IRET Congressional Advisory

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April 17, 2007 **Advisory No. 222**

MEDICARE PART D AND PRESCRIPTION DRUG PRICES

The Senate is about to vote on S.3, a Medicare reform measure. One key provision would remove the current law provision prohibiting the Secretary of HHS from interfering in negotiations between drug manufacturers, pharmacies, and prescription drug plan providers. The bill would not, however, repeal the current law provision prohibiting the Secretary from establishing a specific formulary or a price structure. It would not prevent private Part D drug plans from negotiating lower prices than the Secretary might obtain.

The Congressional Budget Office report to the Finance Committee on April 16th is skeptical that the removal of the "noninterference provision" would obtain a better deal for seniors than the private plans. (See http://www.cbo.gov/ftpdoc.cfm?index=8006&type=1.) It states: "CBO estimates that modifying the noninterference provision would have a negligible effect on federal spending because we anticipate that under the bill the Secretary would lack the leverage to negotiate prices across the broad range of covered Part D drugs that are more favorable than those obtained by PDPs [prescription drug plans] under current law. Without the authority to establish a formulary or other tools to reduce drug prices, we believe that the Secretary would not obtain significant discounts from drug manufacturers across a broad range of drugs."

That is, without taking the dangerous and undesirable step of limiting access to drugs, HHS is not likely to obtain lower prices than the private plans competing to attract participants by offering the greatest choices at the best prices that they can negotiate.

The attached fact sheet* examines how the current competition among private drug plans has fared, and how a mandate for government negotiation of prescription prices might affect prices, drug availability, and consumer choice. It contains links to valuable sources of information on these issues.

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President and Executive Director

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* The fact sheet was jointly prepared by scholars from the American Enterprise Institute, the Center for Medicine in the Public Interest, the Galen Institute, the Heritage Foundation, the Institute for Policy Innovation, the Institute for Research on the Economics of Taxation, the National Center for Policy Analysis, and the Pacific Research Institute.

January 9, 2007

The Facts:

Medicare Part D and Prescription Drug Prices

Price negotiation by competing private plans offering Medicare drug coverage is producing high satisfaction rates among seniors at a much lower cost than if the government had provided a traditional plan. Congress should not impose new government controls that could reduce seniors' access to needed drugs.

Why shouldn't the government negotiate prices and use its buying power to get drug costs down?

Independent experts at both the Office of the Actuary at HHS[1] and the Congressional Budget Office[2] have said that government involvement in price negotiation will not lead to lower costs for taxpayers. And it could lead to significant restrictions in access to drugs for seniors.

The private plans offering Medicare drug coverage are companies with decades of experience in negotiating prices – experience the government does not have. The plans negotiate drug prices for more than nine million people in the Federal Employees Health Benefits Program and for tens of millions of working Americans. And because these private plans are participating in Medicare, seniors can choose the drug plans that work best for them based on the benefit design that suits their needs.

Private competition in Medicare Part D has led to lower costs with broad coverage of prescription drugs for seniors and to savings for taxpayers. According to analyses by the Centers for Medicare & Medicaid Services:[3]

- Premiums for the drug basic benefit have fallen to an average of $22 a month for seniors this year. This is over 40% less than the $37 a month that the coverage originally was projected to cost.

- Average premiums for the basic benefit have actually *fallen* from $23 last year, which CMS attributes to strong competition and beneficiary choices of more efficient plans with lower premiums.

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This fact sheet was jointly prepared by health policy experts from the American Enterprise Institute, the Center for Medicine in the Public Interest, the Galen Institute, The Heritage Foundation, the Institute for Policy Innovation, the Institute for Research on the Economics of Taxation, the National Center for Policy Analysis, and the Pacific Research Institute. See end of document for contact information.

- CMS reports that on average, beneficiaries also are saving nearly $1,200 annually on their drug costs.

- The Medicare drug benefit cost nearly $13 billion less than expected in its first year, 30% below the $43 billion that had been budgeted.

- Long term savings are even greater. HHS Secretary Leavitt just announced[4] that the independent CMS actuaries are lowering their estimate of the cost of the benefit over the next decade by another 10%, with almost all of new savings resulting from competition. The actuaries' new estimates show that total net Medicare costs are 30% lower, or $189 billion less, for the same budget window (2004-2013) than the actuaries originally anticipated before the Medicare drug benefit was implemented.

- And because Medicare now provides prescription drug coverage for beneficiaries who are dually-eligible for Medicare and Medicaid, net costs also are significantly lower than had been projected for the Medicaid program as well.

Future savings for taxpayers will be even greater because competition continues to drive down the average cost of coverage for each enrollee. These declining costs are unprecedented in government-sponsored health care programs, particularly for drug coverage.

Why shouldn't the government negotiate drug prices for Medicare like the Department of Veterans Affairs does?

