An Evaluation of Medicare's Prescription Drug Policy

Testimony Submitted To

Committee on Homeland Security and Government Affairs

**Subcommittee on Federal Financial Management,
Government Information, and
International Security**

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by

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Chairman Coburn, Senator Carper, members of the Committee, thank you for the opportunity to testify on the Medicare Prescription Drug Program. I feel very honored by it.[1]

I especially appreciate this opportunity because there is no more important or scarier policy issue than how to design policies to preserve the efficient operation of health care markets in attempting to pay for our growing health care needs. It is well known that designing policies to improve health-care market efficiency is difficult. But it is not yet widely appreciated how huge Medicare's future financial shortfall is. The Medicare Prescription Drug Improvement And Modernization Act of 2003 (MMA) substantially increases that shortfall and is likely to worsen the operation of markets for prescription drugs and drug insurance. As such it deserves urgent reconsideration—a view that is shared by many health care experts and policymakers including, I suspect, by members of this Committee.

I. Introduction:

MMA offers prescription drug coverage to *all* retirees. The new law will benefit seniors on the whole but will exert several negative economic effects:

Five issues stand out:

- Government intervention is usually justified when private markets fail. With 75 percent of retirees already having prescription drug coverage and 90 percent having access to prescription drugs prior to MMA, this market did not exhibit the symptoms of "market failure." Indeed, passage of MMA is likely to *cause market failure* by displacing the private market's provision of drug insurance.

- MMA will improve access to prescription drugs for poorer retirees – both those who are and those are not currently covered under Medicaid. Well-to-do retirees will also benefit in general but some may experience higher out-of-pocket costs if they lose their private drug coverage and are forced to enroll into Medicare Part D. This law, therefore, appears designed to first displace the private market followed by sustained pressure on Congress to liberalize the MMA's benefit formula over time.

- MMA will influence prescription drug prices in the private market as the share of government-subsidized purchasers expands. Theoretical reasoning and empirical studies suggest that private drug prices would increase with additional government-subsidized patients entering the market. Most of the burden of this increase will fall

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on workers covered by making employer-provided health insurance or private plans more expensive. That will reduce younger workers' likelihood of employment, cause lower wage growth, increase conversion from full- to part-time jobs, and reduce work effort.

- MMA makes a large addition to the already considerable financial shortfall in the rest of Medicare. Unresolved, this shortfall will grow larger and impose higher fiscal burdens on future generations, further eroding their productivity and work incentives.

- MMA will change workers' and younger generations' perceptions about the need to save for health-care expenses during retirement. Studies show that expansion in government entitlement obligations leads to higher consumption and reduces national saving and investment—delivering a further negative impact on future worker productivity and output.

MMA was hastily passed without a proper evaluation of its short- and long-term cost and it lacks appropriate measures to control spending escalations. That means future Congresses may be induced to regulate the actions of pharmacies, drug manufacturers, employers, and plan providers with regard to drug pricing and spending per person on prescription drugs. Such regulations would be counterproductive because they would restrict prescription drug supply, generate illegal prescription drug sales, and reduce the quality of prescription drug coverage for everyone – and not just for retirees.

If MMA's repeal is deemed impractical, a financially and economically sensible course would be to scale it back to a sustainable level by providing coverage only to those seniors who are under financial pressure on account of their prescription drug expenses. That effort needs to be combined with restoring the rest of Medicare to financial sustainability.

II. Pre-MMA Prescription Drug Coverage of Retirees

Prior to MMA's enactment, Medicare Parts A and B provided no limits on out-of-pocket costs and did not insure retirees against outpatient prescription drug expenses.

The vast majority of retirees (75 percent) had prescription drug coverage under private plans: Employer supplemental health coverage (33 percent), Medicaid and state drug programs (17 percent), Medicare+Choice Plans (15 percent), Medigap policies with prescription drug coverage (2 percent) or other sources (8%).[2] New retirees were guaranteed access to 10 alternative Medigap plans, three of which covered prescription drugs.

[2] See "Cost Sharing Policies Problematic For Beneficiaries and Program," Testimony by William J. Scanlon before the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives, May 9, 2001.

