Medicare Reform and Prescription Drugs: Ten Principles

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Executive Summary

In an election-year rush to satisfy impatient voters, politicians of both parties are endorsing ill-considered schemes to add a prescription drug benefit to Medicare. While the problems with the program are bad, most of the proposed solutions are worse. Medicare deserves thoughtful reform — reform that can greatly reduce seniors' exposure to catastrophic prescription drug costs, improve overall health care quality and control taxpayer costs. What follows are 10 principles to guide that reform.

Principle No. 1: Medicare Needs Fundamental Reform. Despite its popularity, Medicare violates almost all principles of sound insurance. It pays too many small bills the elderly could easily afford on their own while exposing them to thousands of dollars of potential out-of-pocket expenses, including the cost of most of their drugs.

Seniors are the only people in our society who have to buy a second health plan to fill the gaps in the first. But even with Medicare and medigap insurance, most do not have the same drug coverage nonseniors have. Some proposals would keep the basic structure of Medicare intact but add a new drug benefit. This approach would be wasteful and inefficient and would create enormous taxpayer burdens in future years.

Principle No. 2: The Failure to Cover Prescription Drugs Creates Incentives to Substitute More Costly Therapies. Dollar for dollar, drugs offer a better return on health care spending than do other major therapies. Yet Medicare's practice of covering very few prescription drugs encourages doctors and their elderly patients to choose physician and hospital services over less costly, more appropriate drug therapies.

Principle No. 3: The Plan that Administers Drug Benefits Should Be the Same Plan that Administers Other Benefits. When two health plans administer two different sets of benefits, the decision makers can avoid the full costs of their bad decisions and cannot reap the full benefits of their good decisions. Suppose one plan controls hospital benefits and another controls drug benefits. Given a fixed premium for each, the incentive of the first plan is to reduce hospital costs. The incentive of the second is to reduce drug costs. Neither plan has an incentive to consider the overall picture and maximize the health benefits of a given money outlay. The solution is to have a single health plan making all treatment decisions.

Principle No. 4: Paying One Premium to One Plan Is Much More Efficient than Paying Several Premiums to Several Plans. When seniors purchase medigap insurance to reduce their exposure under Medicare, the federal government requires that insurance to cover the Part A and Part B deductibles and copayments. Thus seniors with medigap insurance have first dollar coverage for many medical services, even

though they may lack drug coverage. The result is a great deal of waste. Health economists estimate that seniors with both Medicare and medigap insurance spend about 30 percent more on health care than those with Medicare alone.

Some propose creating a third plan with a separate premium to cover drugs. For most seniors, this would mean three premiums for three plans. But this approach would compound the problems of the current system. What is needed is not three premiums for three plans, but one premium for one plan — a plan similar to the health coverage most nonseniors have.

Principle No. 5: Adding a Drug Benefit to Medicare as Currently Structured Would Create an Unbearable Burden for Future Generations. Medicare currently pays only about 5 percent of the cost of the prescription drugs Medicare beneficiaries use. Proposals to add a comprehensive prescription drug benefit to the program could shift as much as two-thirds of senior drug costs to Medicare. Such a benefit would increase the already substantial burden Medicare will create for future taxpayers:

- Even without reform, 48 percent of federal income tax revenues will be needed to meet the annual deficits in Social Security and Medicare by the year 2050 — in addition to the 15.3 percent payroll tax.
- Under the House Republican proposal, 55 percent of income tax revenues will be needed just to pay seniors' benefits by the time today's teenagers reach retirement age.
- Under the House Democrats' proposal, more than two-thirds of income tax revenues will be needed just to pay seniors' benefits by mid-century.

Principle No. 6: A Reformed Medicare Could Cover Prescription Drugs without Any Increase in Taxpayer Subsidies. Add the amount that Medicare spends on the average beneficiary each year to the amount seniors are already paying for the most popular medigap policy and the combined sum should be enough to buy the same kinds of health insurance coverage the nonelderly now have, including prescription drug coverage (assuming the private plans can pay Medicare rates). That is the conclusion of an NCPA study by Milliman & Robertson, Inc., the nation's leading actuarial firm on health benefits.

Principle No. 7: A Reformed Medicare Should Have Different Levels of Cost Sharing for Different Drugs. Almost all proposals to add a prescription drug benefit to Medicare establish a uniform level of cost sharing for all drugs — regardless of the drug and regardless of the condition it is supposed to treat. Yet an insurance plan with this feature makes little economic sense. Just as some general health care services are more discretionary than others, some drugs are more discretionary than others. And when patients exercise greater discretion, less waste and better outcomes will result if patients bear a larger share of the bill.

Principle No. 8: By Using Medical Savings Accounts, Seniors Could Control Drug Costs as Well as or Better than under Managed Care. 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, brand-name drugs, and to encourage the use of prescription drug therapies only if the benefits to the patient's health appear to justify the added cost. Yet one study 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 these restrictions as were people under age 65.

An alternative approach has been taken in South Africa, where patients with Medical Savings Accounts (MSAs) are controlling drug costs as well as managed care, but without the cost of managed care. In one plan, per-member-per-month costs for drugs were 27.6 percent higher when patients were spending insurance company money than when they were spending their own money from MSA accounts.

Principle No. 9: Under a Reformed Medicare, Seniors Should Have Access to the Same Health Plans as Nonseniors. Virtually all of Medicare's shortcomings stem from the fact that Medicare's features have been determined by politicians and not by firms that have to compete for business by pleasing their customers. Dollar for dollar, health plans designed in the marketplace will almost always be superior to health plans designed by politicians. Like for-profit firms, politicians must compete to survive. But the nature of that competition forces them to weigh political costs against political benefits — where "costs" and "benefits" are measured in terms of impact on the next election. Private firms competing in a marketplace, by contrast, must compare economic costs with economic benefits. Our ultimate goal should be to enroll seniors in the same plans to which nonseniors have access.

Principle No. 10: Under a Reformed Medicare, Health Plans Should Not Have Incentives to Overprovide or Underprovide Care. In designing a reformed Medicare, we must be careful not to give health plans incentives to underprovide to the sick and overprovide to the healthy. An ideal structure is for seniors to have long-term enrollment in a health plan so they can establish long-term relationships with physicians and health care facilities. During the contract period, enrollees could switch health plans at any time. However, a switch of plans would require the consent of both the acquiring and the departed plan and this would almost always necessitate a lump sum payment from one plan to the other. In such a system, health plans would have an incentive to compete for the sick rather than to avoid them. Plans would also have an incentive to specialize in certain kinds of care, e.g., cancer care or treatment of heart disease.

Following these principles would not solve every problem under the Medicare program. But adhering to them would keep policy makers from creating problems that are even worse than the problems they are trying to solve.

Introduction

Unlike most of the nonelderly with private health insurance, senior citizens on Medicare do not have coverage for most prescription drugs unless the drugs are administered in a hospital. This is unfortunate. Drugs have already made a major impact on the health and well-being of the elderly:

- Between 1985 and 1999, residence rates in nursing homes declined by 14 percent among persons age 65 to 74, 25 percent among those 75 to 84, and 17 percent among those 85 and older.[1]
- A principal reason for the declines in nursing home admissions was the introduction of new drugs for stroke and depression.
- Also, in part because of access to new drug therapies, the proportion of Americans age 65 or older with a chronic disability declined from 26 percent in 1982 to 20 percent in 1999.[2]

For the future, spending on medicines as a percent of total health care spending is expected to grow. This should be good news, not bad news for seniors. More than 800 new treatments are coming online for such debilitating diseases as Alzheimer's, arthritis, osteoporosis and Parkinson's, and so are new medicines for heart disease, cancer and stroke — the three leading killers of Americans.[3] Yet seniors will not be able to take full advantage of these opportunities if they cannot afford them.

"There are 10 principles to consider in solving the problem of seniors' access to prescription drugs."

What can be done about this problem? Almost everyone agrees that Medicare needs to be changed. But how it is changed makes a big difference. What follows are 10 principles to guide the reformers in their deliberations.

