# Comparing Prescription Drug Proposals
# Bush v. Gore

by

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# Executive Summary

Compared to the health care coverage available to people below age 65, Medicare for seniors is very inadequate, exposing them to thousands of dollars in out-of-pocket costs. To avoid these financial risks, most seniors have private, Medigap coverage — to plug the holes in Medicare. Yet even with two health insurance plans, most seniors typically do not have the same prescription drug coverage as most non-seniors.

The two major presidential candidates, Vice President Al Gore and Texas Governor George W. Bush, are offering competing proposals to deal with this problem:

- Vice President Gore proposes the addition of a third insurance program for seniors — one with a separate premium covering prescription drugs.
- Governor Bush proposes to allow the elderly to enroll in the same kind of comprehensive health plans available to the non-elderly.

Under the Gore proposal, seniors would have three plans and three premiums. Under the Bush proposal, seniors would enroll in one plan with one premium. What difference do these approaches make?

**Achieving Efficient Health Care Delivery.** Failure to cover drugs in the current system creates perverse incentives that waste resources and endanger patient health. Whereas drug therapies are rapidly substituting for more expensive and less effective hospital and doctor therapies in the rest of the health care system, many seniors and their doctors have an incentive to avoid drug therapies simply because patients must pay out-of-pocket. Both proposals move to remedy this problem, but the Bush proposal goes further. Decision makers would be able to choose from among all medical therapies on a level playing field because all benefits would be covered by a single health plan.

**Lowering the Cost of Health Insurance.** Health economists have documented that when the elderly have two separate health plans (Medicare and Medigap) there is a great deal of waste. In fact a study by Milliman & Robertson for the NCPA found that if average Medicare spending is combined with the average Medigap premium, the combined sum would be sufficient to pay the cost of comprehensive health insurance (the same plans non-seniors are enrolled in), including coverage for prescription drugs. Thus the Bush proposal could theoretically solve the gaps-in-coverage problem without any extra spending — either by government or by the elderly, in most cases. By contrast, adding a third plan with a third set of administrators (as Gore proposes) adds to the current efficiencies and would require more spending — both by the government and the elderly.

**Creating Freedom of Choice.** The trend in the workplace is to give employees more choices. The reason: People are different and one-size-fits-all doesn't work. The Bush approach adopts a similar philosophy, giving the elderly the full range of health insurance choices now available to the non-elderly. Gore, on the other hand, has rejected this idea. Under his approach, there would be one drug plan and it would be administered by the federal government (Medicare).

**Protecting Against Catastrophic Expenses.** Under the Bush approach, we would expect to see the same kinds of plan designs currently popular with employers and their employees. In all cases, there would be protection against large-dollar expenses. Out-of-pocket costs to the patient would be limited to small-dollar expenses. Under Gore's proposal, however, government would pay half the cost of drugs

from the first dollar for a middle-income patient. After $2,000 of costs, the patient would pay the next $3,000 and the government would pay all costs above $5,000. Gore's advisors frankly admit that this strange design is a result of political pressures inherent in a government-run health plan.

**Coping with Adverse Selection.** Both proposals would allow seniors to choose to opt into the new arrangement or continue in their current status. And any time people exercise such choices, there is the danger that only the sick will join (adverse selection) making average program costs much higher than originally anticipated. With Bush this is less of a problem because seniors would choose among comprehensive health plans. With Gore, it is a big problem because when drug coverage is sold as a separate benefit, the risk is that only those with high drug costs will be willing to pay the additional premium.

**Controlling Drug Costs.** If the experience of the past is any guide, both these proposals will cost more than their proponents originally projected. What are the likely methods of dealing with these rising costs?

- Gore would explicitly rely on pharmacy benefit managers (PBMs), which function like an HMO for drugs. But PBMs are also likely under the competing health plan options in the Bush proposal.
- Even without PBMs, both plans would probably also rely on drug formularies — where only certain drugs are covered under the plan and other drugs are either not available or would require greater out-of-pocket payments from patients.
- A third technique is to use the bargaining power of an insurer representing a large share of the market; and these techniques are often combined with restrictive drug formularies.
- A fourth technique, common elsewhere around the world, is direct government control of drug prices.

**Dangerous Side Effects from Cost Controls.** The danger in all of these techniques is that seniors will not have access to the newest and latest drugs. Even without reform, increased availability of new drugs is having a remarkable impact on the elderly. They partly explain why:

- The proportion of Americans age 65 or older with a chronic disability declined from 24 percent in 1982 to 21 percent in 1994.
- Occupancy in nursing homes declined by 14 percent among persons ages 65 to 74, 21 percent among persons ages 75 to 84 and 13 percent among those ages 85 and older.

Aggressive attempts to control drug costs could nip this progress in the bud. According to one study of pharmaceutical restrictions in managed care plans:

- Reduced access to drugs led to more emergency room admissions, hospital stays and doctor visits for such illnesses as depression, heart disease, ulcers and diabetes.
- Further, the elderly were twice as likely to be harmed by formulary limits as people under the age of 65.

**Conclusion.** No matter which proposal is adopted, there is a danger that political pressures will induce politicians to attempt to curtail drug costs in ways that are harmful to senior citizens. But because the proposal relies more on competition in the private sector and integrated health care delivery, the Bush plan is much less susceptible to such outcomes.

