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LOWER-THAN-EXPECTED MEDICARE DRUG COSTS REFLECT DECLINE IN OVERALL DRUG SPENDING AND LOWER ENROLLMENT, NOT PRIVATE PLANS Evidence Shows Reliance on Private Insurers Actually Raised Medicare Costs

by Edwin Park

Some supporters of the House budget plan's proposal to replace Medicare with a voucher to purchase private health insurance claim that reliance on private insurers can lower costs.¹ They cite the fact that the costs of Medicare Part D, which took effect in 2006, have been lower than the Congressional Budget Office predicted when Congress enacted the drug benefit.² They attribute this lower spending to efficiencies produced by competition among the private insurers that deliver the benefit.

This claim does not withstand scrutiny. The two primary factors driving the reduction in Medicare Part D spending were:

- **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.³ Drug spending growth began to moderate unexpectedly and then slowed more significantly around the time the Medicare prescription drug benefit took effect in 2006. But this was not caused by enactment of the drug legislation, as is evidenced by the fact that growth in spending on pharmaceuticals slowed throughout the health care system. This slowing of expenditure growth was the result of other developments, including some major drugs going off-patent, fewer new blockbuster drugs coming to market,

¹ For example, Gail Wilensky, former administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) has repeatedly made this claim. See http://www.pbs.org/newshour/bb/politics/jan-june11/medicare_04-21.html and <http://thedianerchmshow.org/shows/2011-04-05/slashing-federal-budget/transcript>.

² In 2003, the Congressional Budget Office estimated that in 2010, Medicare Part D costs (benefits including Medicare subsidies for employer-sponsored retiree coverage, net of premiums and so-called “clawback” payments from states), would cost about \$73 billion; CBO recently estimated that net Part D costs were about \$52 billion in 2010. See Congressional Budget Office, “Letter to the Honorable Don Nickles,” November 20, 2003 and Congressional Budget Office, “March 2011 Medicare Baseline,” March 18, 2011.

³ 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.

and much greater usage of lower-cost generic drugs.⁴ Indeed, *overall* U.S. prescription drug spending was about *35 percent lower* in 2010 than had been projected back in 2003.⁵ As the Medicare Trustees noted in their recent annual reports, these system-wide drug cost trends have been key factors in reducing Medicare Part D spending below the levels projected when the Medicare drug benefit was enacted.⁶

- **Lower-than-expected enrollment in Medicare Part D.** On average, about 93 percent of Medicare Part B beneficiaries were expected to enroll in the Medicare drug benefit (or receive employer-sponsored retiree drug coverage subsidized by Medicare) during its first eight years.⁷ CBO now estimates, however, that only about 77 percent of Part B beneficiaries enrolled in Part D or subsidized retiree coverage in 2010.⁸ That means roughly 6.5 million fewer beneficiaries were enrolled in Medicare Part D last year than originally projected, causing costs to be substantially lower than CBO originally assumed.

Moreover, there is evidence that, far from reducing costs, the use of private plans to deliver the Medicare drug benefit has *increased* costs. Prior to the creation of Medicare Part D, *Medicaid* provided prescription drug coverage to “dual eligibles” — the low-income beneficiaries enrolled in both Medicare and Medicaid. Then, starting in 2006, *Medicare* took over drug coverage for the dual eligibles. When Congress enacted the Medicare drug benefit, it assumed that the private insurance companies that would participate in Medicare Part D would be able to negotiate larger discounts from drug manufacturers than those required under Medicaid. In fact, however, research shows that the private insurers offering Part D coverage are getting significantly smaller discounts for drugs than the rebates that manufacturers are required to provide state Medicaid programs.⁹ One estimate found that drug prices, net of discounts, under Part D to be at least 20 percent higher than the estimated net prices that Medicaid pays.¹⁰

⁴ 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; and IMS Institute for Healthcare Informatics, “The Use of Medicines in the United States: Review of 2010,” April 2011.