Principle No. 1: Medicare Needs Fundamental Reform.

Some people argue that the solution is to add a new benefit to the current Medicare program. Yet this approach would be a major mistake. To accommodate drug coverage and fix a host of other problems as well, Medicare needs fundamental reform.

Gaps in Medicare Coverage. Despite its popularity, Medicare violates almost all the 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 most of their drugs. Each year about 750,000 Medicare beneficiaries spend more than $5,000 out of pocket.[4]

"Medicare needs fundamental reform."

The primary source of these problems is that Medicare was designed as a program separate from the health plans of nonseniors. This fact did not make much difference in the early years because Medicare's benefit structure largely copied that of a standard Blue Cross Blue Shield plan. As time passed, Blue Cross and other private insurers changed their coverage as medical realities changed. But because Medicare is a creature of politics, special interests

thwarted its evolution and led to a program that today is far inferior to the insurance plans of most nonseniors.

Filling the Gaps in Medicare with a Second Insurance Plan. To prevent financial devastation from medical expenses, about two-thirds of Medicare beneficiaries acquire supplemental (medigap) insurance, through a former employer or by direct purchase. Although some medigap policies cover prescriptions, most do not, and the coverage that is provided often is incomplete.[5] Ironically, the poorest seniors may have the best drug coverage because they qualify for Medicaid, the federal-state health program for the poor.

"Seniors are the only people who have to buy a second health plan to fill the gaps in the first."

Seniors are the only people in our society who have to buy a second health plan to fill the gaps in the first. But even with Medicare and medigap insurance, most do not have the same drug coverage that nonseniors have. Moreover, as we shall see below, paying two premiums to two plans is wasteful and inefficient. Some proposals would keep the basic structure of Medicare intact but would require seniors to pay a third premium to a third plan for drug coverage. This approach would be even more wasteful and inefficient.

Temporary Solutions that Won't Work. While conceding that Medicare needs fundamental restructuring, some argue that such reform takes time and seniors' needs are immediate. Accordingly, they propose stop-gap solutions: imposing federal or state price controls, reimporting U.S.-made drugs shipped to other countries such as Canada, weakening patent protection for brand-name drugs and encouraging government health plans to aggressively bargain down the prices they pay. To the extent that these techniques result in below-market prices, they will have unfortunate side effects.

In general, the marginal cost of manufacturing a drug (filling a capsule and packaging it) is only a small fraction of the total cost, including the cost of research and development (R&D). While drug companies are willing to provide drugs to the market so long as they can cover their manufacturing costs, they will not be willing to fund R&D for the next generation of drugs if they cannot charge prices that allow them to recover the cost of that investment.

"Some propose seniors pay a third premium to a third plan — for drugs."

Forgoing new drugs in the future in return for cheaper drugs today is a bargain not worth making. A study by Columbia University professor Frank Lichtenberg found that new drugs have increased life expectancy by as much as 1 percent per year. 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. In terms of dollars and cents, for every dollar we spend on R&D we get back two dollars — every year, indefinitely into the future.[6]

Temporary Solutions that Will Work. A number of temporary measures would ease seniors' problems while fundamental reform is underway — without discouraging the development of new drugs in the future. [See Exhibit I.]

EXHIBIT I

Temporary Relief: Four Simple Solutions

Free Medigap

Allow medigap insurers to forgo coverage for routine expenses in return for providing catastrophic coverage for expensive drugs.

Free Medicare

Encourage private insurers under the Medicare+Choice program to combine Medicare and medigap into comprehensive plans that cover prescription drugs.

Free Roth IRAs

Relax the rigid rules so seniors can use their Roth IRAs as Medical Savings Accounts.

Free the States

Let states use federally provided antipoverty money to fund high-risk pools for seniors needing prescription drugs.

Source: John C. Goodman and Merrill Matthews Jr., "Simple Solutions for Elderly Prescription Drugs," National Center for Policy Analysis, NCPA Brief Analysis No. 300, July 26, 1999.

"Temporary measures could ease the problem while fundamental reform is underway."

As a first step, a simple change in the law would unleash solutions in the medigap insurance market. Under the current system, federal law imposes Medicare's insurance philosophy on medigap insurers. Medigap policies must cover small-dollar items such as the Part A and Part B deductibles, but they need not cover the largest bills.[7] Coverage for drugs also is an option. Were insurers given more freedom, they could create plans more responsive to the needs of their customers. Specifically, if insurers were free to forgo coverage of many routine expenses, they could offer more generous drug coverage with no increase in premiums.

"The goal of fundamental reform: seniors should pay only one premium to one plan."

As a second step, federal policy should encourage rather than discourage the Medicare+Choice program. This program was created in 1996 to give seniors the opportunity to join private health plans that function much like the plans nonseniors are enrolled in. In response, about 16 percent of seniors (more than one in six) moved from traditional Medicare into private sector HMOs. These HMOs are required to cover everything that Medicare covers, but most cover much more. A recent survey found that 95 percent of Medicare HMOs provide their enrollees with a prescription drug benefit.[8]

However, a Medicare bureaucracy hostile to any challenge to its power and authority has managed to halt and even reverse the trend. (See the discussion below.) The bureaucracy also has blocked other options for

seniors. The Medicare+Choice program is supposed to give the elderly the full range of non-HMO options available to the nonelderly, including fee-for-service insurance and Medical Savings Account (MSA) plans. Yet none of these options currently exist. The Bush administration has announced plans to allow the private sector to offer PPO fee-for-service insurance to the elderly as part of a pilot program. But MSA plans are nowhere in sight.

A third opportunity is presented by Roth IRAs.[9] These accounts permit people to set aside up to $2,000 a year after taxes in retirement accounts that grow tax free. After age 59, the funds can be withdrawn without penalty for any purpose, including medical expenses. Since the elderly by definition satisfy the age test, with minor rule changes Roth IRAs could serve as "backended" Medical Savings Accounts for the elderly.[10]

A fourth opportunity is to turn to the states. More than half the states have high-risk pools that permit people who have been denied health insurance to obtain coverage for a reasonable premium.[11] The states also cover many low-income seniors' drug needs through their Medicaid programs, and 34 currently provide low-income seniors with prescription drug assistance. Other states are considering similar legislation.[12]

"Medicare's failure to cover prescription drugs encourages seniors to rely on costlier, less effective therapies."

All of these programs require subsidies, but state budgets are extremely tight. So where would the new money come from? A potential source is antipoverty money — unused as a result of a 50 percent drop in the number of welfare recipients. The 1996 welfare reform law gives states great flexibility on how to spend federal and state welfare funds.[13] Congress should free the states to use these funds to provide temporary relief to the elderly poor.

None of these four proposals would impose new taxes or premiums, nor would they cost the government much. These smaller, less expensive, targeted solutions could help seniors while fundamental Medicare reform is under way.

Principle No. 2: The Failure to Cover Prescription Drugs Creates Incentives to Substitute More Costly Therapies.

Dollar for dollar, drugs often provide a better return on health care spending than do other major therapies. Chronic conditions such as asthma, diabetes, hypertension and even congestive heart failure can be treated far more cost-effectively with drugs. Yet Medicare's practice of covering very few prescription drugs encourages doctors and their elderly patients to choose physician, emergency room and hospital services instead. An exhaustive study by Prof. 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:[14]

- 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 expenditures is associated with a $3.65 reduction in hospital care expenditures.

The decline in total spending due to greater use of prescription drugs is particularly notable in the treatment of cancer, heart disease, Alzheimer's, AIDS and mental illness.[15] For the near future, we can expect more of the same. Most of the expensive new drugs launched in the past few years, such as Rezulin for diabetes, Zocor for cholesterol, Zyprexa for schizophrenia and Claritin for allergies, stabilize patients with chronic conditions. This decreases hospital admissions, shortens hospital stays and lessens reliance on doctors even as it increases the bill for prescription drugs.[16] Yet without drug coverage, many seniors rely on older, more costly therapies.