# Introduction

*"Gore proposes three health plans with three different premiums."*

Compared to the health care coverage available to people below age 65, Medicare health care coverage for seniors is very inadequate. It exposes many of them to thousands of dollars in out-of-pocket costs. Each year, some 360,000 have expenses in excess of $5,000 on services theoretically covered by Medicare. A majority deal with this risk by acquiring Medigap coverage — either from a previous employer or through direct purchase in the marketplace. Yet even with two health insurance plans, most seniors still typically do not have the same prescription drug coverage as most non-seniors. This failing has become a more contentious issue as the development of new, innovative drugs has, in many cases, replaced surgery or other more expensive treatments and reduced hospital stays.

The two major presidential candidates, Vice President Al Gore and Texas Gov. George W. Bush, offer competing proposals to cover prescription drugs costs for the elderly. The two proposals have fundamentally different visions:

- Vice President Gore proposes the addition of a third insurance program for seniors, this one covering prescription drugs; as a result, most seniors would have three plans with three premiums (Medicare Part B, Medigap and prescription drug coverage).
- Gov. Bush, following the recommendation of the National Bipartisan Commission on the Future of Medicare,[1] proposes to allow the elderly to enroll in the same kind of comprehensive health plans available to the non-elderly; as a result, seniors would have one plan with one premium.

This report looks at the implications and consequences of these two approaches.

# Structure of the Two Approaches

*"Under Bush, seniors would enroll in one health plan with one premium."*

Under both the Gore and Bush proposals, when fully implemented, seniors living in poverty would pay nothing for prescription drug coverage. Low-income seniors above the poverty level would receive partial subsidies, and seniors with higher incomes would receive still smaller subsidies.

**The Gore Proposal.** Gore proposes to add a "Part D" for drugs to the existing Medicare program, beginning in 2003.[2] Called "MediCoverage," the program would pay all premiums and copayments for low-income Medicare beneficiaries with incomes below 135 percent of the poverty level (currently $11,300 for individuals and $15,200 for couples). Seniors with incomes between 135 percent and 150 percent of poverty ($12,600 for individuals and

$16,900 for couples)would receive a partial subsidy — the amount not yet specified.

*"The Gore approach would add a prescription drug program to Medicare."*

Beginning in 2003, seniors with incomes above 150 percent of the poverty level would pay a $25 per month ($300 per year) premium, which would rise gradually to $44 ($488 per year) in 2009. Initially, MediCoverage would pay half of a beneficiary's first $2,000 in drug costs, with total out-of-pocket costs capped at $4,000. By 2009, when the program is fully phased in, the benefit would cover half of the first $5,000 in drug costs. Total out-of-pocket costs would remain capped at $4,000.

**The Bush Proposal.** Bush proposes to ultimately integrate prescription drugs into comprehensive health care coverage and give seniors a choice of plans, including the traditional Medicare program. His proposal would not subsidize a universal drug benefit for all seniors. Rather, under the Bush proposal, the government would:

- Cover the full cost of comprehensive health coverage, including prescription drug coverage, for seniors with incomes at or below 135 percent of poverty.
- Subsidize part of the premium for seniors with incomes between 135 percent and 175 percent of poverty (currently $14,600 for individuals and $19,700 for couples).
- Pay at least 25 percent of the premium costs for prescription drug coverage for all seniors.
- Cover all out-of-pocket Medicare expenses — including drug expenses — in excess of $6,000 annually for all seniors.

*"The Bush approach would integrate prescription drugs into comprehensive health care coverage."*

As an interim step, while Medicare reform is being implemented, Bush has proposed giving $48 billion to the states to set up "Immediate Helping Hand" pharmaceutical benefit programs that would:

- Cover the full cost of prescription drugs for seniors with incomes at or below 135 percent of poverty.
- Cover some of the cost of prescription drugs for seniors with incomes between 135 percent and 175 percent of poverty.
- Cover any prescription drug costs in excess of $6,000 annually for all seniors.

As a study for the White House shows, there are about 11 million seniors without any prescription drug coverage, and more than 50 percent of them would be covered by Bush's short-term plan. [See Table I.] The remainder of those without coverage spend, on average, less than 4 percent of their income on drugs and often do not elect to purchase coverage through Medigap policies, existing state programs or HMO Medicare plans.

*"Without coverage for drugs, seniors will turn to more expensive and less effective doctor and hospital therapies."*

Under the Bush proposal, the average Medicare beneficiary would not pay more than 12 percent of the total premium amount for Part B and prescription drug coverage combined, whereas under current Medicare law beneficiaries' contributions are projected to rise to nearly 14 percent of the cost of Part B. The Gore proposal does little to ensure that seniors will see their premiums stay the same and, in fact, the drug benefit requires a premium on top of the existing Medicare premium.

## Key Differences in the Proposals

The Gore and Bush proposals take dramatically opposing approaches to Medicare and prescription drugs for the elderly in at least five ways.