Some retirees, however, faced financial pressure on account of their prescription drug costs: Estimates as of 2000 suggest that average out of pocket costs for retirees in poor health took up about 44 percent of their incomes.[3] Low-income single women not covered under Medicaid spent about 52 percent of their incomes on health expenses, on average.

Enrollment into Medigap plans including prescription drug coverage has been quite low. Such plans impose spending caps and so do not cover catastrophic expenses. Their high premiums, deductibles and cost-sharing requirements make them expensive and their availability varies widely by geographic area. Premium inflation among plans with prescription drug coverages has been very rapid. The plans also provided first-dollar coverage that discouraged prudent use of services and prescription drugs.

These features made Medigap policies inferior to employer supplemental coverage, which generally had low co-insurance requirements, no separate spending caps for prescription drugs, and drug prices after negotiated discounts. Employer plans also do not provide first-dollar coverage, thus promoting prudent use of health services including prescription drugs.

III. MMA, the Drug Market, and Retiree Prescription Drug Coverage

Drug treatments are becoming standard practice treating chronic conditions. Greater intensity of use of existing drugs and the development of new and more effective, but also more expensive, drugs have increased the *entire population's* dependence on drugs therapies. Higher drug development costs and higher demand for drug treatments have caused drug prices to grow rapidly.

1. Is There "Market Failure" in the Prescription Drug Marketplace?

Data (cited earlier) show that a significant share of retirees already had access to prescription drugs and drug insurance. About 90 percent of seniors reported taking at least 1 prescription drug. Thus, MMA represents an increase in government intervention in prescription drug and drug insurance markets where there was no prior market failure.

Whether the provision of a good or service is financed by the government or through private markets makes a large difference to whether the economy's scarce resources are allocated efficiently. Efficient allocation of resources implies their use in meeting the most important needs first—as signaled by peoples' willingness to pay.

[3] The remainder was accounted for by Medicare premiums, deductibles, co-payments and cost sharing. See "Medicare Cost Sharing Policies Problematic for Beneficiaries," Testimony by William J. Scanlon before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 9, 2001. [GAO-01-713T]. See also [GAO-01-941]

It is well known government intervention replaces resource allocation through competitive forces by allocation through fiat. Because the government does not maximize profits, federal price setting and resource allocation decisions are not based on market signals efficient resource use. The usual result is a loss in economic efficiency. This is what will happen to the prescription drug and drug insurance markets because of MMA.

That's not to say that market outcomes are fully acceptable. If there is considerable inequality of wealth or of needs among individuals, market operation will provide goods and services to the rich, whereas the poor will be unable to make their demands effective. Because such outcomes may be socially unacceptable, government intervention could be justified – but only at the margin – to assist those in need of subsidies because of economic misfortunes.

A study based on 2003 data indicates that only 25 percent of retirees reported forgoing medications due to high costs.[4] The most vulnerable categories of retirees on account of prescription drug expenses are those without any drug insurance (50 percent spending $100 or more on prescription drugs), those in low-income groups (34 percent spending more than $100 per month) and those with three or more chronic conditions (42 percent spending more than $100 per month).

It is usually difficult to demarcate the appropriate extent of government intervention on account of wealth inequality. MMA clearly oversteps all reasonable limits, however, because it provides a broad drug subsidy to *all* retirees regardless of their economic status, previous access to prescription drug coverage, and prescription drug needs.

MMAs generosity will significantly worsen the economy's ability to allocate resources efficiently – directly by reducing the size of the private market, increasing drug prices, imposing larger than necessary tax burdens on current and future productive citizens, and indirectly by reducing their ability and willingness to save and invest for the future.

2. Who Will Benefit From MMA?

Dual eligible beneficiaries – those eligible for both Medicaid and Medicare coverage—will now receive drug coverage through Medicare. The lowest income beneficiaries among them will receive premium and cost-sharing subsidies as well—except for nominal drug co-payments. Low-income cost-sharing support would be phased out for families with higher income and assets.

