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May 14, 2012

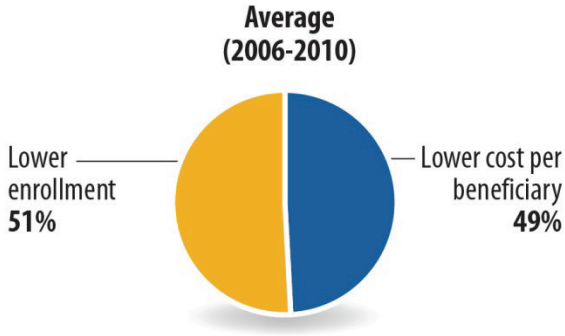
LOWER-THAN-EXPECTED MEDICARE DRUG COSTS MOSTLY REFLECT LOWER ENROLLMENT AND SLOWING OF OVERALL DRUG SPENDING, NOT RELIANCE ON PRIVATE PLANS

by Edwin Park and Matt Broaddus

The House-passed budget would convert Medicare to a "premium support" voucher to purchase private health insurance or traditional Medicare.[1] Some supporters of premium support — most notably House Budget Committee Chairman Paul Ryan, who designed the House proposal — claim that reliance on private insurers would lower Medicare costs. As evidence, they cite the fact that the Medicare Part D drug benefit, which took effect in 2006, has cost less than predicted when Congress enacted it. They attribute this lower spending to efficiencies produced by competition among the private insurers that deliver the drug benefit.[2]

Figure 1

Half of Lower Medicare Drug Spending Due to Lower Than Projected Enrollment



Source: CBPP analysis of the Medicare Trustees 2004 and 2012 reports.

Analysis indicates, however, that reliance on private plans to deliver the Medicare drug benefit had little or nothing to do with Part D's lower-than-expected spending. The two primary factors that drove the reduction in Medicare Part D spending (relative to the earlier cost estimates) were lower-than-expected program enrollment and

[1] For analysis of the budget proposal to convert Medicare into a "premium support" system, see Paul N. Van de Water, "Medicare in the Ryan Budget," Center on Budget and Policy Priorities, March 28, 2012; Paul N. Van de Water, "What You Need to Know about Premium Support," Center on Budget and Policy Priorities, March 19, 2012; and Paul N. Van de Water, "Ryan-Wyden Premium Support Proposal Not What It May Seem," Center on Budget and Policy Priorities, revised December 21, 2011.

[2] See, for example, House Budget Committee Chairman Paul Ryan's March 20, 2012 address at the American Enterprise Institute, http://www.aei.org/events/2012/03/20/a-blueprint-for-american-renewal-an-address-by-house-budget-committee-chairman-paul-ryan/. See also Kathryn Nix, "Recipe for Reform: Success of Consumer-Driven Principles in Medicare Programs," Heritage Foundation, August 10, 2011 and Joseph Antos, "What Does Medicare Part D Say About the Ryan Plan?," *RealClearMarkets.com*, June 15, 2011.

the sharp decline in spending growth for prescription drugs throughout the U.S. health system. A recent analysis issued by the Kaiser Family Foundation reaches similar conclusions.[3]

This analysis expands on earlier work we have conducted on this matter[4] and finds:

- **Lower-than-expected enrollment accounted for more than half of the difference between Part D's actual costs for fiscal years 2006 through 2010 and its projected costs.** According to the Medicare trustees, between 2006 and 2010, actual average enrollment was 10.6 million — or 25 percent — *lower* than they had estimated when Congress enacted Part D. This had a large impact on costs. Lower enrollment accounted for 51 percent of the difference between the trustees' original cost projection and Part D's actual costs over the first five years.

  Congressional Budget Office (CBO) data tell a similar story. Actual Part D enrollment for the period 2006-2010 was, on average, about 7.1 million (18 percent) less than CBO had expected, and this lower enrollment accounted for 57 percent of the difference between CBO's projected costs for Part D and the program's actual costs between 2006 and 2010.

- **Part D costs *per beneficiary* were also lower than projected, but this mostly reflects a slowdown in per-capita prescription spending throughout the U.S. health care system.** Actual net Part D costs per beneficiary in 2010 were 22 percent lower than the Medicare trustees originally projected and 16 percent lower than CBO had estimated. But overall prescription drug spending per capita in 2010, as measured in the National Health Expenditures estimates, was *35 percent* lower than the actuaries at the Centers for Medicare & Medicaid Services (CMS) projected when Congress enacted the drug benefit.

