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WHY MEDICARE DRUG COVERAGE WOULD HURT SENIORS

Despite Medicare's already horrendous finances, the Clinton Administration seeks to expand the government entitlement program by creating Medicare Part D to provide an outpatient drug benefit for senior citizens. This proposal is reminiscent of the Administration's failed attempt in 1993 and 1994 to take over all health care financing in the United States. A key element in the earlier plan was government oversight of the pharmaceutical market, with the government intending to cut costs by squeezing drug prices.

Despite Medicare's already horrendous finances, the Clinton Administration seeks to expand the government entitlement program by creating...an outpatient drug benefit for senior citizens... The predictable result...would be far fewer new drugs to increase life expectancies, to improve the quality of life, and to substitute for more invasive or costly procedures.

One of the reasons the earlier plan was rejected was concern that government control would hurt the quality of health care, especially for people with critical problems. Obviously, the current proposal is more modest, but it would still cause great damage. Tampering with the pharmaceutical market is not just bad economics. It would jeopardize the extremely expensive but hugely beneficial efforts of pharmaceutical companies to develop new, life-saving medicines. People would die.

Fewer New Drugs

Developing, testing, and bringing to market a new drug is an extraordinarily expensive process — usually several hundred million dollars — due in part to government regulatory requirements. Further, the process is very risky; there are many failures for every success. Hence, when a new drug proves safe and effective, it may cost only a few cents to produce, but it must be priced much higher than its marginal cost of production in order to recover both its own massive development costs and the costs of the many efforts that failed. Unless pharmaceutical companies expect to recover those costs, they will stop searching for new drugs.

Moreover, because investors prefer safety to risk, other things equal, they demand higher expected returns before putting their money in risky investments. Thus, companies engaged in the chancy business of searching for new drugs must aim for larger profits than companies in most industries. If the government should attempt to regulate drug companies so that they are not allowed to earn profits exceeding the average in the economy, the companies would respond by cutting their research efforts. After all, concentrating on producing established drugs and limiting most research to making minor improvements in proven drugs entails much less risk than searching for new drugs.

The government already is a major drug purchaser in the United States. By making the government an even larger purchaser, the Administration's plan would increase both the government's inclination to control drug prices and the harm it would cause by doing so. The

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predictable result — contrary to the Administration's sanguine predictions — would be far fewer new drugs to increase life expectancies, to improve the quality of life, and to substitute for more invasive or costly procedures.

It is sometimes noted that many other countries have socialized medicine and strictly regulated drug prices, but the development of new drugs by U.S. and foreign pharmaceutical companies has not stopped. The reason is that the U.S. market is sufficiently large and valuable to justify much drug development, despite price controls elsewhere. The fruits of the discoveries paid for by the U.S. market are then available here and abroad. Most of the world's pharmaceutical R&D would evaporate, however, if the world's drug companies could no longer recover their development costs in the United States.

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Government Would Try To Squeeze Prices

Drug development is a serious and worrisome issue in the context of the Administration's proposal because if the government provided drug benefits, it would almost certainly try to force down drug prices. Doing so would achieve short-term budgetary savings. It would also be tempting because whenever the government subsidizes something, people want more of it. The increased demand raises program costs by pushing up both quantity demanded and price. The cost overrun can be spectacular if government officials have underestimated by how much the subsidized price will boost demand, or in other ways low-balled the numbers. (Medicare and Medicaid both have long histories of huge cost overruns.) The escalating costs then generate intense pressure to reduce program costs somehow. Already, the Congressional Budget Office is already warning that the Administration has underestimated the cost of the proposed drug benefit by $50 billion in the first ten years.

