Center for American Progress

# Better Benefits, Lower Costs: Three Steps to Improving Medicare

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New information in President Bush's budget has returned the spotlight to the inefficiencies built into the Medicare reforms pushed through Congress in 2003. With both health care costs and federal deficits on the rise, responsible policymakers are looking for ways to get the best value out of federal health programs. Eliminating several wasteful provisions from the 2003 Medicare reform law could generate tens of billions of dollars in savings that could be used to get Medicare beneficiaries and taxpayers a better deal on the prescription drug benefit they have been promised.

This brief outlines three proposals to lower Medicare costs and enable better Medicare benefits: rein in excessive drug prices, remove unfair advantages for private plans and HMOs, and eliminate tax shelters that do not help Medicare beneficiaries but could jeopardize job-based health benefits. Efforts to undermine the Medicare benefit package or arbitrarily cap Medicare spending should take a backseat to proposals that lower costs without harming seniors or disabled Americans who rely on Medicare for their health care needs.

### Background

In December 2003, Congress passed the Medicare Modernization Act (MMA), legislation to create a Medicare prescription drug benefit and make other significant changes to the Medicare program. Legislative debate assumed that the cost of the reforms would be less than $400 billion over ten years. Shortly after President Bush signed the law, the administration released its first estimates, which put the costs at $534 billion. Had those figures been publicly available during Congressional debate, the outcome of the legislation probably would have been much different.

Buried in the fine print of President Bush's budget for fiscal year 2006 is a new price tag for the Medicare prescription drug benefit and other reforms he signed into law in December 2003. The total cost for the prescription drug benefit alone now stands at $1.2 trillion in additional federal spending over the next ten years, though some of that amount will be offset by premiums paid by Medicare beneficiaries, by payments from the states to Medicare that are newly required under the reforms, and by savings to Medicaid. Nevertheless, this figure is about 50 percent higher than the administration's original estimate from early 2004.

The administration has attempted to dispel the public's understandable "sticker shock" over these new figures by pointing out that the difference reflects the inclusion of two additional years of drug benefits, not any fundamental change in the administration's assessment of the effects of the reforms. In other words, for the first time we have an estimate of what the first ten years of the drug benefit will cost. It should come as no surprise that costs rise very quickly under the president's reforms. The prescription drug benefit and other changes in the MMA were structured inefficiently in order to meet particular policy objectives of the bill's proponents. The same benefit could have been provided at less cost if different choices had been made.

Rapid cost increases in the wake of the Medicare reforms were inevitable. Several provisions are inefficient by design, guaranteed to generate excessive payments to private insurers and drug companies. The reforms also took money that had been set aside for prescription drug benefits for seniors and disabled Americans and diverted it into new tax-sheltered savings accounts that are not available to Medicare beneficiaries and that disproportionately benefit higher income individuals. President Bush now advocates additional federal subsidies for these accounts, while proposing deep cuts to other important health programs like Medicaid and threatening to veto any attempts to improve the Medicare drug benefit.

If President Bush and Congressional leaders had made different policy choices, Medicare beneficiaries and all taxpayers could have gotten a better deal. Improvements are still possible. Three key changes could generate significant savings that could be used to improve Medicare prescription drug benefits while preserving the choices that seniors and disabled Americans care about most – choice of health care provider and treatment. It is not necessary or appropriate to undermine Medicare benefits to achieve significant savings.

## Opportunities for Improvement

- Rein in excessive prescription drug prices by using Medicare's bargaining power to negotiate lower prices for seniors and disabled Americans.

The prices of the prescription drugs most often used by older Americans are growing at more than three times the rate of general inflation.[1] The Medicare Modernization Act (MMA) signed by President Bush in 2003 does not include effective mechanisms to lower prescription drug prices. Instead, the law is intended to emulate the private market practices that have brought us to where we are today – rapidly rising prescription drug costs that are increasingly borne by patients due to health insurers' restructuring of drug benefits.[2] Even if the Medicare program and its beneficiaries experience similarly unsustainable costs, the new law expressly forbids the secretary of Health and Human Services from acting to ensure reasonable prices under the drug benefit.

The MMA relies on private drug plans (e.g., HMOs and other private health insurers), in conjunction with pharmaceutical manufacturers, to establish the prices beneficiaries and taxpayers will pay for prescription drugs under the Medicare drug benefit. This structure undermines Medicare's negotiating power. Medicare covers more than 40 million seniors and disabled Americans who are projected to consume more than $1 trillion worth of prescription drugs over the next decade.[3] Pharmaceutical companies, like companies in other industries, grant discounts in exchange for volume and market share. It stands to reason, then, that Medicare can get the best prices on prescription drugs by leveraging its group purchasing power – just as Canada, other nations and other large payers in the United States do. States have recognized the importance of leverage by pooling purchasing activities across state agencies and by forming multi-state coalitions to negotiate drug prices. In contrast, the new Medicare law relies on multiple private insurers in each of multiple regions to negotiate separate arrangements with pharmaceutical manufacturers. This dilutes Medicare's bargaining position.