Dual beneficiaries will not lose the value of their coverage. Indeed, their drug coverage is likely to become more generous under Medicare Part D compared to Medicaid—especially as state budget problems increase the likelihood of stricter future cost containment measures under Medicaid. Several states already regulate the number of prescriptions filled per period, the number of allowable refills, size of dosages, and drug

[4] See "Prescription Drug Coverage And Seniors: Findings from a 2003 National Survey," by Dana Gelb Safran and co-authors, Health Affairs, web-exclusive, April, 2005.

dispensing frequencies etc. These limitations will be disallowed when dual-eligible beneficiaries are shifted to Medicare Part D—making their prescription drug coverage more valuable.

Many states facing budget pressures are likely to increase their cost-sharing requirements in the future making Medicaid benefits less valuable. Hence, taxpayer costs of covering dual eligibles' drug insurance may be higher under Medicare Part D because Medicaid savings "clawed back" by the federal government are likely to be smaller than the actual costs saved.

In addition, MMA will benefit seniors with poor health and considerable dependence on costly prescription drugs—including those who purchase Medigap plans offering prescription drug coverage. As mentioned earlier, such plans' premiums, deductibles, and cost-sharing requirements can amount to thousands of dollars. In contrast, Medicare Part D's co-insurance rates are only 5% beyond expenditures exceeding $5,100. For example, under Medigap plan J, retirees must spend $6,250 out of pocket to attain the maximum benefit of $3,000 (implying total annual health care spending of $9,250). In contrast, Medicare Part D's cost-sharing formula would pick-up $5,059 of spending up to $9,250 leaving the beneficiary better off by $2,058 per year.[5]

Medicare Part D will also benefit those retirees who choose to purchase Medigap plans without prescription drug coverage because they face restrictive choices among available plans. Such purchasers constitute the vast majority of Medigap clients.

3. Some Retirees May Pay More During the Long-term

Generally, employer provided retiree health coverage is broad, includes comprehensive drug coverage, requires low co-pay and co-insurance rates, and does not impose separate caps on drug expenses. In contrast, Medicare Part D premium, deductible, and co-insurance costs will be substantial for those with drug expenses up to $5,100 per year. Hence, during the short-term many retirees may choose to remain under employer-provided prescription drug insurance.

Over the long-term, however, MMA is likely to induce employers and other private providers to restrict or eliminate retiree drug coverage. Those covered under such plans would then be forced to sign up for Medicare Part D and could face *larger* out-of-pocket costs—unless they qualify for additional low-income subsidies. This is likely to increase political pressure to shrink or eliminate the "donut-hole" in the benefit formula. That, in turn, could prompt yet more seniors to drop their private coverage and enroll into Medicare Part D, increasing the program's already high overall costs.

Thus, although retirees as a whole would gain considerably on net from the implementation of MMA, some retirees may become worse off over the long-term if employers cut costs by dropping retiree drug coverage. That means some of MMA's benefit won't stick with retirees but flow through to employers. Employers' overall gains

[5] *Ibid,* [GAO-01-713T].

could be limited, however, as prescription drug usage expands and drug prices increase. Those effects would increase the cost of providing health care insurance to workers.

IV. MMA's Impact On The Private Drug Market

The government already subsidizes prescription drug use by Medicaid patients. The federal subsidy is provided through the states' Medicaid programs. States possess set drug reimbursement rates within but must adhere to federally specified upper-payment limits. Drug reimbursement rates to providers, however, must be set to ensure drug provision consistent with the provision of other complementary medical services within each state. Rates must also ensure that comparable service levels available to those eligible for Medicaid in all states.

Drug prices and federal and state drug spending under Medicaid has escalated recently because of increased drug use and availability of new, effective, but more expensive drugs for replacing traditional medical treatments. Because prices of established drugs are not allowed to rise by more that the Consumer Price Index, manufacturers have set high initial prices for drugs that are technically "new" but work very much like older versions already on the market.

The entry of sizable additional government-subsidized patients (retirees) in the drug market means either that drug manufacturers must ramp up drug production or substitute sales to Medicare in place of sales to private purchasers including drug exports.

Some studies have estimated that post-MMA increases in drug demand would be small. But they assume that those who already purchase prescription drugs will not change their use of prescription drugs. That assumption defies past experience.