  Drug spending growth declined unexpectedly — both in Medicare and systemwide — because major drugs went off-patent, fewer costly new blockbuster drugs came to market, and use of lower-cost generic drugs increased substantially, according to the CMS Office of the Actuary (which helps prepare the Medicare trustees' reports and conducts the estimates of National Health Expenditures). Private industry analysts agree. The IMS Institute for Healthcare Informatics found that as more generics became available, the average daily treatment costs of the ten classes of drugs most used by Medicare beneficiaries fell by about *one-third* between 2006 and 2010.

- **Private plans actually *increased* Part D costs by doing a comparatively poor job of negotiating discounts ("rebates") from drug manufacturers.** Requiring private plans to obtain the same rebates that the Medicaid program obtains for the same drugs would reduce Part D costs by $137 billion over the next ten years, according to CBO.

  Prior to creation of Medicare Part D, low-income people enrolled in both Medicare and Medicaid (a group of beneficiaries known as the "dual eligibles") received their drug coverage through Medicaid, which requires drug manufacturers to provide a certain level of rebates on

[3] Jack Hoadley, "Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition," Kaiser Family Foundation, May 2012.

[4] Edwin Park, "Lower-than-Expected Medicare Drug Costs Reflect Decline in Overall Drug Spending and Lower Enrollment, Not Private Plans," Center on Budget and Policy Priorities, May 5, 2011.

prescription drugs in order to lower federal and state costs. When Congress enacted the Medicare Part D drug benefit, it expected private plans to negotiate larger rebates than Medicaid had been getting for drugs prescribed to the dual eligibles, who began receiving drug coverage through Medicare (rather than Medicaid) when Part D started operation. Instead, research shows that the private insurance companies offering Part D coverage are getting much smaller rebates than manufacturers are required to provide to Medicaid, which raises Part D costs as well as beneficiary premiums.

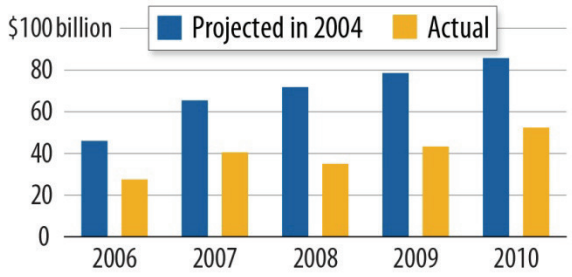
For example, in 2009, on a per-unit basis, Medicaid drug rebates were three times larger than the median rebates negotiated by private insurance plans for the top 100 drugs used by Medicare Part D beneficiaries, according to the Department of Health and Human Services' (HHS) Office of the Inspector General. As a result, Medicaid drug rebates reduced total Medicaid spending for these drugs by *45 percent*, while the discounts negotiated by private plans reduced Part D costs for the same drugs by only 19 percent. Ensuring that Medicare gets the same rebates for drugs dispensed to low-income Medicare beneficiaries that Medicaid obtains for those drugs would reduce Part D costs by *$137 billion* (or nearly 12 percent) over the next ten years, according to CBO — striking evidence of the extent to which Part D overpays for prescription drugs.[5]

Why Were Medicare Part D Costs Lower Than Projected?

Over its first five years, the actual costs of the Medicare Part D drug benefit were significantly lower than both the Medicare trustees and CBO originally projected.[6] For example, in early 2004, the Medicare trustees estimated that net federal Part D costs would equal about $348 billion between 2006 and 2010; actual costs were about $149 billion less (see Figure 2).[7] Similarly, at the time of the drug benefit's enactment, CBO expected net federal Part D costs of $283 billion between 2006 and 2010; actual costs were about $84 billion below that.[8]

Figure 2

Medicare Net Drug Spending Lower Than Earlier Projected



Source: Net of premiums and state "clawback" payments (excluding administration). CBPP analysis of the Medicare Trustees 2004 and 2012 reports.

[5] Congressional Budget Office, "Estimates of the Effects of Medicare, Medicaid and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013 – March 2012 Baseline," March 16, 2012.