The MMA also expressly prohibits Medicare from "interfering" with negotiations between private insurers and pharmaceutical companies, leaving Medicare powerless to prevent or address unfair prices. This prohibition undermines Medicare's ability to set key ground rules that might prevent conflicts of interest or promote lower prices. It also potentially limits the ability of Medicare to monitor what it pays for drugs, both opening the possibility of overpayments and restricting the ability to collect data that could be used to design better Medicare prescription drug benefits over time.[4]

Medicare could get a better deal on prescription drug prices than is likely to be achieved under the MMA. By the administration's own estimates, the MMA will achieve an "ultimate savings level of 25 percent" off of "retail-level, unmanaged prescription drug costs."[5] Other large purchasers have been able to leverage their purchasing power to get much deeper discounts. For example, the Department of Veterans Affairs is able to negotiate discounts of 50 percent or more.[6] The Congressional Budget Office has found that average prices for patented drugs in other industrialized countries are 35 percent to 55 percent lower than in the United States.[7] If Medicare were able to get similar discounts, through negotiation, reimportation, or other means, the "doughnut hole" in the Medicare drug benefit could be eliminated.[8]

- Remove unfair advantages for private plans and HMOs designed to lure seniors out of traditional Medicare at significant taxpayer expense.

Private insurers and HMOs have long been able to participate in Medicare and compete for Medicare beneficiaries' enrollment. Proponents of an increased role for such plans have argued that these private companies can deliver Medicare benefits more efficiently than the traditional Medicare program. Reflecting those expected savings, private plans used to be paid 95 percent of the average per capita Medicare costs in their area. Over time, however, as private plans proved unwilling or unable to meet these efficiencies and withdrew from the program, Congress gradually raised payments in order to entice their participation. Even before enactment of the new law, private insurers were paid an average of 103 percent of what it would have cost traditional Medicare to care for their

enrollees.[9] Despite this competitive advantage, only 12 percent of Medicare beneficiaries were enrolled in private plans in 2003.[10]

The Medicare Modernization Act created further unfair advantages for private insurers by immediately and dramatically increasing their payments. In 2004, private plans were paid an average of 107 percent of what traditional Medicare would have otherwise spent. In some areas, the payments were as high as 123 percent of costs in the traditional Medicare program.[11] Similar results are expected for 2005.[12] It is important to note that these figures understate the true relative costs of private plans, since they also tend to attract healthier (and therefore lower cost) enrollees. Taking that factor into account, this year private plans are expected to receive about 112 percent of what it would cost to cover their enrollees under traditional Medicare.[13] Additional financial incentives – blended payment rates, risk corridors and a $10 billion "stabilization fund" to promote regional and nationwide private plans — begin in 2006. This will exacerbate the current system problems: private plans cost more, selectively serve profitable parts of the country, arbitrarily discontinue coverage, and use premium and benefit changes to attract healthy and avoid sick beneficiaries.[14]

It is clear that increasing the role of private plans in Medicare will not lower total Medicare costs. In fact, the administration originally estimated that Medicare costs would increase by $46 billion over ten years as a result of the MMA's enhanced payments to private plans. The president's budget did not explicitly update that figure for this year, but it has undoubtedly grown. In addition, the president's budget does note a change in policy that would generate an additional $8.3 billion in payments to private plans over the next five years.[15] These structural mechanisms are explicitly designed to generate higher payments to private plans than Medicare would pay to cover their enrollees directly. The clear intent is to increase the role of private plans in the program, even though the primary argument used to justify that role – that private plans would deliver benefits more efficiently – has been abandoned. Removing these excessive payments would create a more level playing field for true competition between traditional Medicare and private plans, allowing beneficiaries to have a fair choice.

- Eliminate tax shelters that do not help Medicare beneficiaries and that threaten to undermine job-based health benefits.

Tucked into the Medicare Modernization Act was a completely unrelated provision creating Health Savings Accounts (HSAs), tax-preferred savings accounts combined with high-deductible health insurance. HSAs provide no assistance of any kind to Medicare beneficiaries, who are ineligible for the accounts under the statute. However, HSAs have potentially severe adverse consequences for other individuals, particularly working Americans who have health coverage through their jobs.

The MMA allows individuals who are covered by a high-deductible health plan – one that requires individuals to pay at least $1,000 out of pocket (in addition to premiums) before coverage begins – to establish tax-preferred savings accounts. Money in these accounts is not taxed going in, while it accumulates, or when it is spent, provided it is

spent on health care. This is a tremendous tax advantage that makes the accounts most attractive to healthy and wealthy individuals, who do not expect to need much health care and who stand to gain the most from the tax break. Conversely, individuals with lower incomes and less than perfect health are less likely to choose an HSA.[16]

As HSAs become more widely available, they are likely to destabilize employer-sponsored health benefits. Healthier and wealthier individuals will drop their traditional employer health coverage in favor of HSAs, leaving a sicker and poorer population in the traditional, more comprehensive plans. As a result, premiums for those plans will rise; prior studies have found that premiums could double.[17] With that added cost pressure, employers are likely to shift even more costs onto employees or "cash out" their benefits entirely. Many employees will not be able to find coverage elsewhere and will become uninsured.

