Medicare and the Prescription Drug Benefit: Increased Pressure for Reform

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Mr. Chairman and Members of the Committee: Thank you for inviting me to appear before you. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. I am also adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. I have previously served as the assistant director for health and human resources at the Congressional Budget Office, and earlier held several research and management positions in the Health Care Financing Administration, the precursor to the Centers for Medicare and Medicaid Services (CMS). The views I present today are my own, and do not represent the position of the institutions with which I am associated.

Passage of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in 2003 marked a major milestone for Medicare. For the first time, all beneficiaries will have access to outpatient prescription drug coverage under Medicare Part D. Special low-income subsidies will be available to needy beneficiaries, and millions of seniors and disabled people will save money when they buy their medicines under the new program.

All of this comes at a cost. The new program is the largest entitlement expansion since Medicare was established four decades ago. The huge sums that the federal government will spend through this program will largely be funded out of general tax revenues. That means the new drug benefit was enacted without being fully financed through specifically earmarked funds, and every dollar spent by beneficiaries will add 75 cents to the federal government's budget deficit. By adding the new benefit without full funding, Congress has increased the cost pressures that threaten Medicare's stability.

My testimony today will address three points related to the Medicare prescription drug benefit and the financing challenges facing the entire Medicare program:

- The drug benefit will be expensive, but we do not yet know what it will cost. Actual spending over the next decade could be substantially larger than assumed in the latest ten-year cost estimates. Moreover, the ten-year cost does not include the trillions of dollars of outlays the drug benefit will incur past 2015.

- The drug benefit has added substantially to Medicare's unfunded liabilities, which will require renewed efforts to reform the program. We cannot simply tax our way out of the problem. Higher taxes reduce future job opportunities and economic growth, which further complicate the problem of providing future generations of older Americans with health care benefits.

- Medicare's traditional approaches to cost containment—federal price setting and limiting access to care—are unlikely to be effective in the long run. Such policies would distort treatment decisions and reduce incentives for the development of innovative new drugs.

Additional reforms will be needed if we are to maintain a financially viable Medicare program. The MMA included elements intended to promote competition, consumer choice, and financial incentives for greater efficiency. It also established the precedent that beneficiaries

most in need should receive greater subsidies in Medicare. Those principles should be the basis for future reforms of the program.

Cost of the Drug Benefit

Public discussion of the Medicare prescription drug benefit has been confused by the plethora of cost estimates that have been released by the Congressional Budget Office (CBO) and the administration over the past few years. Each new estimate seems to be larger than the last, causing some to believe that the program's costs have risen precipitously even before the full benefit was established. That is not correct, if only because we do not yet have any relevant cost experience for the program on which to base a new assessment. Nonetheless, it is likely that even the latest estimate understates the federal cost of the program.

CBO initially scored MMA as increasing federal outlays by $395 billion between 2004 and 2013.[1] That score, released in the fall of 2003, assured that the legislation would not exceed the $400 billion that had been allocated for Medicare in the Senate budget resolution. Subsequently, the administration revealed its analysis, which estimated costs of $534 billion over the same period.[2] The meaning of that difference in estimates may have been lost in the resulting storm of controversy. The disagreement showed that even the experts were uncertain about how the drug benefit would work.

Debate over the numbers flared up again this year with the release of new estimates in the administration's 2006 budget. Payments to health plans for the drug benefit totaled $1.2 trillion between 2006 and 2015. However, that figure excluded savings offsets built into the drug benefit: beneficiary premiums, payments from states (the "clawback"), and lower federal spending in Medicaid. Net of those savings, the cost was $724 billion.

Although the new numbers were higher than the original estimates, the administration had not changed its analysis of the program's cost. The main reason for the seemingly large increase was the change in the time period over which the cost was estimated. The original estimates covered an earlier ten-year period, which included only eight years of a full drug benefit. The other two years (2004 and 2005) included the cost of the prescription drug discount card program, which was far less expensive. The latest estimates measure the cost of the full benefit for the entire 10 years. In other words, the higher new estimates did not imply that program costs had taken an upward turn.

CBO also issued a new, seemingly higher, cost estimate this year. In February, CBO released an estimate showing $795 billion in higher Medicare outlays between 2006 and 2015 as a result of the drug benefit. However, that estimate is not comparable to the administration's new estimate because it omits other savings that would accrue to the federal government outside

[1] CBO estimated that the drug benefit would cost $409 billion, but other provisions of MMA lowered the cost of the full bill to $305 billion.