[6] This analysis examines only the first five years of the Medicare Part D drug benefit (2006-2010) to exclude the effects of the Affordable Care Act provisions to close the so-called "doughnut hole" in the drug benefit and to charge increased premiums for higher-income beneficiaries, which began to take effect in calendar year 2011. The first of these ACA provisions *increased* Part D costs in 2011, while the second *lowered* net costs. Neither was anticipated when CBO and the Medicare actuaries issued their estimates of the drug benefit's costs when the benefit was enacted in 2003.

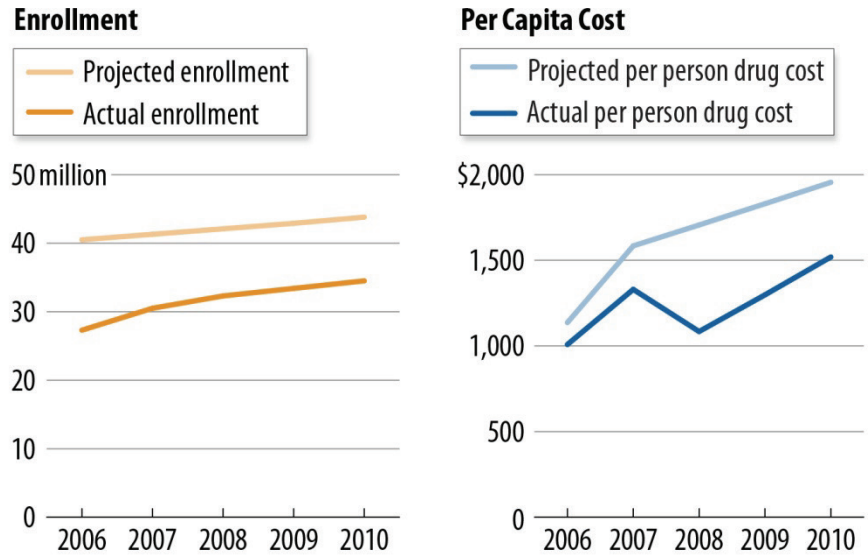
[7] CBPP analysis of 2004 and 2012 Medicare Trustees' Reports. These figures exclude administrative costs (and are net of premiums and "clawback" payments through which states continue to contribute a share of the cost of providing drug coverage to dual eligible beneficiaries).

[8] CBPP analysis of Congressional Budget Office, "Letter to the Honorable Don Nickles," November 20, 2003, Congressional Budget Office, "Letter to the Honorable Joe Barton," February 16, 2005; and CBO Medicare baselines.

Supporters of converting Medicare into a premium support system cite this fact as evidence that private plans lower costs. But careful analysis of the factors contributing to lower-than-expected Part D costs yields a far different result.

Figure 3

Medicare Part D Enrollment and Per-Person Cost Consistently Lower than 2004 Projections



Source: CBPP analysis of the Medicare Trustees 2004 and 2012 reports.

Lower-Than-Expected Enrollment

Enrollment in the Medicare drug benefit was substantially lower than the Medicare trustees and CBO had originally estimated.[9] In early 2004, the trustees expected that average Medicare Part D enrollment over its first five years (2006-2010) would be 42.1 million.[10] The actual figure was 10.6 million (or 25 percent) lower (see Figure 3). This lower-than-expected enrollment accounted for 51 percent of the difference between actual costs and the costs that the trustees originally projected (see Figure 1).

Similarly, when Congress enacted the drug benefit in late 2003, CBO estimated that average Part D enrollment between 2006 and 2010 would be approximately 38.4 million. Actual average enrollment was 31.3 million.[11] Lower-than-expected enrollment accounted for 57 percent of the difference between Part D's actual costs and CBO's original cost projections.

[9] For purposes of this analysis, Part D enrollment also includes individuals who receive employer-sponsored retiree drug coverage subsidized by Medicare Part D.

[10] The Medicare trustees only report actual enrollment and projected enrollment by calendar year. These figures reflect an adjustment to estimate enrollment by fiscal year.

[11] CBO did not project specific year-by-year enrollment figures but had assumed that on average, about 93 percent of Medicare Part B beneficiaries would enroll in the Medicare drug benefit (or receive employer-sponsored retiree drug coverage subsidized by Medicare) during its first eight years.