Principle No. 3: The Plan that Controls Drug Benefits Should Be the Same Plan that Administers Other Benefits.

Appreciating the opportunities to substitute between therapies also helps us understand why a unified health plan is so important.

"The plan that controls access to drugs must be the same plan that controls access to other therapies."

A number of proposals would create an optional prescription drug benefit under Medicare. In most versions, seniors would pay an additional premium, and the benefit would be administered by a private pharmacy benefit manager (PBM) — a sort of managed care approach to prescription drugs. (See the discussion below.) In all versions, premiums would be the same for all — irrespective of preexisting conditions or expected health care costs.

One problem with this approach is that it encourages extreme adverse selection. Everyone whose expected drug costs exceed the premium being charged would quickly enroll, while those whose expected drug costs are below the premium would decline coverage and delay their enrollment. In other words, high-cost sick people would rush to join while low-cost healthy people demurred. The end result would be escalating deficits or, if the premium were intended to cover all costs, a death spiral in which the premium would rise so high that none but the most expensive enrollees would remain in the plan.

But even if this problem could be overcome, as some have attempted to do,[17] a second problem is that if two health plans administered separate sets of benefits, the decision makers could avoid the full costs of their bad decisions and could not reap the full benefits of their good decisions. The result: perverse incentives to make bad decisions and avoid good ones. Suppose, for example, that one plan controls hospital benefits and another drug benefits. Given a fixed premium for each, the principal incentive of the first plan would be to reduce hospital costs. The principal incentive of the second plan would be to reduce drug costs. In neither case would the plan's administrator have an incentive to

consider the overall picture and maximize the health benefits of a given money outlay.

There is also a third problem. Just as these proposals would distort incentives for plan administrators, so they would distort incentives for patients — as the next principle shows.

Principle No. 4: Paying One Premium to One Plan Is Much More Efficient than Paying Several Premiums to Several Plans.

The principal reason why health plans have deductibles and coinsurance is to discourage wasteful overconsumption of medical care. This is especially important for small medical expenditures that are difficult and costly for insurers to monitor. With first-dollar coverage and no out-of-pocket payment, patients may opt for services so long as the smallest probability of medical benefit exists.

Yet, as noted above, the federal government requires that medigap insurance cover the Part A and Part B deductibles and copayments. This provides medigap-covered seniors with first-dollar coverage for many medical services, even though they may lack catastrophic coverage for drugs. The result is a great deal of waste.

"Adding a third plan for prescriptions would be less efficient than unifying coverage under a single plan."

Health economists estimate that seniors with both Medicare and medigap insurance spend about 30 percent more on health care than those with Medicare alone. Further, those with medigap insurance do not appear to have greater health needs than do those without the insurance. Rather, they appear to be responding to the economic incentives created by first-dollar coverage.[18]

As also noted above, some propose creating a third plan with a separate premium to cover drugs. For most seniors, this would mean three premiums for three plans. This would compound the problems of the current system, creating another layer of costly administration and making benefits coordination and information sharing even harder. What is needed is not three premiums for three plans, but one premium for one plan similar to those of most nonseniors.

Principle No. 5: Adding a Drug Benefit to Medicare as Currently Structured Would Create an Unbearable Burden for Future Generations.

Medicare currently pays only about 5 percent of the cost of prescription drugs Medicare beneficiaries use. Proposals to add a comprehensive prescription drug benefit to the program could shift as much as two-thirds of senior drug costs to Medicare.[19] This would increase the already substantial burden Medicare expenditures will place on future taxpayers.

Medicare's Unfunded Long-term Liability. Medicare is a pay-as-you-go program, under which the federal government collects payroll taxes and

promptly spends the money on benefits. The government does not set aside or invest funds to pay future benefits. Anyone who has worked at least 10 years has already earned the right to receive future Medicare benefits, and a previous NCPA study by economists at the Private Enterprise Research Center at Texas A&M University estimated the current accrued liability under Medicare at almost $17 trillion.[20] This is more than five times the official national debt.

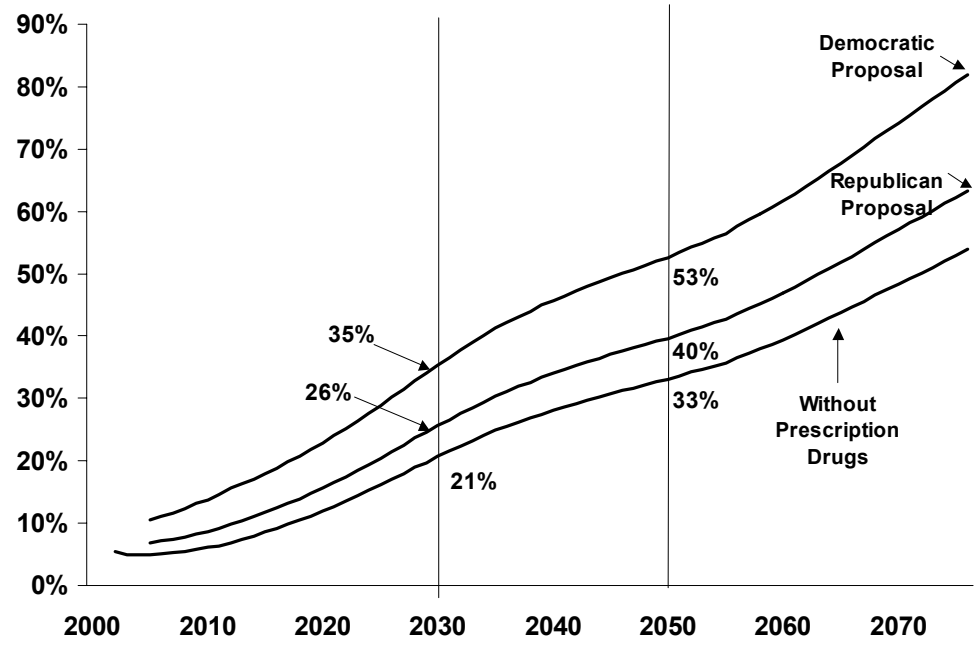
Of course, future payroll tax revenues will help meet these obligations. But Medicare already spends more on benefits than it receives in payroll taxes from workers, premiums from the elderly and taxes on Social Security benefits. In the future, the financial picture will get much worse.[21]

Medicare's Future Deficits. Currently, the government provides additional funds for Medicare from general revenues — mainly personal and corporate income taxes. Figure I shows how much of federal income taxes will be needed to fund future Medicare deficits with no change in the current payroll tax rate. Even without the addition of drug benefits, the long-term outlook for Medicare is bleak:

"Medicare's deficit will require 20 percent of income tax revenues by 2030, and about one-third of income taxes in 2050, even without prescription drug coverage."

FIGURE I

Percent of Federal Income Taxes Needed to Pay Annual Medicare Deficits Under Prescription Drug Proposals



Source: John C. Goodman, "Prescription Drugs for Seniors," NCPA Brief Analysis No. 406, July 23, 2002, National Center for Policy Analysis. Calculations by Andrew J. Rettenmaier, Private Enterprise Research Center, Texas A&M University.

- By 2030, about the midpoint of the baby boomer retirement years, the annual Medicare deficit will consume 20 percent of income tax revenues.
- By 2050, when today's teenagers are reaching retirement age, Medicare's annual deficit will consume about one-third of income taxes.

Transfers to Medicare from general revenues are only part of the picture. After 2017, Social Security also will require general revenue transfers to supplement an inadequate payroll tax:

"The House Democrats' prescription drug plan would increase Medicare's deficit to 53 percent of income tax revenues by 2050."

- In 2030, Social Security will require about 14 percent of federal income tax revenues, and Medicare and Social Security combined will consume more than 34 percent on top of the 15.3 percent payroll tax.
- By 2050, Medicare and Social Security will require more than 48 percent of all federal income tax revenues in addition to all dedicated taxes and premiums.