VA prices reflect an "apples to oranges" comparison with Medicare: VA drug prices do not include the costs of pharmacy and administrative services, which are included in Part D costs, and reflect restrictions on access to medications and pharmacies that do not now occur in the federal employees' health insurance program or in Medicare.

Two elements are needed to negotiate prices – for the VA, private drug plans, or the federal government negotiating on behalf of Medicare: Volume buying and the ability to walk away from the deal if the price is too high.

If the government couldn't reach a deal with a drug company, that would mean seniors would not have access to those drugs.

And that's just what happens with the VA. According to an analysis by Columbia University Prof. Frank Lichtenberg published by the Manhattan Institute,[5] only 38% of the drugs approved by the FDA in the 1990s and 19% of the drugs approved since 2000 are on the VA national formulary, or covered drug list. According to CMS, about 27% of the 3.8 million Medicare beneficiaries enrolled in the VA for health benefits also are enrolled in Part D, which permits them to seek coverage for a broader range of drugs.

With the competitive model Medicare drug benefit, individual drug plans can decide not to sign a contract with drug companies if they can't make a deal on the price, but seniors still have other options: If seniors don't see the drugs and the coverage they want in one plan, they can choose a different plan. And seniors' choices show that they are very concerned about having access to up-to-date medications. Medicare drug plans that are popular with seniors have broader drug lists and much broader pharmacy access than the VA plan.

Couldn't Medicare get better prices by operating like the VA?

The Department of Veterans Affairs runs a different kind of health plan than Medicare:

- The VA uses a closed network of doctors, hospitals, and pharmacies and a national formulary. Covered drugs are generally restricted to those on this VA drug list, which has significantly fewer drugs available than Medicare drug plans, and are generally available only through VA pharmacies from prescriptions by VA doctors.

- Only 4 percent of prescriptions filled by the VA are off-formulary.

- VA drug prices do not include the costs of administering the program or paying for pharmacy services. (These costs are covered separately in the VA budget.)

- The VA keeps prices low by restricting drug choices and by filling 75% of its prescriptions through its own mail order system. (Polls show that seniors on Medicare strongly prefer to get their drugs from their local pharmacy.)

To get prices even lower in Part D, the government would have to take new steps to "walk away" and restrict access to drugs. That would mean seniors would have fewer of the medicines they need.

Do seniors care if they get fewer drugs if they can get lower prices?

The Kaiser Family Foundation conducted a survey that showed that 85% of Americans support allowing the government to negotiate prescription drug prices for Medicare.[6]

But support plummets when voters learn about trade-offs. According to a recent Dutko Research survey, support drops to 30% when people learn that government negotiation would mean they could choose only from a limited list of government-approved prescription drugs.[7] A study from The Tarrance Group[8] also found that only 28% of seniors believe that government would do a better job of setting drug prices than the competitive marketplace. Seniors' preferences for broad access to covered drugs are reflected in their actual drug plan choices.

What is the government's track record in negotiating prices?

Medicare's track record in paying for drugs in the traditional Medicare program is not good. For years, Medicare Part B has paid for a limited number of drugs that doctors administer in their offices. But a GAO study in 2001 found that physicians were able to purchase drugs in the competitive market for up to 86% less than Medicare reimbursed them for the medicines.[9] The prices that Medicare had been paying for these drugs were so much higher than private plans were paying that the Medicare Modernization Act of 2003 had to implement a new system to base payments on competitive prices.

The government also doesn't have a good track record at offering choice. The highest satisfaction rates with Part D are among those who are dually-eligible for both Medicare and Medicaid. These beneficiaries previously received their drug coverage through Medicaid, and therefore have the most experience with traditional government-run drug coverage. More than 9 out of 10 dual-eligible enrollees say they are satisfied with their new and less-restrictive Part D coverage, and 98% say the coverage is working well for them, according to a study by the Rx Education Network.[10] A J.D. Power and Associates survey found that 75% of dual-eligibles – those who were automatically enrolled in Part D – were "delighted" or "pleased" with their new Medicare drug benefit.[11]

Couldn't the Medicare law be revised so that the federal government could obtain lower prices for seniors?

Current proposals for government price negotiation do not offer any specifics about how any real savings on drug costs would be achieved. That's one of the reasons why independent experts like the Congressional Budget Office do not think they would save money. The last time that supporters of government-negotiated prices did offer a specific proposal about how negotiation would work was in 2002, in legislation that stipulated the government would offer seniors a *maximum* of two drugs in each class of medicines. But in the Medicare Modernization Act, the private drug plans must make a *minimum* of two drugs available in each class, with all drugs in a class available for many important types of drugs. And many plans offer many more drugs because that is what seniors want – with costs still far below projections.

As recently as 2005, legislation supported by members of Congress who want more government control over Medicare drug coverage would have locked a premium into law of $35 a month for 2006. But that government-controlled approach would have made seniors and taxpayers much worse off, since the average premium for basic coverage now is just $22 a month. Competitive markets do a better job of finding the price that works for both buyers and sellers than government experts.