Lower-Than-Expected Per-Beneficiary Costs

Lower per-beneficiary costs account for the rest of the difference between Part D's actual and projected costs. Both the Medicare trustees and CBO assumed significantly higher Part D costs per beneficiary than actually occurred. For example, in fiscal year 2010, net federal Part D costs per beneficiary were 22 percent lower than the Medicare trustees originally projected (see Figure 3)[12] and 16 percent lower than CBO had projected.[13]

Arguably, the use of private plans could help explain why per-beneficiary costs were lower than expected. That ignores, however, the sharp decline in growth in spending for prescription drugs throughout the U.S. health care system.

In the late 1990s and early 2000s, prescription drug spending grew rapidly, reflecting the availability of new "blockbuster" drugs, rising prices for existing drugs, and greater utilization by beneficiaries.[14] When Congress enacted the Medicare drug benefit, these trends were expected to continue. For example, in 2004, the National Health Expenditure projections assumed that per-capita retail drug spending would grow by around 10 percent annually between 2006 and 2010; the Medicare trustees incorporated these expected growth rates into their Part D cost estimates.

Drug spending growth, however, began to moderate unexpectedly and then slowed more significantly around the time that the Medicare prescription drug benefit took effect in 2006. This slowdown resulted from developments such as major drugs going off-patent, fewer new blockbuster drugs coming to market, and much greater usage of lower-cost generic drugs, as the CMS actuaries, the Kaiser Family Foundation, and others have explained.[15] Indeed, *overall* drug spending per capita grew an average of only 2.8 percent a year between 2006 and 2010. *Overall retail drug spending per capita in 2010 was 35.3 percent lower than had been projected in 2004*.[16]

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[12] In 2010, actual costs were $1,519 per beneficiary compared to projected costs of $1,955 per beneficiary, according to the Medicare trustees. These per-beneficiary cost figures exclude administration and are net of premiums and state clawback payments.

[13] In 2010, according to CBO estimates, actual costs were $1,532 per beneficiary compared to projected costs of $1,824 per beneficiary.

[14] See Mark Merlis, "Explaining the Growth in Prescription Drug Spending: A Review of Recent Studies," U.S. Department of Health and Human Services, August 2000.

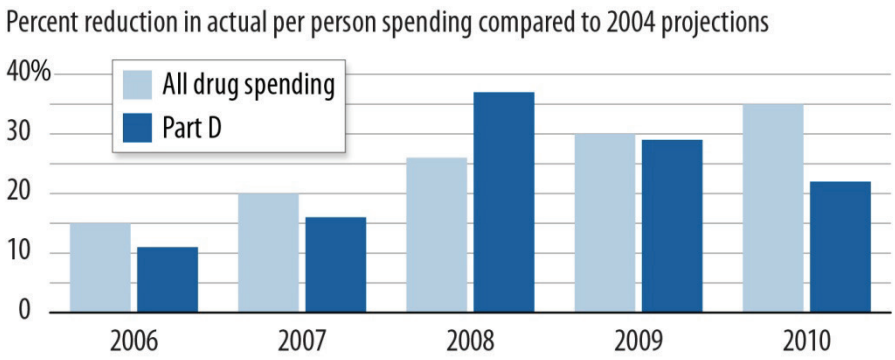
[15] See, for example, Aaron Catlin *et al.,* "National Health Spending in 2006: A Year of Change in Prescription Drugs," *Health Affairs*, January/February 2008; Micah Hartman *et al.,* "National Health Spending in 2007: Slower Drug Spending Contributes to Lower Rate of Overall Growth Since 1998," *Health Affairs*, January/February 2009; Micah Hartman *et al.,* "Health Spending Growth at a Historical Low," *Health Affairs*, January 2010; Anne Martin *et al.,* "Recession Contributes to Slowest Annual Rate of Increase in Health Care Spending in Five Decade," *Health Affairs*, January 2011; Hoadley*, op cit*; and IMS Institute for Healthcare Informatics, "The Use of Medicines in the United States: Review of 2010," April 2011.

[16] CBPP analysis of National Health Expenditure projections and data.