The administration's original cost estimate for the HSA provisions in the MMA totaled $16 billion over ten years – about two and half times the amount Congress assumed when it passed the MMA.[18] The administration is now seeking further subsidies for HSAs, at an additional cost of $51 billion over the next ten years.[19] These policies would exacerbate the destabilizing effect of HSAs and could cause hundreds of thousands of people to lose their health benefits and become uninsured.[20] By rejecting the administration's proposal and eliminating the tax advantages of Health Savings Accounts, Congress can redirect this wasteful spending while simultaneously removing a threat to working Americans' health security.

## Conclusion

When the Medicare Modernization Act was before Congress, a number of cost-saving mechanisms were proposed and debated. Proponents of the enacted legislation rejected those proposals based on ideological preferences for increasing the role of private companies in Medicare. As a result, Medicare costs have increased beyond what would be reasonable to expect for the level of prescription drug benefit provided in the law. The three steps described in this brief would lower Medicare costs and enable better Medicare benefits. These efficiency gains should be considered before any attempt is made to undermine Medicare benefits and shift additional costs onto seniors and disabled Americans.

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[1] AARP Public Policy Institute, "Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans-Second and Third Quarter 2004 Update," December 2004.
[2] C. Smith et al., "Health Spending Growth Slows in 2003," *Health Affairs* 24, no. 1 (2005): 185-194.
[3] Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for Medicare Prescription Drug Benefit," July 2004. Available at: http://www.cbo.gov/showdoc.cfm?index=5668&sequence=2
[4] T. Shaw, "Prescription Drug Prices: Harnessing Medicare's Purchasing Power," *Center for American Progress.* Available at: http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=24890
[5] Memo from Richard S. Foster, Chief Actuary, to Mark B. McClellan, Administrator of the Centers for Medicare and Medicaid Services, "Effectiveness of Drug Price Negotiations by the Federal Government versus Medicare Prescription Drug Plans," February 11, 2005.

[6] Statement of Cynthia A. Bascetta, Director, Health Care—Veterans' Health and Benefits Issues, GAO Testimony, "VA and DOD Health Care: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges," July 22, 2002. Available at: http://www.gao.gov/new.items/d02969t.pdf
[7] Congressional Budget Office, "Would Prescription Drug Importation Reduce US Drug Spending?" April 29, 2004. Available at: http://www.cbo.gov/showdoc.cfm?index=5406&sequence=0
[8] G. F. Anderson et al, "MarketWatch: Doughnut Holes and Price Controls," *Health Affairs*, July 21, 2004, Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.396/DC1?ck=nck
[9] Medicare Payment Advisory Commission, "Medicare + Choice Payment and Eligibility Policy," in *Report to the Congress: Medicare Payment Policy* (Washington: MedPAC, March 2004). Available at: http://www.medpac.gov/publications/congressional_reports/Mar04_Ch4.pdf
[10] B. Biles et al, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans-2005 Update," *Commonwealth Fund*, December 2004. Available at: http://www.cmwf.org/usr_doc/750_Biles_costofprivatization_update_ib_pdf.pdf
[11] Medicare Payment Advisory Commission, "M+C payment rates compared with county Medicare per capita fee-for-service spending," April 8, 2004.
[12] B. Biles et al, "The Cost of Privatization: Extra Payments to Medicare Advantage Plans-2005 Update."
[13] R. A. Berenson, "Medicare Disadvantaged and the Search for the Elusive 'Level Playing Field,'" *Health Affairs*, December 15, 2004. Available at: http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.572/DC1?ck=nck
[14] "Lost in the Fine Print: Ten Overlooked Policies That Harm Medicare and Its Beneficiaries," *Center for American Progress*. December 4, 2003. Available at: http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=13275; J. M. Lambrew, "Fifty Concerns About the Medicare Law and Ideas on How to Fix Them," *Center for American Progress*. July 22, 2004. Available at: http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=128706
[15] Office of Management and Budget, *Analytic Perspectives, Budget of the United States Government* (Washington: US Government Printing Office, 2005). See page 395. Available at: http://www.whitehouse.gov/omb/budget/fy2006/pdf/spec.pdf
[16] G. Shearer and S. Monetzemolo, "The False Promise of 'Consumer-Driven' Health Care," *Center for American Progress*, August 11, 2004. Available at: http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=138321
[17] R. Greenstein and E. Park, "Health Savings Accounts in Final Medicare Conference Agreement Pose Threats Both to Long-Term Fiscal Policy and to the Employer-Based Health Insurance System," *Center for Budget and Policy Priorities*, December 1, 2003. Available at: http://www.cbpp.org/10-27-03health.htm
[18] E. Park and R. Greenstein, "Proposal for New HAS Tax Deduction Found Likely to Increase the Ranks of the Uninsured," *Center for Budget and Policy Priorities*, May 10, 2004. Available at: http://www.cbpp.org/5-10-04health.htm
[19] Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2006 Revenue Proposals," February 2005. Available at: http://www.treas.gov/offices/tax-policy/library/bluebk05.pdf
[20] E. Park and R. Greenstein, "Proposal for New HAS Tax Deduction Found Likely to Increase the Ranks of the Uninsured."

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