Those who lack coverage today would increase their drug usage as they obtain insurance against out-of-pocket costs. So also would those with very high dependence on prescription drugs because MMA reduces their cost-sharing expenses. In addition, MMA is likely to reduce state restrictions on drug usage for dual-eligibles—whose drug costs would now be met through Medicare Part D. And doctors will hesitate less in prescribing drugs now that their retiree patients have acquired access to a new "third party" payer.

As mentioned in testimony by health care expert, Joe Antos, before you today, drug usage intensity is likely to increase as MMA expands retiree budgets for prescription drugs. Consequently, the demand for drugs is likely to increase considerably and will likely cause higher-than-projected program outlays.

If manufacturers can increase drug production without significant additional costs it may be feasible to accommodate the additional demand without significant price increases. However, in a competitive marketplace where manufacturers must accept the highest price offers first, pharmacies and, in turn, the federal government may have to increase offer prices to manufacturers to obtain additional drug supplies for its new Medicare patients. In that case, prices charged in the private market must also increase

and the size of the private drug market must become smaller. Thus, theoretically, an increase in the drug market share of government patients would increase drug prices and shrink the private drug market.

This theoretical expectation is supported by empirical evidence on the relationship between the government's share in particular drug markets and the private market prices of those drugs. A study covering 200 drugs during 1997 and 2001 found that government participation in the drug market through Medicaid significantly increased drug prices faced by non-government payers.[6] An increase in the government's market share by 10 percent was found to be associated with a 10 percent increase in the drug's price. This finding remains true despite to the addition of several controlling factors such as drug therapeutic classes, the existence of generics, the number of close substitutes, and the time since the drug's first introduction.

Considering Medicaid's market share in the top 200 drugs, the study suggests that private-market drug prices would have been lower by 13.3 percent on average in the absence of Medicaid. Greater intensity of drug use by retirees would, therefore, imply yet higher drug prices. Thus, now that all retirees will be guaranteed federal drug insurance, the higher prices will negatively impact *workers* through employer-sponsored or privately provided plans. As a consequence, employers may seek to cut back on wages, reduce workers' health-care coverage, increase health-insurance premiums, or convert full-time jobs to part-time positions that do not include health benefits.

Another recent study documents that higher health insurance costs are taking a heavy toll on workers.[7] Each 10 percent hike in health insurance costs reduces the likelihood of being employed by 1.6 percent, and cuts hours worked by 1 percent. Workers whose health insurance is maintained are forced to accept smaller wage gains: A 10 percent increase in premiums is offset by a 2.3 percent decrease in wages.

The prior study also demonstrates that the government's drug rebate program operated for Medicaid—that limits established drugs' price increases to no more than the Consumer Price Index—leads to larger manufacturer incentives to introduce new drugs with slight performance enhancements but with initial prices set a much higher levels to compensate for the federal drug rebate program.

V. MMA's Financial Implications for Workers and Future Generations

CMS estimates that Medicare Part D's unfunded obligation (future outlays less enrollee premiums and cost-sharing) is zero. However, CMS assumes that Congress will

[6] See "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," by Mark Duggan and Fiona Scott Morton, National Bureau of Economic Research, Working Paper No. 10930.

[7] See "Labor Market Effects of Rising Health Insurance Premiums," by Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, Working Paper No. 11160, August, 2005.

continue to authorize general revenue transfers to Medicare Part D as and when needed to bridge the gap between outlays and enrollee premiums. In present discounted value, total future general-revenue infusions required are estimated at $18.2 trillion. That is, Medicare Part D promises to provide net benefits to current and future generations of retirees to the tune of $18.2 trillion in excess of the premiums they will pay for enrollment into Medicare Part D.

According to CMS, Medicare's Parts A and B combined are estimated to require total financial infusions of almost $50 trillion in present value to meet benefit costs under current laws. MMA's enactment has, therefore, increased Medicare's fiscal burden on current and future taxpayers to $68.1 trillion. The additional charge on federal general revenues from the new drug program is significantly higher than Social Security's future financial shortfall—estimated by Social Security's Trustees to be $11.2 trillion.