As the Medicare trustees and the Kaiser Family Foundation have noted, these system-wide drug cost trends have been key factors in reducing Medicare Part D spending below original projections.[17] Private industry analysts have produced similar findings. The IMS Institute for Healthcare Informatics found that the cost of the average daily treatment of the ten therapeutic drug classes most used by Part D beneficiaries in 2006 declined from $1.50 in January 2006 to $1.00 by December 2010, a reduction of one-third in nominal terms (and an even larger reduction in inflation-adjusted terms). Eight of the ten therapeutic classes experienced price declines. Expiring patents and the resulting substitution of lower-cost generic drugs for brand-name versions played a major role in these lower prices. (The two therapeutic classes that had price increases either had no major expiring patents or a major patent expiration that did not occur until 2010.)[18] As Figure 4 shows, the annual percentage difference between actual Part D costs per beneficiary and the original projections broadly reflects the reductions in system-wide per-capita costs relative to 2004 projections.

Figure 4

Medicare Per-Beneficiary Drug Savings Broadly Reflected Reductions in Drug Costs System-Wide



Source: CBPP analysis of the Medicare Trustees 2004 and 2012 reports and National Health Expenditures estimates.

Nevertheless, some supporters of premium support have argued that without private plans, Medicare Part D would not have benefited from these system-wide trends. For example, one report argued that private Part D plans have been especially successful at encouraging the use of generic drugs.[19] Yet, the use of generic drugs among Part D plans appears to have been no different than the rates of generic utilization in state Medicaid programs during the early years of the drug benefit.[20] Another analysis claimed that Part D was more successful at slowing prescription drug cost growth than the overall U.S. health care system, but the analysis ignored the effects of lower enrollment on

[17] See, for example, the 2007-2010 Medicare Trustees' reports and Hoadley, *op cit.*

[18] Murray Aitken and Ernst Berndt, "Medicare Part D at Age Five: What Has Happened to Seniors' Prescription Drug Prices?," IMS Institute for Healthcare Informatics, July 2011.

[19] Antos, *op cit.*

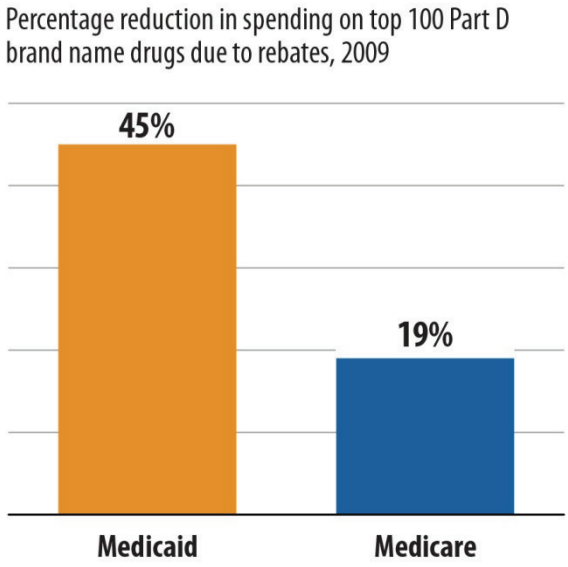
[20] HHS Office of Inspector General, "Generic Drug Utilization in the Medicare Part D Drug Program," November 2007.

the lower-than-expected Part D costs.[21] Net Part D costs per beneficiary actually grew significantly *faster* than overall prescription drug spending per capita between 2006 and 2010, according to National Health Expenditures data. Moreover, the Kaiser Family Foundation study notes that Medicare beneficiaries do not appear to choose plans that minimize their out-of-pocket costs or to switch plans when charged higher-than-average annual premium increases, due largely to the difficulties that beneficiaries face in making informed choices among plans. That reduces the incentives for private plans to lower costs.[22]

The reductions in net Part D per-beneficiary spending between 2006 and 2010, relative to original projections, tend to be somewhat *smaller* than the reductions in per-beneficiary costs system-wide (see Figure 4).[23] As a result, there is little evidence that using private plans to deliver Medicare drug coverage played a significant role in producing lower-than-expected costs per beneficiary, as the trend can be largely explained by slower growth of pharmaceutical costs throughout the health care system.