This track record is why supporters of government-negotiated prices today avoid specifically describing how their plan would actually save money – because it would inevitably lead to more restrictions, more burdensome administrative processes, and the risk of seniors losing access to the broad coverage at much lower than expected costs that they now have.

So what's the bottom line?

Government price negotiation means government would control which drugs are available. Before proceeding with proposals that will surely restrict access to drugs and which most likely won't save money, we should first make sure we do no harm to seniors who are enjoying both choice and lower costs as a result of the competitive Part D model.

More than 38 million seniors have drug coverage. According to CMS, more than 70% of them are not subject the doughnut hole, either because their Part D plan provides coverage in the gap, because they have retiree plans with continuous coverage, or because they qualify for the low-income subsidy and aren't subject to the gap. The great majority of the remaining beneficiaries with no coverage in the gap are not expected to have drug spending high enough to reach the gap. And Medicare is delivering these benefits at a far lower cost than had been expected.

Having the government involved in "negotiating" prices would mean that government choices, rather than beneficiary choices, would be deciding which drugs are available.

Although disagreements remain over whether a universal drug benefit in Medicare was prudent, the drug benefit was created on a new model that brings private competition into play to offer seniors lower prices and greater choice. That is far better than a government-controlled system. Medicare Part D is succeeding beyond expectations in terms of beneficiary satisfaction and costs. Congress should build on this success and use it as a model to reshape other public programs around competition and choice.

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[1] Memo from Richard S. Foster, Chief Actuary, Centers for Medicare & Medicaid Services, to Mark B. McClellan, Administrator, Centers for Medicare & Medicaid Services. February 11, 2005.

[2] Letter from CBO Director Douglas Holtz-Eakin to Senate Majority Leader William H. Frist, January 23, 2004. http://www.cbo.gov/showdoc.cfm?index=4986&sequence=0

[3] "Projected Net Medicare Drug Costs Drop by Another 10 Percent," Medicare Fact Sheet, Centers for Medicare and Medicaid Services, January 8, 2007. "Medicare Prescription Drug Benefit Cost Almost $13B Less In 2006 Than Expected, According To CMS," Medical News Today, December 1, 2006. http://www.medicalnewstoday.com/ medicalnews.php?newsid=57760
Also, "Medicare Part D Spending Projections Down Again," Office of the Actuary, Department of Health and Human Services, July 11, 2006 http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895; and "Strong competition and beneficiary choices result in drug coverage with lower costs than predicted last year," August 15, 2006, http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=1946&intNumPerPage=10&checkDate=&checkKey=&srchType=&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date

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[5] Lichtenberg, Frank R. "Older Drugs, Shorter Lives? An Examination of the Health Effects of the Veterans Health Administration Formulary." Medical Progress Report No. 2, Manhattan Institute for Policy Research, October 2005. http://www.manhattan-institute.org/html/mpr_02.htm

[6] "The Public's Health Care Agenda for the New Congress and Presidential Campaign," December 2006 Kaiser Family Foundation. http://www.kff.org/kaiserpolls/pomr120806nr.cfm

[7] Dutko Research, December 6, 2006. Conclusions summarized at http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/12-21-2006/0004495560&EDATE=

[8] "A Survey of Voter Attitudes in the United States," Nov. 8-9 and 12, 2006. The Tarrance Group. "Some people say that in order to keep drug prices low for seniors, the federal government should SET prices for all medicines sold through the new Medicare prescription drug insurance program. Other people say that the federal government should provide oversight for the new Medicare prescription drug insurance program, but it should NOT be in the business of SETTING PRICES for prescription drugs. Competition between health insurance companies negotiating with drug companies for lower prices is the best way to maximize consumer choice and keep drug prices low. Which viewpoint comes closest to your own? 28% say government should set prices; 57% say competition is best." For more information and to obtain a copy of the study, contact The Tarrance Group http://www.tarrance.com/who/index.html

[9] Payments for Covered Outpatient Drugs Exceed Providers' Cost, GAO-01-1118, September 2001 http://www.gao.gov/new.items/d011118.pdf

[10] The dually eligible population—those enrolled in both Medicare and Medicaid—are among those most satisfied Part D enrollees, with more than 9 out of 10 "very" (73%) or "somewhat" (18%) satisfied with their coverage, 98% say the plan is working well for them, and 87% report feeling "peace of mind" now that they are enrolled in Part D. Source: Seniors' Opinions about Medicare Rx, Second Survey, September 2006. Rx Education Network. Survey conducted by KRC Research. http://www.medicarerxeducation.org/survey/survey.htm

[11] Of those who were automatically enrolled in the Medicare Part D benefit, 50% said they were "delighted" and 25% were "pleased." "Three-fourths of beneficiaries enrolled in Medicare Part D are satisfied with their drug plan," a survey conducted by J.D. Power and Associates, released September 19, 2006. Additional details, including the above, presented during several public briefings. http://www.jdpower.com/corporate/news/releases/pdf/2006200.pdf