

The Excess Cost of the Bush Prescription Drug Plan in Iowa

Republican's Part D prescription drug plan costs Iowa taxpayers, seniors and disabled \$9.2 billion more than a direct Medicare benefit with negotiated prices

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In passing the 2003 Medicare Modernization Act (MMA), the Republican controlled Congress passed a bill written by and for the drug and insurance companies that deliberately built in waste and inefficiency. This Part D will cost Iowa taxpayers and prescription drug beneficiaries \$9.2 billion over the next ten years, compared to a prescription drug bill designed to maximize efficiency. The most simple and efficient way to cover the cost of prescription drugs would have been to extend traditional Medicare with a simple add on to include prescription drugs and by requiring Medicare to negotiate lower prices with the drug companies, like the Veterans Administration currently does.

Instead, Congress actually prohibited Medicare from using its bulk buying power to negotiate better prices for seniors and structured the bill to ensure that multiple private insurance companies would provide the benefit rather than Medicare. This design substantially increases the costs of the program for Iowa seniors and disabled, leaving many with large drug expenses, while at the same time making the program more costly for Iowa taxpayers. In addition, it is difficult for most beneficiaries to understand the differences between the numerous complicated plans being sold by private insurers under part D. As a result, millions of beneficiaries may end up not getting any help at all in paying for their prescription drugs or paying a lifetime penalty of 1% of the monthly premium for every month they fail to sign up after their initial 63 days of eligibility. This penalty, sometimes referred to as the Medicare complexity tax, means that if someone defers signing up for this “voluntary” program for five years, they would pay a 60% penalty every month for the rest of their lives.

This inefficient design of Part D is a result of the Republican’s K Street project that systematically promotes close ties between private industry and the Republican Party. This allowed the pharmaceutical industry unprecedented influence in writing into the bill billions of dollars in industry handouts while giving millions in political contributions. Between 2000 and 2004, health insurance, health services and pharmaceutical companies contributed \$96,370,907 to candidates for public office.¹ 71% of these funds went to Republicans, with only 28% going to Democrats.² In the peak year (2002), 75% of the industry funds went to Republicans and only 25% went to Democrats.³ In the 2004 Presidential election, Health Insurance and Health Services/HMOs contributed nearly five times as much to George Bush as to John Kerry (\$1,021,357 v. \$211,900).⁴

As costs to the public, seniors and the disabled skyrocket, so do industry profits. A recent Senate report found that Medicare revenues of HMOs and PPOs will increase from \$37 billion in 2003 to \$226 billion in 2010 under the new law (up 510%).⁵ Because the federal government is paying prices set by the drug companies – rather than negotiating lower prices as does the Veterans Administration and most other countries – fully 61% of the estimated \$228 billion federal Medicare expenditures will remain with drug makers as added profits, according to Professors Alan Sager and Deborah Socolar of Boston University.⁶

Not only drug companies are profiting from the bill, more than 13 Administration and Congressional officials in key positions during the writing and passage of this bill now work for the pharmaceutical industry. Chief among them is former Congressman Billy Tauzin, who chaired the House Energy and Commerce Committee that has jurisdiction over Medicare and is credited with guiding the law’s passage. Tauzin now works for the drug industry’s PAC, the Pharmaceutical Research and Manufacturers of America (PhRMA). His pay is reported to be at least \$2 million a year, making him one of the highest-paid lobbyists in Washington. Bush’s Medicare Chief from 2001-2003, Tom Scully, is now the top healthcare lobbyist for Alston & Bird with clients such as Abbott Laboratories and Caremark. Scully and Tauzin reportedly negotiated their lobbying contracts while working on the Medicare reform law from inside the U.S. government.⁷

The waste and inefficiency that resulted is easy to show based on projections from the Congressional Budget Office (CBO).⁸ Nationwide, CBO projected that the marketing and the profits of the insurance industry would add \$38 billion to the cost of the MMA over the first eight years of the program's existence (2006-2013 budget window), compared to a program that was administered through Medicare.⁹ If Congress had instead created an add-on benefit to the existing Medicare program, this \$38 billion could have been used to create a more generous prescription drug benefit or to finance federal and state spending in other areas. With Iowa having 499,314 Medicare beneficiaries out of the nearly 43.4 million Medicare beneficiaries in the United States, the wasted administrative costs to taxpayers and beneficiaries in Iowa alone is approximately \$437 million over the next ten years.

However, the most significant source of waste that results from catering to the pharmaceutical companies in writing the MMA, is the excess payments to drug companies due to the fact that Medicare is not allowed to use its bargaining power to gain discounts from the industry. Virtually every other country in the industrialized world imposes some constraint on drug prices, either through formal price controls or government negotiated prices.¹⁰ As a result, people in other countries pay much lower prices than do people in the United States. In a recent study, CBO assessed drug prices in several other wealthy countries. It found that consumers in these countries pay on average between 35 and 55 percent less than consumers in the United States. The discounts obtained by the Veterans Administration were even larger.¹¹

If Medicare was allowed to use its bargaining power to negotiate prices on behalf of beneficiaries, it could almost certainly obtain discounts that are at least as large as the highest discounts obtained in other countries, since it would be by far the largest drug purchaser in the world. If Medicare could negotiate the same schedule of prices as Australia (the current lowest cost country), the savings over the first eight years of the drug benefit would be almost \$560 billion nationally and \$6.4 billion in Iowa.