Figure 5

Medicaid Drug Rebates Much Larger Than Part D Rebates Negotiated by Private Plans



Source: Office of the Inspector General (Health and Human Services), *Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D,* August 2011

Moreover, evidence indicates that the use of private plans to deliver the Medicare drug benefit actually *increased* Part D costs because private plans have done a comparatively poor job of negotiating rebates from drug manufacturers. Prior to the creation of Part D, "dual eligibles" (people enrolled in both Medicare and Medicaid) received drug coverage through Medicaid, which requires drug manufacturers to provide certain rebates to state Medicaid programs for the drugs they purchase. When Congress enacted the Medicare drug benefit, it assumed that the private insurance companies participating in Part D would negotiate larger discounts from drug manufacturers than those that Medicaid requires.[24]

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[21] James Capretta, "The Top Five Flawed Arguments Against Premium Support," Heritage Foundation, January 30, 2012.

[22] Hoadley, *op cit.*

[23] 2008 is the exception as Medicare Part D per beneficiary costs fell between 2007 and 2008, in large part because insurers repaid Medicare for overpayments they received in 2006. (Insurers had overestimated their expected costs in their plan bids for 2006.) In addition, according to the Medicare trustees, premium receipts were higher than expected in 2008.

[24] Under a "best price" provision, drug manufacturers must provide state Medicaid programs the same level of rebates that they provide most other public and private purchasers if the rebates that they provide to other purchasers exceed certain minimum amounts. As part of the Medicare drug law, Congress specifically excluded Medicare Part D rebates from the calculation of best price because of concerns that the best price provision could interfere with the expected ability of private plans to negotiate larger rebates than those required under Medicaid.

In reality, however, research shows that the private insurers offering Part D coverage get significantly smaller rebates than Medicaid does for the same drugs. For example, in 2009, for the top 100 brand-name drugs with the highest total Part D costs, Medicaid drug rebates were *three times* larger on a per-unit basis than the median rebate negotiated by private Part D plans, according to the HHS Office of Inspector General. As a result, the Medicaid cost per drug (net of rebates) was lower than the net Medicare cost for all but seven of these 100 drugs.

Overall, the rebates that Medicaid obtained in 2009 reduced Medicaid spending for these drugs by 45 percent, while the rebates obtained by Medicare Part D plans reduced Medicare costs by just 19 percent (see Figure 5).[25] Medicare thus pays substantially more than Medicaid does for the same drugs, which results not only in higher program costs but also in higher Part D premiums for beneficiaries (and larger profits for drug manufacturers).

Requiring that Part D get the same rebates as Medicaid does just for drugs that Part D covers for low-income Medicare beneficiaries (the large majority of whom are dual eligibles), as the Obama Administration has proposed in its fiscal year 2013 budget, would reduce Part D costs by $137 billion over the next ten years, according to CBO.[26] Requiring Medicaid-level rebates for *all* Part D beneficiaries would produce even greater savings.

Conclusion

Claims that the use of competing private plans in Medicare Part D accounts for lower-than-anticipated federal costs for the Medicare drug benefit do not withstand scrutiny. As the Kaiser Family Foundation analysis states, there "is compelling evidence that factors other than competition offer the best explanations for the lower-than-expected spending trend" in Part D.[27] Lower enrollment explains more than half of the lower-than-expected costs, and the remainder largely reflects a system-wide slowdown in prescription drug costs, driven mainly by expiring patents on major drugs, fewer new blockbuster drugs, and greater utilization of generic drugs. In fact, because private plans have done a poorer-than-expected job of negotiating discounts from drug manufacturers on their own, Medicare is actually incurring higher costs for prescription drugs than it likely would otherwise have spent.

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[25] The gap between Medicaid and Medicare rebates is likely larger today because the Affordable Care Act increased Medicaid drug rebates starting in 2010. See HHS Office of Inspector General, "Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D," August 2011. See also Richard Frank and Joseph Newhouse, "Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing," The Hamilton Project at the Brookings Institution, April 2007; Stephen Schondelmeyer, Statement before the Minority Office of the House Committee on Government Reform, January 2006; and House Committee on Oversight and Government Reform, "Medicare Part D: Drug Pricing and Manufacturer Windfalls," July 2008, http://oversight.house.gov/documents/20080724101850.pdf.

[26] Congressional Budget Office, "Estimates of the Effects of Medicare, Medicaid and Other Mandatory Health Provisions Included in the President's Budget Request for Fiscal Year 2013 – March 2012 Baseline," March 16, 2012.

[27] Hoadley, *op cit.*