**Creating Incentives for Efficient Health Care Delivery.** Medicare currently provides coverage for hospital therapy and doctor therapy, but not drug therapy. Failure to cover drugs in the current system creates perverse incentives that waste resources and endanger patient health. Whereas drug therapies are rapidly substituting for more expensive and less effective hospital and doctor therapies in the rest of the health care system, many seniors and their doctors have an incentive to avoid drug therapies simply because patients

*"Under Bush, decision makers would choose among all therapies on a level playing field."*

**TABLE I**

### Medicare Beneficiaries with and without Prescription Drug Coverage, For at Least One Month, by Income, 1996

| Income as Percent of Poverty | With Drug Drug Coverage | Without Drug Coverage | Percent Without Drug Coverage |
|---|---|---|---|
| <100% | 5,498 | 2,619 | 32.3% |
| 100-135% | 2,829 | 1,795 | 38.8% |
| 136-150% | 1,020 | 676 | 39.8% |
| 151-175% | 1,708 | 926 | 35.2% |
| 176-200% | 1,812 | 995 | 35.5% |
| 201-300% | 5,178 | 2,226 | 30.1% |
| 301-400% | 3,094 | 1,031 | 25.0% |
| >400% | 4,482 | 1,355 | 23.2% |
| Total | 25,621 | 11,623 | 31.2% |

Note: Not all differences in coverage rate by income groups are statistically significant. The differences between the groups with the highest rates of coverage and the groups with the lowest rates of coverage are statistically significant. The federal poverty threshold for couples 65 and over in 1996 was $9,491.

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

must pay out-of-pocket. Both the Gore and Bush proposals would improve on the current situation, but the Bush proposal goes further.

The Gore approach considers drug treatment apart from a patient's other care. There would be three separate sets of decision-makers — one for Medicare, one for Medigap and one for prescription drug coverage, making integrated delivery of health care difficult if not impossible.

By contrast, the Bush proposal would offer one comprehensive package to make sure a single set of decision-makers evaluates all therapies on a level playing field. This integrated delivery of health care is vital. A 1996 study by the National Bureau of Economic Research found that every dollar spent on prescription drugs is associated with a decrease of four dollars in hospital expenses. A $10,000 drug treatment may be more effective than a $100,000 heart bypass operation. But whereas a health insurer covering a patient's prescription drugs along with other care would benefit from the switch to the drug treatment, an insurer whose policy covered only drugs would view the treatment as merely a $10,000 outlay.

*"Studies show that when the elderly have two separate health plans (Medicare and Medigap), there is a great deal of waste."*

**Lowering the Cost of Health Insurance.** Economic studies show that when the elderly have two separate health plans (Medicare and Medigap), there is a great deal of waste. A study by Milliman & Robertson, the nation's leading actuarial consulting firm on health benefits, asked what coverage could be purchased with the combined amounts now spent on Medicare and Medigap if seniors enrolled in a single plan without distorted incentives. Milliman & Robertson estimated that the resulting savings would be enough to pay for the same type of comprehensive coverage routinely available to the non-elderly, including prescription drugs.[3] By following this approach, the Bush proposal theoretically would not require any additional spending, either by government or by seniors, in most cases. However, because the Gore proposal would build upon the inefficiencies of the current system, additional premiums would be needed for prescription drug coverage through a third plan.

**Creating Freedom of Choice.** The trend in the workplace is to give employees choices among health plans, rather than forcing everyone into a one-size-fits-all program. The Bush proposal would take the same approach to the elderly, allowing seniors to choose from among the same kinds of comprehensive health plans available to the non-elderly. In this respect, the Bush proposal would follow the recommendation of the National Bipartisan Commission on the Future of Medicare. Premiums would be set by market forces, just as they are for health plans used by millions of federal workers. Seniors could choose one comprehensive plan that included prescription drug coverage. They could choose an average-priced plan and pay the same premiums they pay under the current system. They could also choose plans that provide more or fewer services, and pay more or less than the average, depending on their choice.

*"Gore would add a third plan, leading to more waste and higher costs."*

*"Theoretically, the Bush approach would not require more spending by the government or by seniors, in most cases."*

**Protecting Against Catastrophic Expenses.** Despite its political popularity, Medicare violates almost all principles of sound insurance. It pays too many small bills the elderly could easily afford on their own, while leaving them exposed to thousands of dollars of potential out-of-pocket expenses, including the cost of their drugs. The Gore proposal would exacerbate the problem by paying half of the first $2,000 of drug costs, none of the next $3,000 and then all of the remainder for a middle-income patient. Gore's advisors frankly admit that this strange design is a result of political pressures inherent in a government-run health plan.[4]

The Bush proposal advocates catastrophic coverage for all out-of-pocket health care expenses, including prescription drugs, above $6,000. Beyond that, health plans would be free to adopt the same designs routinely employed in health plans available to non-seniors.

**Coping with Adverse Selection.** Both proposals would allow seniors to choose either the new arrangement or continue in their current status. Any time people exercise such choices, there is the danger that only the sick will join (adverse selection), making average program costs much higher than originally anticipated. With Bush's proposal, this is less of a problem because seniors would choose among comprehensive health plans. With the Gore proposal, it is a big problem because drug coverage is sold separately.