Notwithstanding the Administration's denials, its plan does contemplate controls on drug prices and drug availability to hold down costs. The Administration would impose the controls indirectly. The Health Care Financing Administration (HCFA), which oversees Medicare, would divide the country into regions, let entities such as pharmacy benefit managers, HMOs, drug store chains, and states bid on administering the program in each region, and award the single administrative contract for the region to the entity whose bid it liked best. In bidding for the regional administrative contract, entities would indicate how they intended to restrict drug coverage to limit costs. Thus, the federal government could forcefully, albeit indirectly, regulate drug prices and covered medications when it choose which entities would receive the contracts. As with Medicare and Medicaid, the controls might be modest at first, but would become progressively more stringent over time as the cost overruns mounted. Since only one entity would administer the drug benefit in each region (i.e., a regional monopoly), seniors and providers would have few choices if they did not like the restrictions. A bureaucratic advantage for the government of levying controls through intermediaries is that it could disclaim responsibility when the controls created difficulties.

If the government pays for seniors' drugs, it could also try to save money by rationing medications, either by limiting amounts prescribed or denying coverage for more expensive drugs in favor of less expensive ones. This is not a new problem. For example, in 1993, just when the Administration was trying to nationalize Americans' health care in one swoop, Defense Secretary Les Aspin needed to be hospitalized for four days after he suffered serious side effects from a 35 cents-a-dose typhoid vaccine that cost-conscious government doctors gave him instead of a safer $1.90 vaccine. (John Greenwald, "Ouch! (Bill Clinton Attacks Drug

Prices)," *Time*, March 8, 1993, p. 53.). Rationing denies patients access to existing drugs that are expensive but that are more effective or have fewer side effects than cheaper drugs. It also slows the development of new and better drugs by causing pharmaceutical companies to doubt whether they can recover their development costs.

Medicaid and Medicare already provide abundant warnings that price controls create problems. For example, because the government has set low Medicaid reimbursement rates, many doctors now refuse to see Medicaid patients, with the result that most medical care is "free" to Medicaid recipients but access to doctors is a major problem. Medicare patients are beginning to experience similar difficulties as the government tries to save money by tightening Medicare's price and usage controls. Legislation enacted in 1997 but only now taking effect has reduced Medicare reimbursement rates at nursing homes. For some very ill Medicare patients, the new reimbursement rates are substantially below nursing home's costs. Not surprisingly, nursing homes are increasingly refusing to admit high-care Medicare patients. (David S. Hilzenrath, "Nursing Homes Shun Medicare Patients," *The Washington Post*, June 7, 1999, p. A1.)

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The government is also sharply cutting what it pays HMOs for providing health care to seniors, forcing many HMOs to pull back from the Medicare market. HMOs dropped 407,000 Medicare beneficiaries this year, and have notified the government that they will drop 327,000 next year. (David S. Hilzenrath, "HMOs Will Drop 327,000 Medicare Beneficiaries Next Year," *The Washington Post*, July 16, 1999, p. A2.) Many of those HMOs provided drug coverage to members (restricting various other benefits to keep costs manageable). Ironically, then, an Administration which claims that Medicare must be greatly expanded so seniors can receive drug benefits is stripping away from many seniors their *existing* drug benefits (and preventing additional seniors from joining HMOs to obtain drug benefits) by squeezing too hard on Medicare reimbursement to HMOs.

Better Options

There are better and less costly ways to help needy seniors obtain medication than the Administration's misguided drug benefit proposal.

Realistic HMO reimbursement. Because many HMOs provide a prescription drug benefit to members, the quickest way to deliver drug coverage to seniors is to provide HMOs with sufficient Medicare reimbursement so that they are willing to serve the Medicare population. The Administration is being inconsistent with its stated objective when it drives seniors out of HMOs by slashing reimbursement.

Streamline the drug approval process. The government should admit its own role in driving up development costs, and streamline the labyrinthine drug-approval process. For instance, it might allow greater use in the approval process of clinical trials that have already been conducted overseas. Such reforms would not only lower costs but reduce suffering and improve people's health by allowing new drugs to become available sooner.