Bleak as this financial picture is, adopting any of the prescription drug proposals currently before Congress would make it far worse.

The House Democratic Proposal. To extend Medicare's coverage to prescription drugs, Democrats in the House of Representatives have proposed a plan that includes a $100 deductible, a $25 monthly premium, 80 percent coverage between $101 and $2,000, and 100 percent coverage beyond $2,000 in expenditures. Under this plan, the federal government's subsidy would be quite large, and it would grow through time:

"The House Republicans' plan would increase Medicare's deficit to 40 percent of income taxes by 2050."

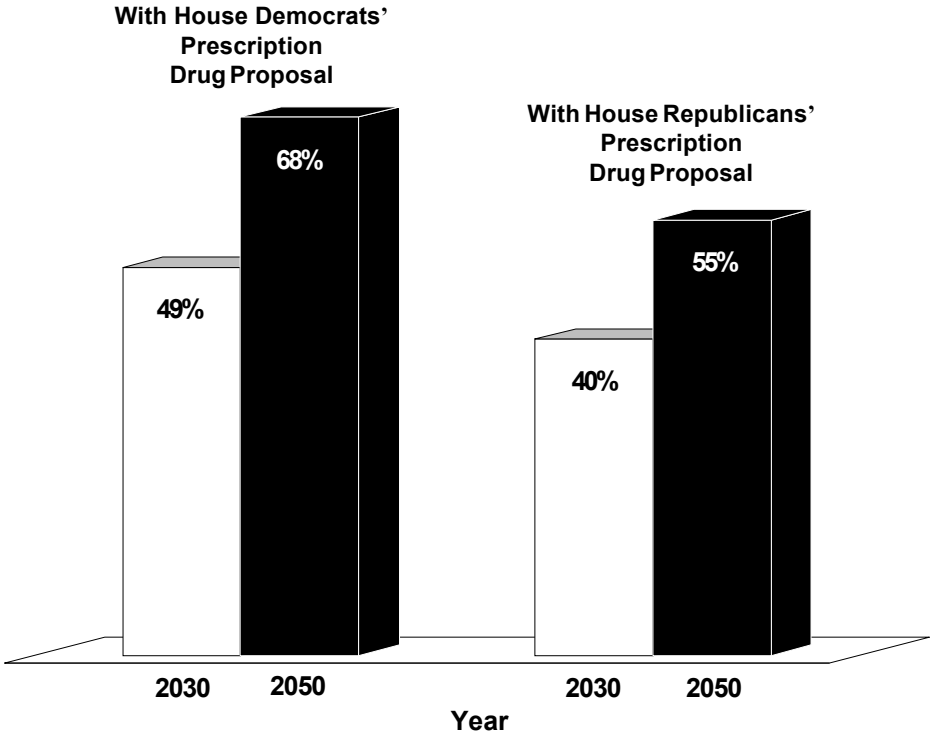
- Assuming all seniors participate, Medicare likely would pay about two-thirds of their drug costs.
- A rough estimate is that this proposal would raise Medicare's deficit to 35 percent of income taxes by 2030 and 53 percent by 2050.
- When the Social Security deficit is included, more than two-thirds of income tax revenues would be needed just to pay seniors' benefits by mid-century, when today's teenagers are reaching retirement age. [See Figure II.]

The House Republican Proposal. Republicans in the House of Representatives have proposed a prescription drugs benefit package that includes a $34 monthly premium, a $250 deductible, 80 percent coverage of prescription drug costs between $251 and $1,000, 50 percent coverage between $1,001 and $2,000, no coverage between $2,001 and $4,800, and 100 percent coverage above $4,800. No senior would pay more than $3,700 out of pocket per year.[22] As with the Democratic plan, the Republican plan

"Under the House Democrats' prescription drug proposal, Social Security and Medicare deficits would require two-thirds of income taxes by mid-century."

FIGURE II

Percent of Income Taxes Needed to Pay Social Security and Medicare Deficits Under Prescription Drug Proposals



Source: John C. Goodman, "Prescription Drugs for Seniors," NCPA Brief Analysis No. 406, July 23, 2002, National Center for Policy Analysis. Calculations by Andrew J. Rettenmaier, Private Enterprise Research Center, Texas A&M University.

would require large and growing subsidies — mainly paid by younger taxpayers:

- Assuming all seniors participated, Medicare likely would pay for a little more than one-fourth of their drug costs.
- A rough estimate is that the GOP drug benefit would raise Medicare's claim on other revenue to 25 percent of income taxes by 2030 and 40 percent by 2050.
- When the Social Security deficit is included, 55 percent of income tax revenues would be needed just to pay seniors' benefits by mid-century, when today's teenagers are reaching retirement age. [See Figure II.]

Principle No. 6: A Reformed Medicare Could Cover Prescription Drugs without Any Increase in Taxpayer Subsidies.

The elderly could have better health care coverage — including a prescription drug benefit — if they were allowed to combine their Medicare funds with the money they currently spend on private insurance and pay one premium into a comprehensive private plan. Add the amount that Medicare will spend on the average beneficiary each year to the amount seniors are already paying for the most popular medigap policy, and the combined sum should be enough to buy the same kinds of health insurance coverage the nonelderly now have, including prescription drug coverage (assuming the private plans can pay the same rates Medicare currently pays). That is the conclusion of a study prepared for the National Center for Policy Analysis by Milliman & Robertson, the nation's leading actuarial firm on health benefits.[23]

"Prescription drug coverage would not require increased tax subsidies if seniors were allowed to combine public and private spending on a single, private sector health care plan."

Medicare+Choice. Congress thought it was allowing seniors to use their Medicare money to join private health plans when it passed Medicare+Choice in 1997. The program was supposed to give the elderly the full range of health insurance options currently available to nonseniors: HMOs, MSAs, fee-for-service plans, doctor-run plans, etc. However, the Centers for Medicare & Medicaid Services (CMS), which regulates Medicare, has behaved as if it is hostile to private insurance, hostile to competition and hostile to choice. As a consequence, the program is saddled with so many rules, regulations and constraints that seniors have few of the options originally promised.[24]

The program was an initial success, with private sector HMOs attracting 6.3 million Medicare beneficiaries (about 16 percent) and federal officials predicting that number would double by 2005. However, the program has virtually collapsed as low reimbursements and red tape have driven out insurers. With the latest withdrawals, 2.4 million elderly and disabled enrollees have lost their private plan coverage since 1998.[25]

Premium Support. One reason why so many HMOs are leaving the Medicare+Choice program is the claim that their level of reimbursement is too low. These plans are generally free to charge enrollees an out-of-pocket premium on top of what Medicare pays, however. And if the plan supplants medigap, seniors should be able to pay the extra HMO premium with the savings they realize from no longer paying medigap premiums. As a practical matter, however, Medicare HMO enrollees tend to be lower-income seniors who often do not have medigap insurance.[26] Many cannot afford higher HMO premiums for the same reason that they cannot afford medigap insurance.

To meet the needs of these seniors, some advocate Medicare reform that would condition Medicare's contribution on the income of the senior citizen. Under these "premium support" plans, private health plans would be an alternative to traditional Medicare and medigap insurance. The plans would also provide catastrophic coverage for prescription drugs.[27]

The idea behind premium support is that the share of the total premium paid by Medicare to the private plan would be inversely related to the senior's income. For example, Medicare might pay 100 percent of the premium for the lowest-income seniors and much less for those with the highest incomes. Although supporters of this reform expect that it will require additional federal spending, it is not obvious that more taxpayer subsidy is needed.

Principle No. 7: A Reformed Medicare Should Have Different Levels of Cost Sharing for Different Drugs.

Almost all proposals to add a prescription drug benefit to Medicare establish a uniform level of cost sharing for all drugs. In other words, the patient's share of the bill is the same — regardless of the drug and regardless of the condition it is supposed to treat. Yet an insurance plan with this feature makes little economic sense.

