2006.
[12] Schemo 2007.
[13] Pear 2007.

In short, the excess costs associated with the Medicare prescription drug benefit dwarf the cost of many of the programs that are viewed as crucial by much of the public. For this reason, there is good cause to take the unnecessary expense associated with Medicare Part D very seriously.

Conclusion

The Medicare drug benefit designed by Congress in 2003 costs far more than necessary. While the most recent projections show the program costing somewhat less than earlier projections, much of the savings are attributable to the fact that drug prices have risen less than had been projected and fewer beneficiaries are choosing to enroll in the Part D. The slowdown in the growth of drug prices is primarily attributable to the industry's failure to develop new drugs. The lower than expected enrollment is a sign of the program's failure, not its success.

If the program were designed so as to offer a benefit as an add-on to the existing Medicare program and to have Medicare negotiate prices directly with the pharmaceutical industry, it could save the government and beneficiaries more than $30 billion a year. This sum dwarfs the amount of money that has been involved in major public debates over issues such as subsidized student loans and the SCHIP program. For this reason, the amount of waste in the Medicare drug program should be a cause for concern.

References

"An Election on Drugs." *Washington Post* (2 Nov 2006), A16. [http://pqasb.pqarchiver.com/washingtonpost/access/1155173421.html?dids=1155173421:1155173421&FMT=ABS&FMTS=ABS:FT&date=Nov+2%2C+2006&author=&pub=The+Washington+Post&edition=&startpage=A.16&desc=An+Election+on+Drugs].

Baker, Dean. 2007. "Stagnation in the Drug Development Process: Are Patents the Problem?" Washington, D.C.: Center for Economic and Policy Research Briefing Paper (March). [http://www.cepr.net/documents/publications/healthcare_stagnation_2007_03.pdf].

CBO (Congressional Budget Office). 2004a. "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Plan," Washington, D.C: CBO (July). [http://www.cbo.gov/ftpdocs/56xx/doc5668/07-21-Medicare.pdf].

CBO (Congressional Budget Office). 2004b. "Would Prescription Drug Importation Reduce U.S. Drug Spending?" Washington, D.C.: CBO (29 April). [http://www.cbo.gov/ftpdocs/54xx/doc5406/04-29-PrescriptionDrugs.pdf].

CBO (Congressional Budget Office). 2007. *The Budget and Economic Outlook: Fiscal Years 2008-2017*. Washington, D.C.: CBO (January). [http://www.cbo.gov/ftpdocs/77xx/doc7731/01-24-BudgetOutlook.pdf].

CMS (Center for Medicare and Medicaid Services). 2007. "National Health Care Expenditure Projections 2006-2016." Washington, D.C.: CMS, Office of the Actuary. [http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf].

Families USA. 2006. "Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices," Washington, D.C.: Families USA (20 June). [http://www.familiesusa.org/resources/publications/reports/big-dollars-little-sense.html].

FDA (Food and Drug Administration). 2004. "Innovation or Stagnation: Challenge and opportunity on the Critical Path to New Medical Products." Washington, D.C.: FDA (March). [http://www.fda.gov/oc/initiatives/criticalpath/whitepaper.html].

FDA (Food and Drug Administration). 2005. "Center for Drug Evaluation and Research NDAs Approved in Calendar Years 1990-2004 by Therapeutic Potential and Chemical Type." Washington, DC: FDA (March). [http://www.fda.gov/cder/rdmt/pstable.htm]

GAO (Government Accountability Office). 2006. "New Drug Development: Science, Business, Regulatory and Intellectual Property Issues Cited as Hampering Drug development Efforts." Washington, D.C: GAO-07-49. [http://www.gao.gov/new.items/d0749.pdf].

Lee, Christopher. 2007. "Medicare Benefit Appears to Slow Spending on Drug Growth." *Washington Post* (21 Feb), A6. [http://www.washingtonpost.com/wp-dyn/content/article/2007/02/20/AR2007022001346.html].

Pear, Robert. 2007. "Child Health Care Splits White House and States." *Washington Post* (27 Feb), A1. [http://www.nytimes.com/2007/02/27/washington/27govs.html?ex=1330232400&en=b18f12e4b84e6e91&ei=5090&partner=rssuserland&emc=rss].

Schemo, Diane Jean. 2007. "House Democrats Propose Cut in Student Loan Rates." *Washington Post* (13 Jan), A10. [http://select.nytimes.com/gst/abstract.html?res=F70617F938540C708DDDA80894DF404482].

USDOC (United States Department of Commerce). 2005. *Pharmaceutical Price Controls in OECD Countries: Implications for U.S. Consumers, Pricing, Research and Development, and Innovation*, Washington, D.C.: USDOC. [http://www.cptech.org/ip/health/rnd/evidenceregardingrnd.pdf].