[2] The administration estimated that the drug benefit would cost $511 billion, with other provisions of MMA raising the cost of the full bill to $534 billion.

the Medicare program. A comparable number would be somewhat lower than $795 billion. CBO, like the administration, had not fundamentally changed its view of the cost of the program.

The CBO estimate has since been revised twice, in March and again in August, to capture changes in economic and technical budget assumptions. The drug benefit was projected to increase Medicare outlays by nearly $850 billion using the March scoring baseline. The latest revised estimate using the midsession baseline came in at $855 billion over the next ten years. As was the case with the February estimate, those projections do not include some savings that would accrue to programs other than Medicare.

The administration and CBO seem to agree that the drug benefit will increase federal outlays by more than $700 billion and perhaps as much as $850 billion over the next ten years. However, a ten-year cost estimate only scratches the surface. Medicare provides a permanent entitlement to payment for covered services, and under current law that commitment will not expire.

Over the longer term, Part D's cost is much higher. The Medicare trustees estimate that Part D spending net of beneficiary premiums and state payments will total about $8.7 trillion over the next 75 years, measured in present value terms. That is the amount of money that must be transferred from general tax revenue to pay the cost of Part D in full. Measured over the infinite horizon, the necessary amount of general revenue transfers rises to $18.2 trillion.

The cost of the prescription drug benefit could be even larger if the actuaries have misjudged the response of patients, drug plans, employers, and others to the new program. Beneficiaries might respond to the new subsidies by using more prescription medicines than assumed in the estimates. The use of prescription drugs also might increase more than expected if there are unexpected breakthroughs in pharmaceutical research and development, bringing more innovative products to the market. Drug plans might find that seniors' drug use is less amenable to their cost management practices (such as step therapy, which requires the patient to start with the least expensive drug in a class). More employers might drop their retiree drug coverage than assumed in the cost estimates. There are many other possible changes in behavior that could lead to program costs higher than have been estimated.

Perhaps the greatest vulnerability to higher-than-expected Part D spending stems from the activities of policymakers. The way in which the Centers for Medicare and Medicaid Services (CMS) implements and regulates the new benefit could have a significant impact on the prospects for cost containment. For example, CMS has taken steps to ensure that drug formularies are not overly restrictive. While that may mean greater access to prescription drugs for beneficiaries, such actions could limit the drug plans' ability to shift market demand toward lower-cost drugs.

Congress might also be tempted to increase the generosity of the Medicare drug benefit in future years. For example, there may be pressure to fill the "donut hole," a gap in coverage requiring that the patient pay the full cost for drug spending between $2,250 and $5,100, or the

low-income subsidy might be extended to more beneficiaries. Such policies could increase the cost of the benefit substantially above the levels suggested by current estimates.

Can We Make Good on Medicare's Promises?

By any metric, the Medicare prescription drug benefit represents an enormous additional commitment of the nation's resources to the cost of seniors' health care. The benefit also has added significantly to the financial pressures facing the country in the decades ahead as the baby boomers age into retirement. Over the next 75 years, Part D will require new general revenue transfers of $8.7 trillion. That is on top of the $21.0 trillion shortfall projected by the Medicare trustees for Part A and Part B.

Medicare is facing a fiscal crisis of historic proportions. Broadly speaking, there are three possible responses to such a crisis: ignore it, raise program revenue, or reduce program spending. We consider each in turn.

Ignore the crisis. If we took no action—in effect, ignoring the crisis—we would be relying on the economy to grow sufficiently to accommodate the rise in health spending without unduly sacrificing other important spending priorities. Even when economic growth is accounted for, spending on the three major entitlement programs (Medicare, Medicaid, and Social Security) could increase from the current 8.4 percent of GDP to 17.4 percent by 2030, according to the Congressional Budget Office.[3] By 2050, spending for those programs could reach 27.6 percent of GDP. According to CBO, this situation is unsustainable unless the health spending slows significantly below historical rates. Even then, tax revenues would probably need to be higher than in the past.

Raise program revenue. We could raise program revenue by increasing the income tax or the payroll tax, or by increasing premiums paid by beneficiaries. We will focus on the first two forms of revenue raising because they each have a broad tax base and it is conceivable that their tax rates could be raised sufficiently to cover the Medicare financial shortfall. Premium increases could supplement the revenue raised through higher broad-based taxes but premiums alone are unlikely to be sufficient given the vast sums that would be necessary.