Let's begin with the basics. Why have any patient cost sharing in the purchase of prescription drugs? Why not let Medicare, or a private payer, bear all the costs? The reason is that patients are often more effective and more efficient monitors of prescription drug therapy than are third-party payers, even when the third-party payers impose a regime of strict managed care. Switching from a brand-name drug to a generic equivalent may affect some patients differently than others. Different dosage levels also may have different effects on different patients. And some prescription drugs are no more effective than over-the-counter medications. No one is in a better position to observe these effects and weigh the costs against the benefits of alternatives than are the patients themselves.

"Where patients exercise more discretion, they should have more control over health care dollars."

Patient Discretion. Given the desirability of some patient cost sharing, should the rate be the same for all drugs? Both common sense and basic principles of health economics suggest otherwise. Like some health care services, some drugs are more discretionary than others. And, all other things being equal, patients exercising greater discretion and bearing a larger share of the bill tend to reduce waste and enhance health outcomes.

Ideally, we do not want to spend a dollar on health care unless it produces a dollar's worth of value. But if patients pay, say, only 20 percent of the cost, they have an incentive to consume drugs until they are worth only 20 cents on the dollar. This incentive may not mean very much if the drug is lifesaving and there is very little discretion about dosage. But the incentive makes a great deal of difference when the outcome of drug therapy is experienced subjectively and there is a lot of discretion about dosage.

Allergy relief is one example. No outsider can directly observe how uncomfortable you are, so no third party can objectively measure the value of relieving your discomfort. You may find adequate relief from a $5 over-the-

counter antihistamine, or you may decide a more expensive prescription like Claritin is a better value. But you cannot make a rational choice unless that choice has cost consequences.

Possible Adverse Consequences of Patient Discretion. In general, patient discretion is desirable. There are exceptions, however. The reason is that even if patients are paying the full cost of their drugs, they are certainly not going to pay the full costs of hospital therapy and physician therapy that may result from the underuse or misuse of prescription drugs. Because drugs often are an alternative to more expensive therapies, failure to follow an appropriate drug therapy regime may lead to higher health care spending — including higher Medicare costs.

"In South Africa, patients use Medical Savings Accounts for discretionary therapies but have first dollar coverage for chronic conditions."

South Africa's Experience with Flexible Deductibles. The considerations outlined in this section are already influencing the design of private health insurance in the United States. For example, health expert J. D. Kleinke points out that health plans are rapidly moving toward multitier drug coverage wherein insurers prepay for drugs that are the most "medically and economically useful" for patients while assigning a copayment to drugs that are not.[28] However, there is a problem with this approach. If patients are living from paycheck to paycheck, they may not have the funds to pay the deductibles for drugs that are more promising. Medical Savings Accounts are a possible solution to this problem.

Under the government of Nelson Mandela in the 1990s, South Africa conducted a unique experiment in the market for private health insurance. After deregulation in 1994, virtually every type of health insurance plan sold in the United States was able to enter the South African market — from health maintenance organizations (HMOs) to preferred provider organizations (PPOs) to Medical Savings Account plans (MSAs). And after a favorable ruling from the tax authorities, employer deposits to MSAs received the same tax treatment as employer payment of third-party insurance premiums. Employees were free to use their MSA funds to pay expenses not paid by third-party insurance.[29]

Thus in South Africa, MSA plans have competed against other forms of insurance on a level playing field for several years. The result has been remarkable. Since 1994, MSAs have captured about half of the private health insurance market, covering about 7 million people. By contrast, HMO-type managed care has made only small inroads.

In the United States, the design of tax-free MSA plans allowed under a special pilot program is rigidly defined in the tax code.[30] In general, MSA plans in this country must have a uniform high deductible, regardless of the health service. In South Africa, by contrast, insurers have been free to innovate and experiment. The result is a far more interesting product — one better designed to meet patient needs.

South African MSA plans typically have varying deductibles. For example, a representative plan has no deductible for hospital care, on the theory that patients exercise little discretion within hospitals. But a $1,100 deductible for annual outpatient care is common, on the theory that patients have far more discretion in that setting. The high deductible also applies to prescription drugs. However, for chronic conditions for which skimping on medication could lead to more expensive care later on, the deductible drops back to zero.[31]

South African insurers also have experimented in other ways. In one of the most popular plans, diabetics are able to enroll in "centers of excellence," special treatment centers that are effective and efficient. If they do, they pay one-third of the monthly fee from their MSA; their health insurance pays the other two-thirds. Since employers are making most of the deposits to the employees' MSAs as well as paying insurance premiums, ultimately almost all the money comes from the employer. But these plans are designed so that the employees make choices in which they have a financial stake.[32]

Principle No. 8: Using Medical Savings Accounts, Seniors Could Control Drug Costs as Well as or Better than Managed Care.

Drug spending is a growing part of the cost of medial care, totaling more than $120 billion a year.[33] In an effort to control these costs, third-party payers have experimented with a number of techniques.

"Patient control is preferable to restrictive drug formularies used by the Veterans Administration and to Medicaid-type rationing."

Drug Formularies. In general, a formulary is a list of generic and brand-name medications a health plan covers. For years, state Medicaid programs have used restrictive formularies to control drug costs. The Federal Employees Health Benefits Plan (FEHBP) and the Veterans Affairs health care system use them as well. [See the two sidebars.] Among the cost control mechanisms are:

- Restrictive formularies that narrow selection to one or two drugs for each type of therapy.
- Requirement for prior authorization before using drugs that are not on a formulary.
- Refusal to pay for branded drugs or establishment of a price ceiling on all but generic drugs in any therapeutic class.

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 and manufacturers, limit coverage to lower-price generic drugs and encourage the use of prescription drug therapies only if the benefits to the patient's health appear to justify the added cost. What difference do these techniques make?

Controlling the Cost of Prescription Drugs in the VA Health System

Some have pointed to the Veterans Affairs health system as a model of how prescription drug costs might be controlled under Medicare. Yet the VA approach is far from ideal, as the following examples show. In general, the VA places strict limits on where people can get drugs and what drugs they can get:

- 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.[1]
- A study that found 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.[2]
- 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 it.[3]
- 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.[4]

[1] Veterans Affairs National Formulary Section.

[2] 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, September-October 1997, pp. 1011-1016.

[3] 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.

[4] Condra et al., "Assessment of patient satisfaction."

Source: Robert Goldberg, "Comparing Prescription Drug Proposals: Bush v. Gore," NCPA Policy Report No. 239, November 2000, National Center for Policy Analysis.

Controlling the Cost of Prescription Drugs under Medicare and Medicaid

Consider the Medicare program's handling of erythropoietin (EPO), a biotechnology product used to control anemia in kidney dialysis patients. (This is one of the exceptions to the general rule that Medicare does not pay for prescription drugs.) Dialysis patients are healthier and longer-lived with EPO than without it. In 1994, to limit its expenditures for EPO, Medicare put a price cap on the drug, rationed the amount patients could get and refused to cover patients with healthy blood cells above a certain level.

Subsequently the number of people who died in the program increased and people with healthy blood levels wound up getting sicker and spending more time in dialysis and in hospitals. It took five years of lobbying and administrative review to get Medicare to loosen its chokehold over the lives of dialysis patients.[1]

Drug rationing in state Medicaid programs also has been strongly associated with spikes in hospitalizations and doctor visits. In general, money saved on drugs has been more than offset by the cost of untreated illness. For example:[2]

- A 1991 study published in the *New England Journal of Medicine* found that when New Hampshire restricted the number of prescriptions reimbursed by Medicaid, the elderly entered nursing homes at 60 percent higher rate.
- Although drug utilization fell 35 percent, overall health care expenditures increased.
- When the restrictions were lifted, nursing home admissions decreased.
- A follow-up study in the *New England Journal of Medicine* found that New Hampshire's prescription drug caps saved an average $57 per year on drugs for schizophrenia patients — but added $1,530 per year in costs for visits to mental health clinics and emergency rooms.