The combined savings from having Medicare negotiate prices directly with the industry and from having Medicare directly offer the benefit in Iowa would be more than \$9.2 billion over the following decade. These savings are so large that with the money appropriated in the MMA, it would be possible to fully pay for all drugs for Medicare beneficiaries, with no premiums, deductibles or co-payments. Alternatively, it would be possible to keep a modest schedule of co-payments, comparable to those in most private health insurance plans, but eliminate the gap in coverage known as the "doughnut hole" and still save more than \$100 billion nationally compared to the current spending projected in the MMA.

If Congress were to restructure the program and allow the Medicare system to negotiate directly with drug companies and to offer a plan that competed side-by-side with the plans offered by private insurers (as the current Medicare system does more generally under the Medicare Plus Choice program), then it would recoup much of the unnecessary waste incurred due to the structure of the MMA. These savings would be roughly proportionate to the share of Medicare beneficiaries who chose to sign up with the new Medicare-run plan. For example, if 50 percent of the beneficiaries signed up with the Medicare-run plan, the total savings to Iowa beneficiaries and taxpayers would be approximately \$4.6 billion over the next ten years. If 80 percent of beneficiaries opt to join the Medicare-run plan (more than 85 percent of beneficiaries opt for the traditional Medicare insurance rather than Medicare funded H.M.O.'s) then the savings for Iowa residents would be \$7.4 billion over the first ten years.

While the huge savings from a Medicare-managed drug plan would be very important, the greater simplicity could be almost as important to beneficiaries. There is no reason to force seniors to struggle with complex pricing and payment schedules to determine the drug plan that is best for them. A simple benefit provided through the Medicare program could save beneficiaries the time and effort needed to choose between the long list of insurance companies offering plans under the MMA. It would also save beneficiaries the anxiety that they may make the wrong choice or that their health care needs may change and they may find themselves needing drugs that are not covered under the plan that they have selected. This worry is heightened by the fact that once individuals sign up for a plan, they are locked in

for at least one year while insurance companies can change their benefits, including what drugs they cover, at any time.

Usually there is a trade-off between simplicity and cost, where it is more costly to keep everything simple for users. In the case of the Medicare drug benefit, the opposite is true. The simplest route would be to include a drug benefit as an add-on to the existing Medicare program, following the example of most private health insurance plans. This simple route would save Iowa beneficiaries and taxpayers more than \$9.2 billion over the next ten years. Both beneficiaries and taxpayers are paying the price of the Republican culture of corruption that allowed Part D to be written for the interests of pharmaceutical companies instead of American seniors.

¹ Public Campaign, *Health Care Paybacks* (August 2004), p. 7, 12, using FEC data from the Center on Responsive Politics. Accessed March 2006 at:

http://www.publiccampaign.org/healthcarepaybacks/healthcare_paybacks_report.pdf

² Public Campaign, *Health Care Paybacks* (August 2004), p. 7, 12, using FEC data from the Center on Responsive Politics. Accessed March 2006 at:

http://www.publiccampaign.org/healthcarepaybacks/healthcare_paybacks_report.pdf

³ Public Campaign, *Health Care Paybacks* (August 2004), p. 7, 12, using FEC data from the Center on Responsive Politics. Accessed March 2006 at:

http://www.publiccampaign.org/healthcarepaybacks/healthcare_paybacks_report.pdf

⁴ Public Campaign, *Health Care Paybacks* (August 2004), p. 9. using FEC data from the Center on Responsive Politics. Accessed March 2006 at:

http://www.publiccampaign.org/healthcarepaybacks/healthcare_paybacks_report.pdf

⁵ *The Impact of Republican Medicare Proposals on Insurance Industry Revenues and Profits*. A Senate Committee on Health, Education, Labor, and Pensions Minority Staff Report, Revised January 16, 2004. Available at http://www.ourfuture.org/docUploads/200104_HELP.pdf

⁶ Alan Sager and Deborah Socolar, "61 Percent of Medicare's New Prescription Drug Subsidy is Windfall Profit to Drug Makers," Boston University School of Public Health October 31, 2003. Accessed February, 2006 at http://dcc2.bumc.bu.edu/hs/Medicare_Rx_bill_windfallprofit.pdf

⁷ Dana Milbank, "Lowering the Bar for Government Ethics?" Washington Post, Page A04, December 31, 2004.

⁸ This discussion is based on the analysis in Baker. D. 2006, "The Savings From an Efficient Medicare Drug Plan," Washington, D.C.: Center for Economic and Policy Research [http://www.cepr.net/publications/efficient_medicare_2006_01.pdf].

⁹ Congressional Budget Office, 2004a. "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," Washington, D.C.: Congressional Budget Office [<http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0>], Table 3.

¹⁰ It is important to remember that the government is granting the pharmaceutical companies patent monopolies, which is what allows them to charge high prices in the first place. The question is not whether companies can sell their drugs in a free market, the question is whether the government will grant drug companies an unconstrained monopoly or whether it will impose some limits on the extent to which drug companies can exploit their patent monopolies.

¹¹ CBO, 2004b, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" Washington, D.C.: Congressional Budget Office, Page 4.