According to the Medicare trustees, the payroll tax would have to be immediately and permanently doubled—rising from 2.9 percent to 5.99 percent of taxable earnings—to fully fund Medicare Part A for the next 75 years. However, Part A is only part of Medicare's underfunding problem.

Unless we are prepared to cut back drastically federal spending for education, housing, transportation, defense, and other program areas, taxes also would have to be increased to

[3] The long-range projections use CBO's "high spending path" estimates for health programs, reported in CBO, *The Long-Term Budget Outlook*, December 2003. Those projections assume that the historical growth in health spending continues into the future. Since they were developed before the Medicare drug benefit was enacted, the projections may understate future health spending.

finance Medicare Part B and Part D if we took no actions to cut spending. In research forthcoming from the Heritage Foundation's Center for Data Analysis, Tracy Foertsch and I estimate that the Medicare payroll tax would rise to about 13.4 percent of taxable earnings if we funded the entire Medicare shortfall (including Part B and Part D) through that tax vehicle.

Such a large increase in payroll taxes would be intolerable. The tax hike would slow growth in the economy, significantly reducing GDP, employment, saving, and investment. Policymakers are unlikely to propose such a drastic long-term tax increase, but they might consider more modest revenue increases to fund Medicare over a shorter time period. However, even a short-term revenue-raising policy would have deleterious economic effects.

We simulated the impact of raising payroll and income taxes to finance Medicare fully through 2015, using Global Insight's short-term U.S. Macroeconomic Model. That would be a temporary solution. After 2015, Medicare would again spend more than it received in earmarked revenue. According to our estimates, GDP would fall by $90 billion annually and nearly 880,000 jobs would be lost each year, on average. By dampening economic activity, large tax increases undercut our ability to finance future consumption.

Our estimates might be optimistic, however, since they assume that Congress would use the additional revenue solely to pay for Medicare spending or to buy down the national debt. If policymakers followed their historical behavior, they would use some of the new tax revenue to finance increased federal spending outside the Medicare program—necessitating a higher tax increase. In that case, the economic consequences would be more severe than we have estimated.

Reduce program spending. Most analysts agree that growth in Medicare spending should be reduced, but there is little agreement on how that should be done. Some argue that the program's regulatory approach, which relies on direct government price setting and limiting access to health services, has been effective at controlling cost. Others argue that Medicare spending would be slowed more effectively if beneficiaries could choose from among competing private plans.

Price controls and other regulatory restrictions could push prices below the level that would prevail in a competitive market, but only for a limited time. Below-market prices ultimately cause shortages as patients demand more health care goods and services than providers and manufacturers are willing to produce. If the shortage—or the perception of shortage—became severe, policymakers would take actions to ease restrictions on price.

That reaction has been demonstrated with Medicare's "sustainable growth rate" formula, which mandates cuts in physician fees when past spending exceeds a target. Faced with the prospect of 4 to 5 percent annual fee reductions, physicians have demanded relief, asserting that Medicare patients were beginning to experience problems accessing services. Congress has responded several times, although only with temporary price increases since the budgetary cost of a permanent change in the formula is large. This remains an issue of great concern to

policymakers, who continue to seek ways of providing rate relief to physicians.[4]

Over the long term, price controls would be no more effective in limiting spending growth than a competitive system.[5] However, controls would distort the pricing signals that promote efficiency in competitive markets. In such markets, prices rise when demand for a product increases, encouraging producers to supply more of the product. A price kept artificially low provides no incentive for producers to increase supply and satisfy consumer demand.

An approach to cost containment embraced by all sides acknowledges that some portion of Medicare spending is wasteful. Medicare pays for both necessary and unnecessary care, of high quality and low, delivered in efficient and inefficient manners. If we could eliminate the unnecessary, poor quality, inefficient care, Medicare spending would be reduced significantly. We do not have the means to accomplish this, although the expansion of health information technology, evidence-based medicine, pay for performance, and other initiatives could begin to chip away at some of the wasteful spending in Medicare. Despite a great deal of recent interest, such methods may develop slowly and are unlikely to yield enough savings by themselves to resolve Medicare's long-term financing crisis.

Cost containment in Part D. MMA prohibits CMS from negotiating pharmaceutical prices with manufacturers. Such negotiations, which are essentially government price controls by another name, would have a serious unintended consequence. Government price setting creates additional uncertainty about the potential returns to innovation, discouraging research and development that could lead to new drugs for cancer, dementia, or other diseases of the elderly.