[1] A. J. Collins et al., "Trends in Anemia Treatment with Erythropoietin Usage and Patient Outcomes," *American Journal of Kidney Disease*, Vol. 32, No. 6, Supp. 4, December 1998, pp. S133-41.

[2] S. B. Soumerai et al., "Effects of Medicaid Drug Payment Limits on Admissions to Hospitals and Nursing Homes," *New England Journal of Medicine*, Vol. 1, No. 2, October 10, 1991, p. 337; and S. B. Soumerai et al., "Effects of a Limit on Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia," *New England Journal of Medicine*, Vol. 331, No. 10, September 8, 1994, pp. 650-55.

Source: Robert Goldberg, "Ten Myths about the Markets for Prescription Drugs," NCPA Policy Report No. 230, October 1999, National Center for Policy Analysis.

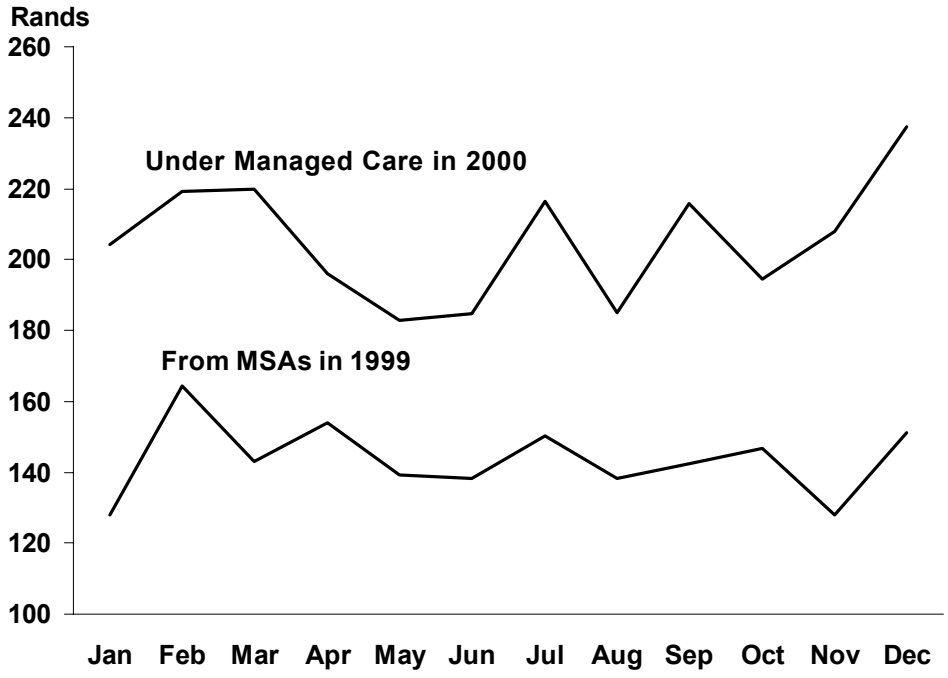
Dr. Susan Horn conducted a study of pharmaceutical restrictions in six managed care plans.[34] She found that restricting seniors' access to pharmaceuticals was associated with more emergency room admissions, hospital stays and doctor visits for such illnesses as depression, heart disease, ulcers and diabetes. The elderly were twice as likely to be harmed by formulary limits as were people under age 65. That is, faced with the same restrictions as someone under age 65, an elderly person in the same HMO was twice as likely to be hospitalized or see a doctor as a result of efforts to control drug costs.

Medical Savings Accounts and Prescription Drugs: Evidence from South Africa.[35] The experience of Discovery Health in South Africa provides convincing evidence that Medical Savings Accounts — when designed and used in the right way — can control drug costs as well as managed care, but without the cost of managed care. In 2000, of the 202,595 Discovery members who were active for the whole year, 76,072 (37.5 percent) reached their deductible for outpatient spending. Before reaching the deductible, patients paid for drugs from their MSAs; after the deductible was reached, drug costs were paid by the insurer. Because patients were essentially spending their own money below the

"Patients with Medical Savings Accounts reduced spending on Ritalin by 20 percent compared to the costs under managed care."

FIGURE III

Spending on Ritalin Among Patients in South Africa[1]



[1] Cost per number per month among those who use Ritalin.

Note: R1.00 ≅ US$0.15 (2000).

Source: Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," NCPA Policy Report No. 254, August 2002, National Center for Policy Analysis.

deductible, they had an incentive to spend wisely. But once they reached the deductible, they were essentially spending insurance company money and had no economic incentive to spend it wisely.

This plan design allowed investigators to ascertain the effects of MSAs on the cost of medication. One study found that:

- The average cost of a prescription rose 7.1 percent after members reached the deductible.
- The average number of prescriptions filled per month increased by 19.1 percent after members crossed the deductible threshold.
- Overall per-member-per-month costs rose 27.6 percent after members exceeded their deductibles!

Clearly, economic incentives matter in the market for prescription drugs.

MSAs versus Managed Care: Evidence from South Africa.[36] Mental health drugs are one area in which patients are assumed to exercise considerable discretion. South Africa's experience with Medical Savings Accounts tends to bear out that assumption. One study found that:

"Spending on drugs rose more than 27 percent when patients were spending insurance company money instead of their own MSA money."

- In one health plan, evidence indicated that parents exercised lot of discretion over the use of Ritalin (for children with attention deficit disorder); when spending from an MSA these parents reduced their spending on Ritalin by almost 20 percent compared to spending under a managed care arrangement, without any adverse health affects. [See Figure III.]
- Patients using their MSAs also were much more likely to purchase a generic equivalent that cost only 38 percent as much as Prozac (for depression); by contrast, use of the brand-name drug jumped 45 percent when patients were spending insurance company money. [See Figure IV.]

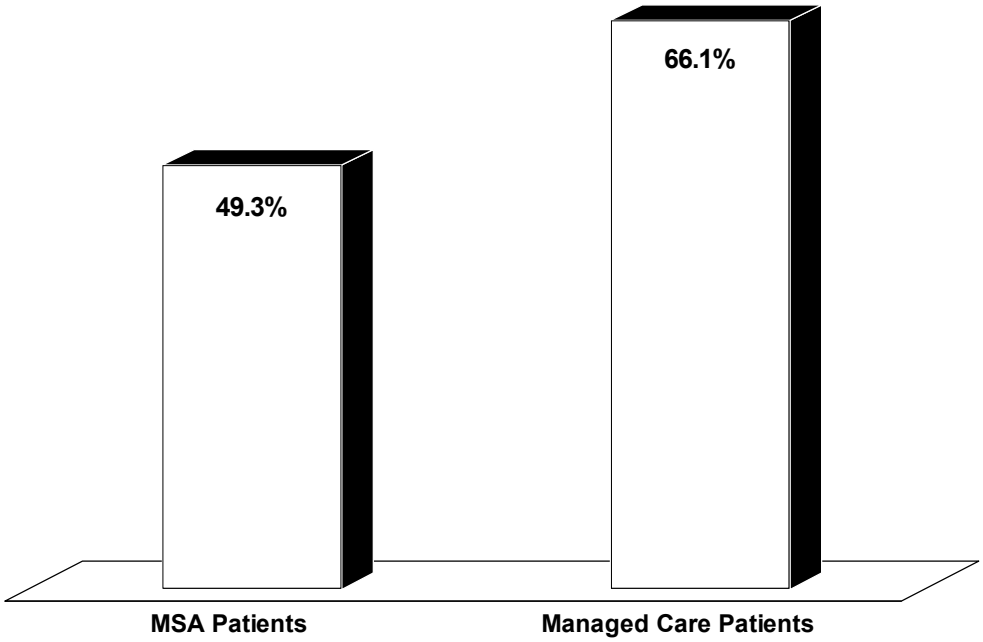
In both these examples, patients with MSAs controlled costs as well as or better than managed care — without the costs associated with managed care.