*"Seniors would choose among health plans similar to those available to non-seniors."*

Since Medicare beneficiaries would pay $300 annually in prescription drug premiums under the Gore proposal, and would still have to pay half the cost of their drugs, they would not gain unless they have more than $600 in drug costs. Further, their total benefit could only be $700 ($1,000 minus the $300 premium) until they spent another $3,000 out-of-pocket on drugs, making their out-of-pocket drug costs $4,000, after which all drug costs would be covered. With this limited benefit to healthy people, it is likely that the prescription drug coverage would attract few of them. Conversely, seniors who expect to have high drug costs anyway would jump at the chance to enroll. If the plan disproportionately attracts the sick rather than the healthy (adverse selection), its costs will be much higher than originally proposed.

## Drug Subsidies and Drug Costs

A recent study for the White House concluded that when people have insurance coverage for drugs, they get more drugs. "Average spending for people with coverage is consistently higher than for people without coverage across income groups."[5] The difference between those with and without coverage is greater at the poverty level than for other income groups. But as Table II shows, there is no significant difference in the size of the spending gap between covered and noncovered among beneficiaries with incomes at any income level above poverty. This suggests that insurance coverage increases consumption of prescription drugs, irrespective of income.

TABLE II

## Average Total Spending and Out-of-pocket Spending for Prescription Drugs by Medicare Beneficiaries with and without Drug Coverage, by Family Income as a Percent of Poverty, 1996

| Income as a Percent of Poverty | Covered | | | Not Covered | Ratio: Covered/ Not Covered | |
|---|---|---|---|---|---|---|
| | Average Total Spending | Average Out-of-Pocket Spending | Out-of-Pocket as Percent of Total Spending | Average Total Spending (all Out-of-Pocket) | Average Total Spending | Average Out-of-Pocket Spending |
| Total | $769 | $253 | 33% | $463 | 1.66 | 0.55 |
| <Poverty | $800 | $200 | 25% | $368 | 2.18 | 0.54 |
| Poverty-135% | $767 | $269 | 35% | $476 | 1.61 | 0.57 |
| 136-150% | $673 | $272 | 40% | $555 | 1.21 | 0.49 |
| 151-175% | $790 | $279 | 35% | $453 | 1.74 | 0.62 |
| 176-200% | $791 | $255 | 32% | $512 | 1.54 | 0.50 |
| 201-300% | $778 | $284 | 36% | $487 | 1.60 | 0.58 |
| 301-400% | $782 | $264 | 34% | $453 | 1.72 | 0.58 |
| >400% | $717 | $248 | 35% | $525 | 1.37 | 0.47 |

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

*"Seniors with insurance coverage for drugs buy more drugs."*

Supporters of an expansive Medicare program argue that any prescription drug program should cover part of the cost for everyone in Medicare, regardless of income. As Table III shows, higher-income seniors make up a large percentage of the Medicare population spending the most on drugs. Under the Gore proposal, MediCoverage would offer discounts on prescriptions for everyone on Medicare because pharmacies would be required to sell them prescription drugs at the same discounted price given federal employees under the Federal Employees Pharmacy Benefit Plan. (The implications of this are discussed more fully below). If, as the White House study indicates, a universal benefit will result in greater drug spending by more affluent seniors, the resulting increase in the cost of providing the benefit inevitably will draw significant pressure to rein in costs. The techniques used likely will place restrictions on the supply of prescription drugs that will come at the expense of the poor and chronically ill.

## Options for Controlling Rising Drug Costs

The driving force behind higher drug costs is the increased *use* of drugs, not increases in prices. For example, a study published in *Health Affairs* of large managed care and major employer-sponsored health benefit

plans nationwide, covering more than two million people, found that increased volume of prescriptions accounted for $5 of cost increases for every $1 of price increases, even when the price of new drugs was taken into account.[6] That being the case, controlling the total cost of prescription drugs becomes more of a challenge, especially when considered on a stand-alone basis rather than as a part of a comprehensive health plan.

*"Under both proposals costs will probably be higher than expected."*

**Pharmacy Benefit Managers.** Managed health care plans in general have attempted to hold down their drug cost increases by using pharmacy benefit managers (PBMs) to negotiate discounts with pharmacy chains, to limit coverage to lower-price generic drugs instead of patented, branded drugs and to encourage the use of prescription drug therapies only if the benefits to the patient's health clearly justify the added cost. However, these efforts have had limited success in cost savings. Costs for employers with drug benefit plans are trending significantly higher, with increases in 1998 ranging from 14 percent to 18 percent above 1997 costs. Many plans with rich benefit designs and/or longer-term membership experienced cost increases of as much as 40 percent in 1998.[7]

**TABLE III**

## Medicare Beneficiaries with and without Drug Coverage, as Share of Total Population and Share of the Highest Drug Spenders, by Selected Demographic Characteristics, 1996

| | Covered | | Not Covered | | Total | |
|---|---|---|---|---|---|---|
| | **Percent ofAll Beneficiaries** | **Percent of Highest Drug Spenders** | **Percent of All Beneficiaries** | **Percent of Highest Drug Spenders** | **Percent of All Benenficiaries** | **Percent of Highest Drug Spenders** |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |
| Poverty/Income | | | | | | |
| <Poverty | 21% | 22% | 23% | 18% | 22% | 22% |
| Poverty-135% | 11% | 11% | 15% | 17% | 12% | 12% |
| 136-150% | 4% | 3% | 6% | 7% | 5% | 4% |
| 151-175% | 7% | 7% | 8% | 7% | 7% | 7% |
| 176-200% | 7% | 8% | 9% | 9% | 8% | 8% |
| 201-300% | 20% | 21% | 19% | 20% | 20% | 21% |
| 301-400% | 12% | 12% | 9% | 9% | 11% | 12% |
| >400% | 17% | 16% | 12% | 13% | 16% | 16% |

Source: Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration: Medicare Current Beneficiary Survey Cost and Use File, 1996.