An $18.2 trillion figure is better understood as a share of the present value of GDP from which it must be financed. According to CMS's projections, that share equals 1.9 percent. That is, MMA commits 1.9 percent of all future GDP to funding seniors' drug coverage.

Because, the entire GDP is not (and will never be) subject to taxes, it is more instructive to compare MMA's general revenue charge to the present value of the future income tax base from which all federal general receipts are drawn. Unfortunately, there is no official estimate of the present value of the income tax base. However, if future taxable (personal and corporate) income averages about 55 percent of GDP – its current ratio -- Medicare Part D's $18.2 trillion charge on general revenues would equal 3.5 percent of the present value of the income tax base.[8]

Because Medicare Part D is not financed out of a dedicated revenue sources, it is impossible to know when the implied fiscal burden -- either higher taxes or federal spending cuts -- would be imposed. It is also impossible to know how this fiscal burden will be distributed across different income groups and across living and future generations.

The calculation of MMA's fiscal burden above involves a critical assumption: That GDP and the tax base will remain unchanged despite the imposition of higher taxes or spending cuts. However, higher taxes will adversely impact work incentives and spending cuts may degrade critical economic infrastructure, both of which would adversely affect productivity. Thus, financing the $18.2 trillion charge on general revenues is likely to require an income tax-rate increase exceeding 3.5 percentage points because the "feedback" effect of financing MMA benefits through higher taxes on national output would reduce future national output.

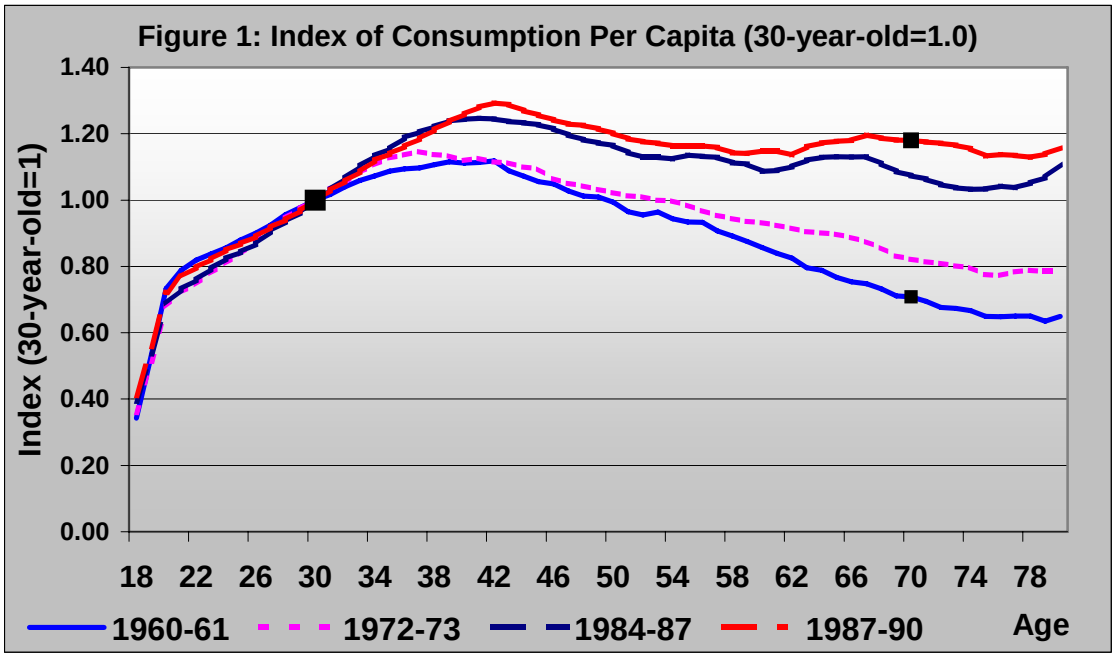
[8] The assumption that the share of taxable income in GDP will remain constant at 55 percent is quite optimistic. Labor income – a large component of taxable income – is expected to decline as a share of GDP as the baby-boomers leave the work force and enter retirement during the next two decades.