Fundamental Medicare reform. Several months ago the majority of the National Bipartisan Commission On The Future Of Medicare (the Breaux Commission) concluded that the Medicare program, baring fundamental reform, is not financially sustainable. The Breaux Commission noted that most private insurers have more modern benefit packages which are financially sound and offer a drug benefit. Most Commission members favored

replacing Medicare with a health insurance system similar to the Federal Employees Health Benefits Program. Their plan would give all seniors "premium supports" (i.e., vouchers) to cover most of the cost of a basic policy, allow seniors the option of selecting a policy with drug coverage, and provide extra premium assistance to seniors below 135% of the poverty level. The commission did not make a formal recommendation, however, because a recommendation required a supermajority under commission rules and *all* the Clinton Administration's appointees opposed basic reform.

Focus on the needy. Most seniors do not need welfare to pay their drug bills any more than they need welfare to pay for their food, clothing, or housing. The prescription drug problem is not a problem with the price of drugs. It is a welfare problem. Those in genuine need should be helped, but there is no reason to impose price controls to hold down drug prices for everyone.

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Contrary to the President's declaration that seniors require government assistance with their drug bills because drug costs are "the greatest growing need of seniors", over 50% of seniors spend less than $200 a year out of pocket on drugs, and over 70% spend less than $500 annually. (Michael E. Gluck, "A Medicare Prescription Drug Benefit," National Academy Of Social Insurance, April 1999, online at www.nasi.org/Medicare/med-br1.htm.) About two-thirds of seniors have some prescription drug coverage. For most seniors, then, prescription drug expenditures are moderate relative to their incomes (considerably lower, for example, than restaurant meals) and do not provide a compelling basis for government aid.

A legitimate welfare issue is helping the very poor — but the very poor are already eligible for Medicaid, which provides prescription drug reimbursement. Thus, impoverished seniors would not receive any benefit from the Administration's drug plan.

Society may feel that some seniors who are too rich for Medicaid but still "near poor" need help buying medication, food, clothing, and shelter. If so, "near poor" seniors should be given some financial assistance to enable them to buy drugs and other necessities in the market, like everyone else. There is no need for the general population to subsidize medication for all seniors, regardless of income.

A humanitarian argument might be made for people with extremely high prescription drug bills relative to their incomes. But that group is very small. A recent study found that just 4% of beneficiaries have annual costs above $2,000. (Gluck, *op. cit.*) The number of seniors with high drug bills is reduced because Medicare already covers inpatient drug expenses. Perversely, the design of the Administration's plan is exactly *opposite* what it should be to serve those with catastrophic medical bills. The Administration would begin coverage with the first dollar but then stop just when drug costs are becoming high. A design that would focus on those with the highest bills — and also be much less expensive than the Administration's proposal — would provide coverage only on drug bills in excess of some burdensome dollar amount or percent of income. That design may not be politically appealing because it would affect only a few voters (covering everyone, not just the needy, curries more political favor), but it would make better humanitarian and economic sense than the Administration's welfare-for-all-seniors program.

Conclusion

Because the Administration refuses to support fundamental Medicare reform, it wants to transfer $700 billion of general revenues to Medicare over the next 15 years to postpone real reform and shore up the existing program *temporarily*. To partially finance the proposed drug benefit, it would transfer another $95 billion of general revenues to Medicare

over the next 15 years and increase senior's Medicare premiums by over 50%.

Although the Administration insists its proposed Medicare expansion would be humane and cost effective, it actually would be very costly, *fail* to appreciably help the seniors most in need, and *harm* everyone, including seniors, by lowering the quality and availability of medications. Moreover, the taxes inherent in the Administration's big-government approach would be a burden for taxpayers and would slow the economy by taking a bite out of work and saving incentives. Other policies would be more economical and, simultaneously, more effective.

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Note: Nothing written here is to be construed as necessarily reflecting the views of IRET or as an attempt to aid or hinder the passage of any bill before Congress.