Instead, Part D plans will tailor their benefits and premiums to attract enrollment, and they will be partially at risk for costs that exceed their bid amounts. That provides an incentive for the plans to manage their costs and negotiate the best price they can for the products.

Significant savings are possible under this structure. The Government Accountability Accounting Office (GAO) found that pharmacy benefits managers (PBMs) in the Federal Employees Health Benefits Program obtained substantial discounts, ranging from 18 percent below the cash price for brand-name drugs purchased at retail pharmacies to 53 percent for

[4] Rep. Bill Thomas and Rep. Nancy L. Johnson, Letter to Mark McClellan on Medicare physician payment, July 12, 2005.

[5] Previous empirical studies of the effectiveness of Medicare cost controls compared to private sector approaches have been interpreted as supporting both sides of the argument. One approach compares the trends in health spending under Medicare and private insurance (see Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs* (March/April 2003), pp. 230-237; Joseph Antos, "The Role of Market Competition in Strengthening Medicare," testimony before the Senate Select Committee on Aging, May 6, 2003; and Michael J. O'Grady, "Health Insurance Spending Growth: How Does Medicare Compare?," Joint Economic Committee, June 10, 2003). Such estimates are sensitive to adjustments necessary to make "apples to apples" comparisons, and the results vary depending on the time period over which spending is observed. Those studies look at the *past* performance of Medicare and the private sector in controlling cost growth. That may not be adequate to assess how well a *specific* reform of Medicare would control cost growth *in the future*.

generic drugs purchased through mail-order pharmacies.[6] In addition, PBMs received manufacturer rebates of 3 to 9 percent, and saved 1 to 9 percent through interventions such as prior authorization and drug utilization review. These impressive results are the product of a strongly competitive private market for prescription drugs.

Whether Part D plans can achieve similar savings remains to be seen. Much depends on how CMS implements the program and the restrictions that are placed on the use of private sector cost management tools in Medicare. Congress and CMS will discourage overly vigorous cost containment methods that could adversely affect patients.

Policymakers will be tempted to impose government pricing on prescription drugs in Part D, particularly if program spending rises even faster than expected. However, government price setting is guided by social and political concerns, not market realities. If there are short-term budget savings, they would be offset by the cost imposed on patients from policy-induced shortages of pharmaceuticals. Although there might be a great demand for new drugs to treat particular diseases, pricing distortions would discourage firms from making the sizeable and risky investments necessary to invent those products. That misallocation of resources ultimately leads to a less efficient pharmaceutical sector.

It is incorrect to assume that if the government takes direct action on a problem, it will deliver the desired result—in this case, price controls leading to lower drug spending. Much of drug spending is driven by increased use of pharmaceuticals and the shift to newer drugs, which the drug benefit presumably is intended to promote. Spending growth is not primarily the result of price increases. As we have seen with past attempts to control spending for other health services, price control policies have only a limited effect on Medicare spending trends.

Conclusion

Although the Medicare drug benefit will help millions of seniors and disabled people, the new benefit has placed an unprecedented financial burden on the larger program. Unless significant changes are made in Medicare, rapid spending growth as the baby boomers start to reach age 65 in a few years will drain money from the federal budget. We have all been reminded that natural catastrophes can strike us, and recovery can cost hundreds of billions of dollars. By tightening our spending in other areas, we have the fiscal capacity to meet that challenge today. Will we be able to say that a decade from now?

Fortunately, important elements of MMA can provide a basis for the next, more thorough reforms that are needed. More private health plans will be competing in Medicare than ever before, and they will for the first time be paid according to their own assessment of the costs of doing business in their local communities—supplanting the formula-based pricing system that dictated reimbursements for such plans since the mid-1980s. Medicare Advantage plans should be permitted to compete fairly with the traditional Medicare program, and consumers should decide which type of health plan they want. MMA borrowed some ideas from the highly

[6] Government Accountability Office, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, Report GAO-03-196, January 2003.

successful Federal Employees Health Benefits Program, but there are more lessons to be learned.

Congress must face the hard truth. We have made promises in Medicare that cannot be kept, and we have compounded those promises with the Medicare Modernization Act. We cannot expect even a robustly growing economy to solve this problem for us, and we cannot tax our way out of the fiscal crisis without doing damage to the economy. Prudence demands a reform that focuses on the incentives that drive Medicare spending.