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Congress Should Not Undermine What Works in the Medicare Drug Benefit

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Over the past several years, one small corner of America's vast entitlement superstructure—the Medicare drug benefit—has been working well, satisfying program participants, and holding cost growth to a bare minimum. This is unheard of in the entitlement arena, where cost overruns are the norm. Naturally, encountering that kind of success, some politicians—especially those who had nothing to do with making sure it was properly designed—now want to change it.

The drug benefit, known as Medicare Part D, was enacted in 2003 amid controversy. It was an expensive new add-on to the Medicare program that increased the government's already immense unfunded liabilities. At the time, many analysts correctly warned that the last thing the federal government should do is expand unfunded entitlement promises.[1] Medicare was already teetering under the weight of its existing unfunded commitments.

Yet, despite the added costs, the drug benefit also broke significant new ground in its design and policy.

The Design of Part D. At the insistence of the Bush Administration and market-oriented health experts, the Medicare drug benefit was built on a foundation of a functioning marketplace, not government micromanagement. Indeed, unlike the rest of Medicare, there is no such thing as a government-run Medicare drug benefit—at least not at the moment. Instead, the beneficiaries select from competing *private* drug plans. The government's contribution toward these plans is based on the weighted average of the premiums charged by the competing insurers in a given region of the country. Importantly, the government's contribution does not vary based on the plan selected by an individual beneficiary. Beneficiaries who pick plans that are more expensive than average pay the added costs out of their own pockets, and beneficiaries who select less expensive plans cut their premiums commensurately.

Part D: Confounding Its Critics. When the drug benefit was debated in Congress, critics said it would never work. They feared beneficiaries would find the program too complex to navigate and therefore would not sign up. Private insurers would see the program as too risky for their businesses and therefore would not offer plans to beneficiaries, critics said. Costs would explode for those who did sign up, they said, because only the heavy hand of government can keep drug spending under control.

All those predictions were wrong. Since its rollout in 2006, the drug benefit has been an incredible success. Thanks to the addition of Part D to existing employer-sponsored coverage, today 90 percent of Medicare participants are in secure drug coverage of some sort. Survey after survey has shown that bene-

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ficiaries like the program and are very satisfied with how it works. And, most importantly, costs for the drug benefit have come in some 40 percent below initial expectations. The Department of Health and Human Services recently announced that the average beneficiary's premium for the program will be about $30 in 2012, down from $30.76 in 2011.[2] Remarkably, that is just $4 more per month than the average premium in 2006. Over the first six years of the program, the average premium increase has been just 2.5 percent per year—well below cost growth in the rest of Medicare.

In addition, new research has documented cost savings in the rest of Medicare from providing a stable source of drug coverage for seniors. A recent study by Harvard researchers shows the drug benefit is keeping more seniors out of hospitals and nursing homes, thus reducing Medicare spending for patient care in those institutions by $12 billion annually.[3]

Despite this success, critics of the program simply cannot accept that they were wrong. They continue to insist on changes that would move away from this market-driven model toward the command-and-control approach that is dominant in the rest of Medicare—and has never worked to control costs.

Part D "Rebate" Proposal Would Doom Program. The latest iteration of this ongoing campaign to undo the Part D model is a proposal to import Medicaid's government-imposed rebate provisions into the Medicare drug benefit. When states purchase drugs on behalf of their Medicaid recipients, the drug manufacturers are required to pay a "rebate" to the federal government, based on a complex formula tied to the average price charged per drug. Some in Congress want drug companies to pay these rebates for beneficiaries in the Medicare drug benefit who are dually eligible for Medicaid.

But, of course, these "rebates" are really just a form of taxation. The question is: Who will bear the burden of payment? A recent study from the American Action Forum (AAF) makes it clear that much of the burden will fall on the seniors who are already enrolled in the Medicare drug benefit.[4] That is because drug manufacturers, faced with the requirement to pay this new tax, will pass on a portion of the added costs in the form of higher Part D premiums. AAF estimates that the average Medicare drug benefit enrollee would see a premium hike of between 20 and 40 percent as a result of the rebate proposal.