VI. The Impact of MMA on National Saving

The difference between what current generations earn by way of income each year and their annual consumption determines how many resources are saved and invested. The more current generations consume, the less is available for investment. The $18.2 trillion estimate of the present value of Part D benefit encompasses the entire future without a time limit. That is, it includes benefits that will accrue to future generations.

Unborn generations, obviously, do not consume out of current income. The impact of Medicare Part D's net benefit on *current* consumption depends on the share of it accruing to those alive today. The Medicare program's Trustees' have estimated that federal general revenue infusions into Medicare Part D on account of living generations (both workers and retirees) will equal $6.7 trillion. That is, today's retirees and workers (those aged 15 and older) can, under MMA, expect to receive from the federal government $6.7 trillion dollars on net by way of prescription drug coverage.

As the drug law is implemented and as today's generations' expectations regarding their drug benefits become firmer, they will perceive an improvement in their total wealth position. Their natural response to higher perceived wealth would be to increase their consumption. As a consequence, national saving would decline.



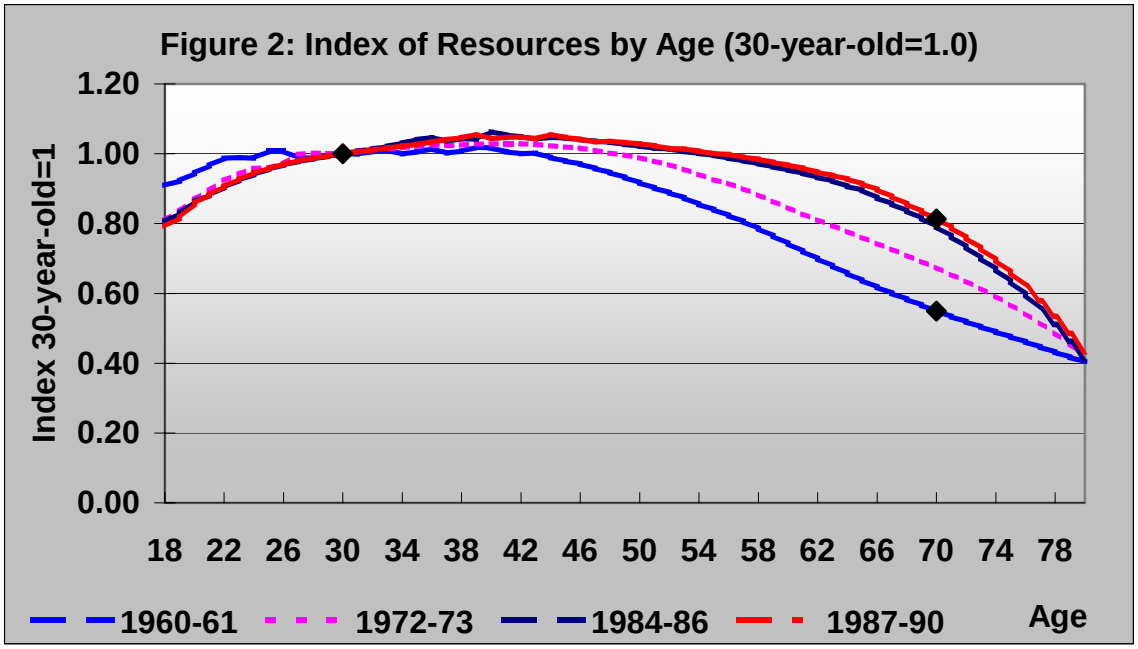
Evidence from survey data confirms that retirees increase their consumption in response to receipt of additional entitlement benefits.[9] Figure 1 shows consumption

[9] See "Understanding the Postwar Decline in U.S. Saving: A Cohort Analysis," by Jagadeesh Gokhale, Laurence J. Kotlikoff, and John Sabelhaus, Brookings Papers on Economic Activity, Winter 1996, pp. 315-407.

indices by age derived from the Consumer Expenditure Surveys for four periods: 1960-61, 1972-73, 1984-87 and 1987-90. In each period, the consumption per capita of all age groups is shown relative to the consumption of a contemporaneous 30-year-old person—whose consumption index is set equal to 1 in each of the four periods.