**Drug Formularies.** Formularies probably will exist under either a Gore or Bush approach. A formulary is a list of generic and brand-name medications a health plan will cover. The question is: under which plan will these lists of drugs be more likely to be used to limit access to new and better drugs at the price of increased risk to patients?

Dr. Susan Horn conducted a study of pharmaceutical restrictions in six managed care plans.[8] She found that restricting seniors' access to pharmaceuticals was associated with more emergency room admissions, hospital stays and doctor visits for such illnesses as depression, heart disease, ulcers and diabetes. The elderly were twice as likely to be harmed by formulary limits as people under the age of 65. That is, faced with the same restrictions as someone age 65 and under, an elderly person in the same HMO was twice as likely to be hospitalized or see a doctor as a result of the loss of choice.

*"Even the better-run federal programs try to control drug spending with restrictive formularies and price controls."*

**Closed Formularies.** Pharmacy directors sometimes close all or part of a formulary to new drugs. In a 1997 survey of HMOs, at least 50 percent of pharmacy directors reported that they had closed or planned to close at least some formulary classes to any new drugs. According to the survey, these decisions are rarely made with any outcomes data to support the use of one product over another.[9] As a result, decisions are based solely on available safety, efficacy and cost data, which would seem to conflict with the move toward outcomes-based "disease management."

**Techniques Used by Other Government Health Programs.** Even the better-run federal programs that provide prescription drug benefits, such as the Federal Employees Health Benefits Plan (FEHBP) and the Veterans Affairs health care system, try to control spending — the FEHBP with restrictive drug formularies and the VA with both restrictive formularies and price controls. Similarly, to control drug costs, Medicaid limits both the number of prescriptions people can obtain and their access to new drugs, often without regard to the impact such limits have on total health spending or individual well-being.

The U.S. General Accounting Office (GAO) concluded in a report, "Pharmacy benefit managers and plan officials, as well as industry experts, acknowledge that any additional efforts to control FEHBP pharmacy benefit costs in the future might require plans to adopt more restrictive cost-containment procedures that could possibly limit enrollees' access to drugs and pharmacy services and reduce enrollees' satisfaction with their pharmacy benefits."[10]

*"The elderly are twice as likely to be harmed by restrictive formularies."*

Many advocates of the Gore drug proposal point to the VA system as an example of how to provide drug coverage to the elderly. A closer look reveals that the VA places strict limits on where people can get drugs and what drugs they can get:

*"The VA system — regarded as a model by some Gore advisors — places strict limits on where people can get drugs and what drugs they can get."*

*"Drug innovation is related to greater life expectancy."*

- Patients are restricted from obtaining prescriptions anywhere except VA pharmacies.
- VA patients with pancreatic cancer are not allowed to receive Gemzar, the newest drug for that disease, as a matter of course. They must "fail" on other drugs first.[11]
- A study which found that VA patients at risk for heart attacks are more likely to respond to newer ACE inhibitors concluded that these drugs should be first-line antihypertensive therapy in elderly patients and that they should be considered for elderly patients who are unresponsive to older ACE inhibitors; yet the VA formulary limits access to newer ACE inhibitors as a matter of course.[12]
- Another study was conducted to determine whether VA patients felt a difference in the efficacy, side effects and value of omeprazole versus lansoprazole for gastroesophageal reflux disease maintenance therapy after a formulary conversion, and to evaluate the costs of the conversion. Although the study found that patients preferred omeprazole, the VA restricted access to omeprazole.[13]
- Several studies have demonstrated that VA patients suffering from schizophrenia have a better quality of life under clozapine in both high and low hospital user groups; yet haldol —- an older drug — is on the formulary, while clozapine and newer drugs such as risperdal and olanzapine are not.[14]

**Potential Danger of Price Controls.** As the number of old people grows and as people have longer lifespans, the prevalence of many diseases is increasing. Between 1984 and 1995, the prevalence of stroke increased by 1 percentage point, diabetes by 2 percentage points, arthritis by 3 percentage points, heart disease by 5 percentage points and cancer by 7 percentage points.[15] What would happen to the growing ranks of seniors with chronic illnesses under a cost containment regimen that severely limited access to new, innovative drugs?

A study by Columbia University professor Frank Lichtenberg found that "...in the absence of pharmaceutical innovation, there would have been no increase and perhaps even a small decrease in mean age at death, and that new drugs have increased life expectancy, and lifetime income, by about 0.75-1.0 percent per annum. The drug innovation measures are also strongly positively related to the reduction in life-years lost [from 1970-1991]. Some of the more conservative estimates imply that a one-time R&D expenditure of about $15 billion subsequently saves 1.6 million life-years per year, whose annual value is about $27 billion."[16]

*"New drugs are the principal reason for the decline in chronic disability and nursing home episodes among the elderly."*

In other words, based on the Lichtenberg study, one could argue that if seniors had been limited to older drugs or generic substitutes from 1980 through 1991, there would have been a decrease in life expectancy. A principal reason the incidence of nursing home admissions among the elderly declined between 1985 and 1997 is the introduction of new drugs for stroke and depression.