Worse, introducing rebates in this way would begin the process of destroying the market-based design that has made the Part D program so successful. Today, the private plans competing for the business of Part D participants know they must negotiate aggressively with the drug manufacturers to ensure they can offer coverage at an attractive price. If they do not, they will lose market share to a more aggressive competitor. It is this competitive pressure that has suppressed cost and premium growth over the past six years.

The "rebate"—which really amounts to government price controls—would change everything. Today, pricing is determined entirely by a negotiation between private insurers and drug manufacturers focused on the value of prescription drug products for the patients. With rebates, the government would get involved in the conversation, and that spells trouble. Drug manufacturers would seek

1. Stuart Butler, "The Medicare Drug Bill: An Impending Disaster for All Americans," Heritage Foundation *WebMemo* No. 885, June 13, 2003, at *http://www.heritage.org/Research/Reports/2003/06/The-Medicare-Drug-Bill-An-Impending-Disaster-for-all-Americans*.
2. Press release, "Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole," U.S. Department of Health and Human Services, August 4, 2011, at *http://www.hhs.gov/news/press/2011pres/08/20110804a.html* (September 8, 2011).
3. J. Michael McWilliams, Alan M. Zaslavsky, and Haiden A. Huskamp, "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults With Limited Prior Drug Coverage," *The Journal of the American Medical Association*, Vol. 306, No. 4 (July 27, 2011), pp. 402–409, at *http://jama.ama-assn.org/content/306/4/402.abstract* (September 8, 2011).
4. Douglas Holtz-Eakin and Michael Ramlet, "Cost Shifting Debt Reduction to America's Seniors," American Action Forum, July 21, 2011, at *http://americanactionforum.org/sites/default/files/AAF_Part%20D%20Financial%20Impact%202_0.pdf* (September 8, 2011).

to use the rebate requirement to extract higher pricing from the insurers, even as they lobbied the government to base the rebates on the most inflated measure of "average" price they could find. In time, as in other parts of Medicare, the government's price-setting reach would expand further and further based on new legislative proposals and the natural tendency of bureaucracies to seek to control more and more decisions. Eventually, the private plans now participating in Part D would lose their ability to determine their own fates, which would spell doom for the current program.

Going down the price control road is the last thing Congress should allow to happen. Medicare's administrators have been trying for four decades to micromanage their way toward slower cost growth and higher-quality care, without success. The bureaucratic model has failed, and it should not be tried again in Part D.

Apply Market-Based Principles and Adjust for Income. What Congress should be doing is taking the important lessons of Part D and applying them to the rest of Medicare, which is badly in need of reform. Cost growth for non-drug expenses continues to grow rapidly with no end in sight. The solution is cost-conscious consumer choice with strong price and quality competition among providers of coverage and services to seniors. That is the design that has been tested and proven to work for six years in the drug benefit. And it can work in the rest of Medicare, too.[5]

Of course, just because the drug benefit's market-based design is working does not mean the government must continue to subsidize coverage for the well-to-do at the levels assumed in current law. The program works today because the government's contribution is fixed by region, independent of the premium charged by any one insurance plan. That assures cost-conscious choices by participants because they must pay more from their own pocket if they select coverage that is more costly than the average plan. But the government's contribution need not be the same for rich and poor. Indeed, the fact that premium growth has been so moderate during the program's first years only highlights that some seniors with higher incomes and assets could pay a bit more than they are today for the drug coverage. That could be done without disrupting any of the key features that make today's drug benefit work so well to hold down overall cost growth.

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5. For a more detailed description of how to preserve Medicare for future generations, see "Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity," 2011, at *http://thf_media.s3.amazonaws.com/2011/pdf/sr0091.pdf*.