The figure shows that consumption per capita of 70-year-olds in 1960-61 fell short of 30-year-olds' consumption per capita in the same period by 29 percent. However, by 1987-90, 70-year-olds consumed 18 percent more per capita than 30-year-olds in the same period. More recent data also show the same pattern of increasing consumption levels by retirees relative to the consumption of their younger contemporaries.

One of the most important elements driving the change in relative consumption patterns by age appears to be the change in the pattern of resource ownership by age. The expansion of federal benefits by way of growing Social Security and Medicare outlays have transferred resources from workers to retirees during the past four decades. That process is continuing today with liberalized Social Security benefits and the enactment of new entitlement benefits -- such as Medicare Part D.



Those transfers have increased retirees' command over resources relative to those available to younger generations. Figure 2 shows total resource indices by age for the same four periods, where total resources include current net worth per capita and present values per capita of lifetime earnings, pensions, and government transfers from all programs.[10]

[10] *Ibid.*

Figure 2 shows that retirees' had more resources at their disposal compared to their younger counterparts' resources in 1987-90 than did retirees in 1961-62. The passage of MMA will continue the trend of increasing retiree resources relative to those of workers and younger generations. As a result, consumption by retirees is likely to increase and national saving will continue to decline.

How large would be the impact of MMA's cross-generation resource redistribution on saving? A Congressional Budget Office study reviewed academic literature on this question and concluded that for every $1 increase in federal unfunded entitlement obligations, national saving declines by between 0 and 50 cents.[11]

That range indicates the considerable uncertainty surrounding such estimates. However, it suggests that the best estimate of the MMA's impact on national saving is negative. Taking the mid-point of the range of estimates, national saving may be expected to cumulatively decline by $1.7 trillion by the time today's workers achieve retirement age. That is, by 2050 (when today's 15-year-olds would approach retirement), the national capital stock would erode by $1.7 trillion and future Americans' income and living standards would decline correspondingly.

VII. Conclusion

MMA subsidizes retirees' prescription drug expenses but will probably lead to considerable economic inefficiency. It will improve prescription drug coverage for low-income seniors who were previously covered under Medicaid. It is also likely to benefit low-income seniors without Medicaid coverage and those with high drug expenses. It will also provide a substantial subsidy for those seniors previously covered against drug expenses under a Medigap policy. However, out-of-pocket costs of those seniors previously covered under an employer-provided prescription drug plan are likely to increase as employers increase their premiums to soak up the subsidy or reduce, possibly drop, their coverage completely leaving retirees to foot MMA's premiums and cost-sharing expenses.

MMA will increase the share of government-subsidized patients in the market for prescription drugs. That is likely to shrink the share of privately purchased drugs via higher drug prices. The adverse impact will mostly be on workers as the cost of employer provided health insurance plans increases. That will trigger lower employment, slower wage growth, reduced hours worked, and conversion of more full-time jobs to part-time jobs.

MMA's long-term costs represent a massive addition to the already steep fiscal burdens implicit in current Medicare Part A and Part B policies. This massive cost must eventually be met via tax increases or cuts in other federal spending such as defense, infrastructure, education, social welfare programs, R&D and so on. Meeting future health-care needs as projected under current policies through tax increases alone appears

[11] See "Social Security and Private Saving: A Review of the Literature" Congressional Budget Office, July 1998.

infeasible as higher tax burdens erode work incentives, lower employment, reduce national output and the tax base—requiring yet higher tax rates to draw the necessary revenues.

Past experience indicates that redistributing sizable amounts of resources from workers and future generations toward retirees will erode national saving and investment, and increase our dependence on foreign savings. Implementing MMA will induce a similar intergenerational redistribution of resources, causing higher consumption by retirees and reducing national saving. This is likely to further reduce worker productivity and exacerbate the output-reducing effects of higher taxes.

Overall, MMA is a bad and shortsighted economic policy. This program needs to be re-evaluated and recalibrated from its current focus on covering all retirees regardless of their health-care costs and ability to pay for prescription drugs. It should be refocused on those retirees who most need financial support against prescription drug expenses.