- In 1985, the age-adjusted nursing home residence rate was 54 persons per 1,000 age 65 or older.
- By 1997 the residence rate had declined to 45 persons per 1,000.
- Residence rates declined by 14 percent among persons ages 65 to 74, 21 percent among persons ages 75 to 84 and 13 percent among those ages 85 and older.

In part because of access to new drug therapies, the proportion of Americans age 65 or older with a chronic disability declined from 24 percent in 1982 to 21 percent in 1994.[17] However, if disability rates had not declined, then the disabled population would have increased by almost 1.5 million.

## The Candidates and Cost Containment

Faced with the prospect of rising drug costs, the Gore and Bush proposals differ in the way they propose to contain costs.

**The Gore Proposal: Pharmacy Benefit Managers and Price Negotiations.** Gore proposes to contract with pharmacy benefit managers (PBMs) to administer the drug benefits on a stand-alone basis. He also proposes to hold down the prices of prescription drugs by negotiating with manufacturers. But this approach means the impact of prescription drugs on total costs and total health benefits of seniors will be difficult to coordinate or integrate. When the U.S. General Accounting Office (GAO) looked at President Clinton's prescription drug proposal (which Gore has essentially adopted as his own), it concluded that negotiation would work only if Medicare adopted a formulary and required beneficiaries to make additional payments if they wanted drugs not on the formulary. Without these limits, the GAO said, manufacturers would have no incentive to offer a deep discount because Medicare couldn't guarantee a larger market share for a specific drug if beneficiaries had a wider choice.[18]

*"Gore proposes to contract for administration of drug benefits on a stand-alone basis."*

There is no such flexibility in the Gore proposal as it now stands, since the formulary would be open (that is, Medicare beneficiaries would have access to "medically necessary" drugs, even if they weren't on the formulary) and no copayment would be more than 50 percent, regardless of the drug selected. However, political pressure likely would force Medicare to enact a national formulary if, say, PBM A limited access to certain drugs in one part

of the country while PBM B made the same drugs available in another part of the country. The GAO has suggested that PBMs, which now make decisions privately, might lack the flexibility under Medicare that they have now, adding, "Implementing a formulary and other utilization controls could prove difficult for Medicare,...which must have transparent policies that are determined openly."[19]

Gore's proposal projects that prescription drug spending will increase an average of 5 percent per year (the same projection used by the Clinton administration). However, discussions with private-sector PBM executives and congressional testimony by those executives suggest a higher rate of increase.[20] Some former PBM executives predict that to limit spending increases to 5 percent a year, the Gore administration would have to do the following:

- Impose mandatory price cuts and freezes.
- Create restrictive formularies that would narrow selection to one or two drugs for each type of therapy.
- Institute a policy to not pay for any branded drugs or put a price control on all but generic drugs in any therapeutic class.
- Establish government directives and formularies using PBM databases telling doctors what to use.
- Require prior authorization before using drugs that are not on a formulary.

**The Bush Proposal: Marketplace Competition.** Bush stresses an approach that will put health care for the elderly on an equal footing with health care for the non-elderly. He would leave the formulary and utilization control decisions in the private sector, since prescription drug coverage would be one part of the Medicare beneficiary's coverage by a private plan. Unleashing millions of elderly consumers into the marketplace, most of whom are — as the previous tables show — healthy and relatively well off, will shift the way in which prescription drug coverage is offered and provided. Or rather, it will move health plans in a direction that some were already heading. Health expert J.D. Kleinke points out that health plans are rapidly moving towards multi-tier drug coverage where insurers prepay for drugs that are the most "medically and economically useful" for patients while assigning a copayment to drugs that are not.[21] More to the point, individual health plans — driven by competition for consumer dollars — will have an incentive to show how the availability and use of new and better drugs pay off in terms of improved health and well-being (and fewer dollars spent on other services).

*"Bush stresses an approach that will put health care for the elderly on equal footing with health care for the non-elderly."*

A consumer-driven Medicare system will be able to more effectively capture the savings inherent in the use of newer pharmaceuticals. Confirming

Kleinke's observation, an exhaustive study by Lichtenberg found that the number of hospital stays, bed days and surgical procedures declined most rapidly for those diagnoses with the greatest increase in the total number of drugs prescribed and the greatest change in the use of new drugs. His estimates imply:[22]

- An increase of 100 prescriptions is associated with 1.48 fewer hospital admissions, 16.3 fewer hospital days and 3.36 fewer inpatient surgical procedures.
- A $1 increase in pharmaceutical expenditure is associated with a $3.65 reduction in hospital care expenditures.