⁵ CBPP analysis of National Health Expenditure data available at <http://www.cms.gov/NationalHealthExpendData/downloads/nheprojections2003-2013.pdf> and <http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf>.

⁶ See the 2007- 2010 Annual Reports of the Boards of Trustees of the Federal Hospital and Federal Supplementary Medical Insurance Trust Funds.

⁷ See Congressional Budget Office, “Letter to the Honorable Don Nickles,” *op cit.*

⁸ CBPP analysis of CBO’s Medicare March 2011 baseline. Relying on CMS enrollment data, the Kaiser Family Foundation has produced similar enrollment figures. See Kaiser Family Foundation, “The Medicare Prescription Drug Benefit,” October 2010.

⁹ See 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>.

¹⁰ Schondelmeyer, *op cit.*

As a result, the federal government is incurring considerably higher drug costs for the dual eligible beneficiaries than were previously paid under Medicaid. According to CBO, requiring drug manufacturers to pay Medicaid-level rebates (or discounts) for drugs dispensed to the Medicare beneficiaries who receive Medicare’s “low-income subsidy” to help them afford the premiums for Medicare drug coverage (most of whom are dual eligibles) would reduce Medicare Part D costs by *\$112 billion* over the next ten years.¹¹ This is strong evidence that reliance on private insurance, has raised, rather than lowered, the government’s costs.

Furthermore, Medicare beneficiaries have long had the option of enrolling in private insurance through the Medicare Advantage program (and its predecessors) rather than in traditional Medicare, on the theory that private insurers could deliver higher-quality care at lower cost. Yet experience shows that private plans have cost substantially more than in traditional Medicare, with little evidence they furnish better care.¹² For example, according to the Medicare Payment Advisory Commission, in 2011 Medicare will pay, on average, 10 percent more for beneficiaries enrolled in private insurance than for comparable beneficiaries enrolled in traditional Medicare.¹³ (The Affordable Care Act will begin to curb these overpayments starting in 2012.)¹⁴

Finally, CBO’s analysis of the budget plan that the House of Representatives approved on April 15 found that in 2022, when the budget plan would convert Medicare into a voucher program for newly eligible seniors, the cost of a private insurance plan providing comparable benefits would be almost 40 percent higher than the cost of traditional Medicare. That is because private plans have higher administrative costs (including profits) and pay higher provider reimbursement rates.

Not only would a private plan be more costly overall, but beneficiaries would end up paying far higher out-of-pocket expenses. CBO found that in 2022, typical beneficiaries turning 65 that year would pay more than twice what they would have paid under regular Medicare — \$12,500 rather than \$6,150.¹⁵ CBO also reported that the degree to which seniors would pay more out of pocket under the House budget plan would increase over time as the value of the voucher steadily eroded relative to the cost of private insurance.

¹¹ Congressional Budget Office, “Reducing the Deficit: Spending and Revenue Options,” March 10, 2011. State Medicaid programs receive rebates from pharmaceutical companies for drugs dispensed to Medicaid beneficiaries. The proposal that CBO estimated would save \$112 billion over ten years would require pharmaceutical manufacturers to pay the same level rebates for drugs dispensed to Medicare beneficiaries who receive the “low-income subsidy” as the manufacturers pay for drugs dispensed through Medicaid.

¹² See, for example, January Angeles, “Ending Medicare Advantage Overpayments Would Strengthen Medicare,” Center on Budget and Policy Priorities, September 14, 2009 and Edwin Park, “Informing the Debate About Curbing Medicare Advantage Overpayments,” Center on Budget and Policy Priorities, May 13, 2008.

¹³ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2011.

¹⁴ January Angeles, “Health Reform Changes to Medicare Advantage Strengthen Medicare and Protect Beneficiaries,” Center on Budget and Policy Priorities, July 27, 2010.

¹⁵ Congressional Budget Office, “Long-Term Analysis of a Budget Proposal by Chairman Ryan,” April 5, 2011.