Some MSA critics contend that the introduction of deductibles might induce members to forgo necessary care in order to save money. To test this proposition, the same study examined the use of two drugs (Fosamax and Trisequens) used primarily for the prevention and treatment of osteoporosis in postmenopausal women. Patients used some of their MSA funds to buy these drugs in 1999, but switched to managed care the following year so the insurer bore the entire cost of the drugs. Here, the results are quite different from those of Ritalin. The amounts spent using MSAs are almost indistinguishable from those under the chronic benefit. Clearly, members were not forgoing necessary care.

"Patients with Medical Savings Accounts were more likely to use the generic equivalent of Prozac than were those under managed care."

FIGURE IV

Use of Prozac Rather than a Generic Equivalent among South African Patients



Source: Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," NCPA Policy Report No. 254, August 2002, National Center for Policy Anaysis.

Principle No. 9: Under a Reformed Medicare, Seniors Should Have Access to the Same Health Plans as Nonseniors.

There has been considerable debate over the past several years about whether Medicare should be a government program or a private program in which health plans compete in the marketplace. That this issue lingers is a bit of a surprise. As noted above, virtually all of the ways in which Medicare falls short of its private insurance counterparts stem from the fact that Medicare's features have been determined by politicians and not by firms that compete for business by pleasing their customers.

That adding prescription drug benefits is a contentious issue speaks to the limits of federally administered health programs. The private sector has been covering prescription drugs for decades with very little controversy. But political forces continue to block Medicare reform.

Dollar for dollar, health plans designed in the marketplace almost always are superior to health plans designed by politicians. The reason flows from fundamental differences between political and economic competition. Like for-

profit firms, politicians have to compete in order to survive. But the nature of that competition forces them to weigh political costs against political benefits — where costs and benefits are measured in terms of impact on the next election.

Private firms competing in a marketplace, however, are forced to compare economic costs with economic benefits. And provided the rules of competition are structured properly, this means the firms are balancing social costs against social benefits. Under these circumstances, the inevitable tendency is to maximize the social value of any given outlay of money.

In another context we have shown that extreme departure from the social optimum is almost inevitable when politicians allocate health care resources.[37] The reason is that in a typical private plan a small percent of patients consume the vast majority of health care dollars.[38] For example, about 5 percent of Medicare beneficiaries spend about half of all Medicare dollars.[39] Politicians competing for office, however, will naturally resist spending so much of the health care budget on such a small number of patients — most of whom are probably too sick to vote anyway.

"All the problems of Medicare stem from the fact that it was shaped by politicians rather than by the marketplace."

Competition for votes is the underlying reason why politicians have designed a Medicare system that pays small medical bills that most seniors could pay on their own while leaving a tiny minority exposed to catastrophic expenses, including catastrophic drug expenses that very few seniors could pay. The small bills are incurred by the many, the large bills by the few.

One reason the design of Medicare is not even worse is that private sector forces shape and mold the larger health care system of which Medicare is a part. In Britain, where virtually the entire health care system is subject to politics, the distortions are much worse. The British government denies its own citizens state-of-the-art cancer care and access to such technology as CAT scans and MRI scans — all the while spending billions on minor services for people who are only mildly ill or disabled.[40]

The upshot is that seniors fare better if they have access to health plans designed to compete in the private marketplace. This implies that our ultimate goal should be to enroll seniors in the same types of health plans as nonseniors. Indeed, there is no reason why seniors and nonseniors should not be in the same health plans.

A health care plan connected to previous employment, for example, is one possibility. Many people who turn 65 and become eligible for Medicare have been retired for 10 or more years. Many others continue working for another 10 or more years. In either case, they might prefer to continue in the health plan they already know.

Principle No. 10: Under a Reformed Medicare, Health Plans Should Not Have Incentives to Overprovide or Underprovide Care.

A major problem for all health insurance is overcoming the distorted incentives providers face. For example, under fee-for-service reimbursement (which is the way Medicare pays doctors), physicians have an incentive to overprovide services because the more they provide the more they are paid. By contrast, under a fixed-payment system (which is the main way Medicare pays hospitals), the staff has an incentive to underprovide because they get the same amount of income regardless of how much or how little they do.

In the private sector, competition among insurers helps hold some of these distortions in check. However, Medicare is a monopoly. As a result, Medicare's only method for avoiding overprovision or underprovision of services is to burden providers with paperwork and regulations. Medicare also threatens to punish providers in a way no private insurer can: by criminalizing what it regards as serious contract violations. When ordinary mortals have contract disputes they must resort to the civil courts. They can't send the other party to prison.

"Health plans should not have incentives to avoid the sick."

Few people familiar with the way Medicare functions believe it is efficient. To the contrary, almost everyone believes it is quite wasteful. That is one reason why Congress created the Medicare+Choice program and why other proposals would allow senior citizens to enroll in competing, private sector health plans.

In the eyes of some, the ideal model is the Federal Employees Health Benefit Plan (FEHBP). Under this arrangement, federal employees and their employer, the federal government, pay community-rated premiums to enroll in competing, private sector health plans. Although there is competition in this system, the competitors are not allowed to charge premiums that reflect an individual's expected health care costs. Because of the community-rating requirement, healthy people are overcharged and unhealthy people are undercharged relative to the costs they are likely to generate.

Observers of the FEHBP system have long known that health plans in the system have an incentive to avoid the sick and attract the healthy. But about a decade ago, researchers at the National Center for Policy Analysis discovered something more insidious. Under managed competition (as FEHBP-type insurance has come to be known), health plans have strong incentives to underprovide to the sick and overprovide to the healthy.[41] Risk-adjusted premiums that cause Medicare to pay more for sick enrollees and less for healthy ones can ameliorate this problem somewhat. However, mathematical modeling by Goodman, Pauly and Porter has shown that risk-adjustment cannot eliminate the problem and under some circumstances can make it worse.[42]

In designing a reformed Medicare, we must be careful not to repeat these mistakes. In particular, we need FEHBP-type competition in which the competitors have good incentives rather than bad ones. How can that be done?

Under the FEHBP system, federal employees join health plans for a period of 12 months; once a year, they reselect their health plan during an "open season." A better structure is to have long-term enrollment — lasting, say, three to five years. Under this arrangement, enrollees also would be able to have long-term relationships with physicians and health care facilities because they would have long-term relationships with the health plans that contract with those physicians and facilities.

"There should be a market for sick, high-cost patients — in which insurers actively compete to treat them."

During the contract period, enrollees could switch health plans at any time. However, a switch of plans would require consent of both the new and the old plans and would almost always necessitate a lump sum payment from one plan to the other. For example, if a sick and high-cost enrollee switched from Plan A to Plan B, A would have to compensate B for the extra expected costs B would subsequently incur over and above the annual premium B would receive on the patient's behalf. If a healthy and low-cost enrollee switched from Plan A to Plan B, B would have to compensate A for the difference between the premiums it was collecting and the health care costs it likely would have incurred.

Under this system, health plans could not dump their sick enrollees on other plans without compensating the other plans for their expected losses. Nor could health plans lure healthy enrollees from another plan without compensating the other plan for its lost profit.

In such a system, health plans would have an incentive to compete for the sick rather than to avoid them. Plans would also have an incentive to specialize in, e.g., cancer care or treatment of heart disease. Any plan that discovered ways to provide better care for less money would attract patients from other plans. And the other plans would gladly agree to the transfers because they could reduce their losses (by paying the new plan something less than what the patients would have cost if there were no transfers.)

In other words, an ideal Medicare system is one in which health plans have no incentive to overprovide or underprovide care and a continuous incentive to improve their quality and lower their costs.

Conclusion

In an election-year rush to satisfy impatient voters, politicians of both parties are endorsing ill-considered schemes to add a prescription drug benefit

to Medicare. While the problem is bad, most of the proposed cures are worse. They are a disservice to elders as well as taxpayers.

Medicare deserves thoughtful reform. Such reform can at the same time decrease senior exposure to catastrophic prescription drug costs, improve the quality of their health care and control taxpayer costs.