However, the current environment does not encourage health providers to consider drug coverage in the context of its effect on the cost of a patient's total health care. Kleinke suggest that health plans often use the cost of expensive drugs as an excuse to raise rates. "Expensive drugs are guilty of driving up total medical costs until proven innocent...the plan can point to highly visible increases in pharmacy costs as the sole justification for its premium increases...," he wrote in *Health Affairs*."[23]

Kleinke notes that even if a health plan's pharmaceutical cost increased 20 percent, it would only raise a typical plan's drug costs from the current 8 percent of total health care spending to 10 percent. "This increase does not square with average premium increases of seven to 10 percentage points in 1999-2000," he says.[24] Indeed, HMOs continue to report declines in the time people spend with doctors and in hospitals. Most of the new expensive drugs launched in the past few years, such as Rezulin for diabetes, Zocor for cholesterol, Zyprexa for schizophrenia and Claritin for allergies, are keeping patients with chronic conditions more stable. This means fewer admissions, shorter stays, less reliance on doctors for care. Premiums have increased out of proportion to increases in total medical costs because HMOs are attempting to recover lost profit margins.

*"More prescriptions lead to fewer hospital admissions and fewer surgeries."*

Critics will say that the Bush proposal in its present form does not do enough to encourage competition among plans for subscribers and to give consumers more control over health care dollars to promote the more appropriate use of pharmaceuticals by provider groups, insurers and HMOs. They are partly right. Seniors must have additional incentives to invest in and save for their own health care, consistent with their expected future ability to do so. More of the money currently used for premiums or payments to insurance companies and health care systems should, in the future, be sitting in the personal accounts of retirees in the form of long-term care or medical savings accounts.

In addition, health plans need to provide better information on price and quality of care. The Choice Plus system, run by the Buyers Health Care

Action Group (BHCAG) in Minneapolis, offers an example of what can be done. Retirees from companies that are members of BHCAG use a combination of premium allowances and consumer guidebooks to drive health plans towards better care at lower cost.

## Conclusion

*"The Bush approach has the potential to hold down total Medicare spending more effectively with less pain."*

The Bush prescription drug proposal is not perfect, but perhaps its greatest asset is that it assumes that drug therapy is a part of overall health care treatment for the elderly. Thus, rather than dealing with drug benefits as a separate matter, Bush treats them as an integral part of reforming Medicare. Further, the Bush proposal does not promote price controls and offers wider access to new drugs than the Gore proposal. By encouraging greater use of newer, more cost-effective drugs and consumer choice and by confining subsidies to seniors in real need, the Bush proposal will hold down total Medicare spending more effectively with less real pain than the Gore proposal. Under the Gore proposal, rising drug costs as a stand-alone budget item would be a tempting target for price controls and rationing.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

# Notes

[1] See "Building A Better Medicare For Today And Tomorrow," National Bipartisan Commission on the Future of Medicare, Final Version, March 16, 1999, available at http://medicare.commission.gov/medicare/bbmtt31599.html.

[2] Medicare Part A covers hospitalization and Part B covers physician and other non-hospital costs. There is no Part C.

[3] Mark E. Litow, "Defined Contributions as an Option in Medicare," National Center for Policy Analysis, Policy Report No. 231, February 2000.

[4] Alan B. Krueger, "The Model Doesn't Quite Fit Medicare Drug Insurance," *New York Times*, October 12, 2000, p. C2.

[5] "Medicare Current Beneficiary Survey Cost and Use File, 1996," Information and Methods Group, Office of Strategic Planning, Health Care Financing Administration.

[6] Robert W. Dubois et al., "Explaining Drug Spending Trends: Does Perception Match Reality?" *Health Affairs*, Vol. 19, No. 2, March 2000.

[7] Ibid.

[8] S.D. Horn et al., "Formulary Limitations and the Elderly: Results from the Managed Care Outcomes Project," *American Journal of Managed Care*, Vol. 4, No. 8, August 1998, pp. 1105-35.

[9] Debi Reissman, "Issues in Drug Benefit Management: It's Not Always Best to Follow California Trends," Drug Benefit Trends , Vol. 12, No. 6, 2000, pp.27-28.

[10] "Pharmacy Benefit Managers: FEHBP Plans Satisfied with Savings and Services, but Retail Pharmacies Have Concerns," U.S. General Accounting Office, Letter Report, February 21, 1997, GAO/HEHS-97-47.

[11] Veterans Affairs National Formulary Section.

[12] R. E. Small et al., "Evaluation of the total cost of treating elderly hypertensive patients with ACE inhibitors: a comparison of older and newer agents," *Pharmacotherapy*, Vol. 17,No. 5, Sept-Oct 1997, pp. 1011-16.

[13] L. I. Condra et al., "Assessment of patient satisfaction with a formulary switch from omeprazole to lansoprazole in gastroesophageal reflux disease maintenance therapy," American Journal of Managed Care, Vol. 5, No. 5, May 1999, pp. 631-38.

[14] Ibid.

[15] "Older Americans 2000: Key Indicators of Well-Being," Federal Interagency Forum on Aging-Related Statistics,

[16] Frank Lichtenberg, "Pharmaceutical Innovation, Mortality Reduction and Economic Growth, National Bureau of Economic Research, NBER Working Paper W6569, May 1998.

[17] Because of the rapid growth in the elderly population, the *number* of older Americans with chronic disabilities increased by about 600,000, from 6.4 million in 1982 to 7 million in 1994.

[18] Statement of Laura A. Dummit, Associate Director Health Financing and Public Health Issues Health, Education, and Human Services Division Medicare: Considerations for Adding a Prescription Drug Benefit (Testimony, 06/23/99, GAO/T-HEHS-99-153).

[19] "Pharmacy Benefit Managers: FEHBP Plans Satisfied with Savings and Services, but Retail Pharmacies Have Concerns."

[20] See, for example, testimony by Jeff Sanders, Senior Vice President, PCS Health Systems, Inc.; Scottsdale, Ariz., Hearing on Considerations for a Medicare Prescription Drug Benefit, Senate Committee On Finance, June 23, 1999.

[21] J.D. Kleinke, "Just What the HMO Ordered: The Paradox of Increasing Drug Costs." *Health Affairs*, Vol. 19, No. 2, March/April 2000.

[22] Frank Lichtenberg, "The Effect of Pharmaceutical Utilization and Innovation on Hospitalization and Mortality," National Bureau of Economic Research, NBER Working Paper W5418, January 1996.

[23] Kleinke, "Just What the HMO Ordered: The Paradox of Increasing Drug Costs."

[24] Ibid.

# About the Author

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# About the NCPA

The National Center for Policy Analysis is a nonprofit, nonpartisan research institute founded in 1983 and funded exclusively by private contributions. The mission of the NCPA is to seek innovative private-sector solutions to public policy problems.

The center is probably best known for developing the concept of Medical Savings Accounts (MSAs). The *Wall Street Journal* called NCPA President John C. Goodman "the father of Medical Savings Accounts." Sen. Phil Gramm said MSAs are "the only original idea in health policy in more than a decade." Congress approved a pilot MSA program for small businesses and the self-employed in 1996 and voted in 1997 to allow Medicare beneficiaries to have MSAs.

Congress also relied on input from the NCPA in cutting the capital gains tax rate and in creating the Roth IRA. Both proposals were part of the pro-growth tax cuts agenda contained in the Contract with America and first proposed by the NCPA and the U.S. Chamber of Commerce in 1991. Two other recent tax changes — an increase in the estate tax exemption and abolition of the 15 percent tax penalty on excess withdrawals from pension accounts — also reflect NCPA proposals.

Another NCPA innovation is the concept of taxpayer choice — letting taxpayers rather than government decide where their welfare dollars go. Sen. Dan Coats and Rep. John Kasich have introduced a welfare reform bill incorporating the idea. It is also included in separate legislation sponsored by Rep. Jim Talent and Rep. J. C. Watts.

Entitlement reform is another important area. NCPA research shows that elderly entitlements will require taxes that take between one-half and two-thirds of workers' incomes by the time today's college students retire. A middle-income worker entering the labor market today can expect to pay almost $750,000 in taxes by the time he or she is 65 years of age, but will receive only $140,000 in benefits — assuming benefits are paid. At virtually every income level, Social Security makes people worse off — paying a lower rate of return than they could have earned in private capital markets. To solve this problem, the NCPA has developed a 12-step plan for Social Security privatization.

The NCPA has also developed ways of giving parents the opportunity to choose the best school for their children, whether public or private. For example, one NCPA study recommends a dollar-for-dollar tax credit up to $1,000 per child for money spent on tuition expenses at any qualified nongovernment school — a form of taxpayer choice for education.

The NCPA's Environmental Center works closely with other think tanks to provide common sense alternatives to extreme positions that frequently dominate environmental policy debates. In 1991 the NCPA organized a 76-member task force, representing 64 think tanks and research institutes, to produce *Progressive Environmentalism*, a pro-free enterprise, pro-science, pro-human report on environmental issues. The task force concluded that empowering individuals rather than government bureaucracies offers the greatest promise for a cleaner environment. More recently, the NCPA produced *New Environmentalism*, written by Reason Foundation scholar Lynn Scarlett. The study proposes a framework for making the nation's environmental efforts more effective while reducing regulatory burdens.

In 1990 the NCPA's Center for Health Policy Studies created a health care task force with representatives from 40 think tanks and research institutes. The pro-free enterprise policy proposals developed by the task force became the basis for a 1992 book, *Patient Power*, by John Goodman and Gerald Musgrave. More than 300,000 copies of the book were printed and distributed by the Cato Institute, and many credit it as the focal point of opposition to Hillary Clinton's health care reform plan.

A number of bills before Congress promise to protect patients from abuses by HMOs and other managed care plans. Although these bills are portrayed as consumer protection measures, NCPA studies show they would make insurance more costly and increase the number of uninsured Americans. An NCPA proposal to solve the problem of the growing number of Americans without health insurance would provide refundable tax credits for those who purchase their own health insurance.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA experts appear regularly in national publications such as the *Wall Street Journal, Washington Times* and *Investor's Business Daily*. NCPA Policy Chairman Pete du Pont's radio commentaries are carried on more than 400 radio stations across America.

According to Burrelle's, the NCPA reached the average household seven times in 1999. More than 55,000 column inches devoted to NCPA ideas appeared in newspapers and magazines in 1999. The advertising value of this print and broadcast coverage was more than $97 million, even though the NCPA budget for 1999 was only $5 million.

The NCPA has one of the most extensive Internet sites for pro-free enterprise approaches to public policy issues, www.ncpa.org, receiving about one million hits (page views) per month. All NCPA publications are available online, and the website provides numerous links to other sites containing related information. The NCPA also produces an online journal, *Daily Policy Digest,* which summarizes public policy research findings each business day and is available by e-mail to anyone who requests it.

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