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] Federal Interagency Forum on Aging-Related Statistics, *Older Americans 2000: Key Indicators of Well-Being* (Washington, D.C.: U.S. Government Printing Office, August 2000), Table 30a, "Rate of Nursing Home Residence Among Persons Age 65 or Older, by Sex and Age Group, 1985, 1995, 1997, and 1999."

[2] Despite the rapid growth in the elderly population (from 26.9 million in 1982 to 35.3 million in 1999), the number of older Americans with chronic disabilities has remained relatively stable at around 7 million. See Kenneth G. Manton and XiLiang Gu, "Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population above Age 65 from 1982 to 1999," *Proceedings of the National Academy of Sciences of the United States of America,* Vol. 98, No. 11, May 22, 2001, pp. 6354-6359.

[3] The Pharmaceutical Research and Manufacturers of America, "New Medicines in Development for Older Americans," 2002 Survey.

[4] *Health Care Financing Review: Medicare and Medicaid Statistical Supplement*, *1999,* HCFA Pub. No. 03417, November 1999, U.S. Department of Health and Human Services, Figure 19, p. 37.

[5] Although almost two-thirds of seniors have some type of prescription drug coverage, many of these face coverage limits and significant out-of-pocket costs. See Mary A. Laschober et al., "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," *Health Affairs*, Web Exclusive, February 27, 2002. Figures vary; the Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, places the figure of those seniors without any drug coverage during the year at 25 percent. See "The Effects of Congressional Proposals on Prescription Drug Costs for Medicare Beneficiaries," Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, June 19, 2002.

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

[7] Part A requires an $812 deductible per hospital admission, except no deductible is required for subsequent admissions that occur within 60 days. There is a $203 copayment per day for days 61-90 and a $406 copayment for days 91-150, at which point Medicare coverage ends and the elder bears all further hospitalization costs. Part B requires a $100 deductible each year with 20 percent copayment for most services. Mental health services are subject to a 50 percent copayment. See "Medicare & You 2002," Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Pub. No. CMS-10050, rev. January 2002. For more information on Medicare cost sharing, see William J. Scanlon, "Medicare: Cost-sharing Policies Problematic for Beneficiaries and Program," General Accounting Office, GAO-01-713T, May 9, 2001, Table 1, "Medicare Coverage and Beneficiary Cost-Sharing for 2001."

[8] Margaret Davis et al., "Prescription Drug Coverage, Utilization, and Spending among Medicare Beneficiaries," *Health Affairs*, Vol. 18, No. 1, January/February 1999, pp. 231-43; also see John A. Poisal and George S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs*, Vol. 19, No. 2, March/April 2000, pp. 248-56.

[9] John C. Goodman and Merrill Matthews Jr., "Simple Solutions for Elderly Prescription Drugs," NCPA Brief Analysis No. 300, July 26, 1999, National Center for Policy Analysis.

[10] On the specific legislative changes that are needed, see John C. Goodman, "Prescription Drugs for Seniors: The Roth IRA Solution," NCPA Brief Analysis No. 315, March 16, 2000, National Center for Policy Analysis.

[11] Thirty states have passed high-risk-pool legislation, with varying benefits and conditions. See Bruce Abbe, ed., "Comprehensive Health Insurance for High-Risk Individuals — A State-by-State Analysis," 16th ed., 2002, Communicating for Agriculture and the Self-Employed.

[12] Richard Cauchi, "State Pharmaceutical Assistance Programs," National Conference of State Legislatures, September 13, 2002.

[13] By February 2001, states had accumulated $7 billion in unspent federal antipoverty TANF funds. See Office of Sen. Paul Wellstone, "Wellstone to Minnesota State Legislature: Do Not Misuse Federal Antipoverty Funds," Press Release, March 22, 2000. Many states are taking advantage of their flexibility with regard to TANF funds to engage in "supplantation." That is, they are using TANF funds to supplant state funds in programs not targeted to low-income groups. See the report, "States Behaving Badly: America's 10 Worst Welfare States," National Campaign for Jobs and Income Support, February 22, 2002.

[14] Lichtenberg, "The Effect of Pharmaceutical Utilization and Innovation on Hospitalization and Mortality."

[15] Robert Goldberg, "Ten Myths about the Market for Prescription Drugs," NCPA Policy Report No. 230, October 1999, National Center for Policy Analysis.

[16] Robert Goldberg, "Comparing Prescription Drug Proposals: Bush v. Gore," NCPA Policy Report No. 239, November 2000, National Center for Policy Analysis.

[17] See, for example, Grace-Marie Turner and Joseph Antos, "Prescription Drug Security Plan," July 29, 2002, Galen Institute.

[18] Most studies have found that the increased spending is due to perverse insurance incentives and not to worsening health among seniors. For a discussion, see Susan L. Ettner, "Adverse Selection and the Purchase of Medigap Insurance by the Elderly," *Journal of Health Economics*, Vol. 16, No. 5, October 1, 1997, pp. 543-62; and Michael D. Hurd and Kathleen McGarry, "Medical Insurance and the Use of Health Care Services by the Elderly," *Journal of Health Economics,* Vol. 16, No. 2, April 1997, pp. 129-54. Also see Sandra Christensen and Judy Shinogle, "Effects of Supplemental Coverage on Use of Service by Medicare Enrollees," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, U.S. Department of Health and Human Services.

[19] These proposals would shift costs for seniors' prescription drug purchases, mainly from seniors to taxpayers. Currently, enrollees pay 41 percent of the costs from their own pockets, with Medicaid, Medicare, and employer-sponsored and privately purchased insurance picking up the rest. With a new prescription drug plan available, some private plans likely would drop out of the market, and Medicare would pick up some costs now borne by Medicaid.

[20] Andrew J. Rettenmaier, "How Big Is the Government's Debt?" NCPA Brief Analysis No. 402, June 21, 2002, National Center for Policy Analysis.

[21] The material that follows is taken largely from John C. Goodman, "Prescription Drugs for Seniors," NCPA Brief Analysis No. 406, July 23, 2002, National Center for Policy Analysis. Calculations were made by Andrew J. Rettenmaier, Private Enterprise Research Center, Texas A&M University.

[22] House Ways and Means Committee, "Comparison on Key Components of Leading Prescription Drug Bills," August 7, 2002. Accessed September 30, 2002, at http://waysandmeans.house.gov/fullcomm/107cong/medreskit/side-by-side.pdf

[23] Mark E. Litow, "Defined Contributions as an Option in Medicare," NCPA Policy Report No. 231, February 2000, National Center for Policy Analysis. This report is summarized in John C. Goodman and Sean R. Tuffnell, "Prescription Drugs and Medicare Reform," NCPA Brief Analysis No. 314, March 16, 2000, National Center for Policy Analysis.

[24] See "Mass Exodus of Medicare+Choice Plans Projected for 2002," *Healthcare Financial Management*, November 2001; Jeanne Schulte Scott, "Medicare+Choice: Facing an Uncertain Future," *Healthcare Financial Management*, July 1, 2001; and Marilyn Moon, "Medicare," *New England Journal of Medicine*, Vol. 344, No. 12, March 22, 2001, pp. 928-31.

[25] Robert Pear, "H.M.O.'s for 200,000 Pulling Out of Medicare," *New York Times*, September 10, 2002.

[26] Almost 70 percent of Medicare HMO enrollees have annual incomes of $25,000 or less. Less than 5 percent earn more than $50,000 annually. See "Medicare and Health Care Chartbook," Committee on Ways and Means, U.S. House of Representatives, May 17, 1999, Table 4.17, "Age, Income and Health Status of Medicare HMO and FFS Enrollees," p. 196.

[27] John Hoff, "On Reforming Medicare," NCPA Policy Backgrounder No. 151, February 4, 2000, National Center for Policy Analysis.

[28] J. D. Kleinke, "Just What the HMO Ordered: The Paradox of Increasing Drug Costs." *Health Affairs*, Vol. 19, No. 2, March/April 2000, pp. 78-91.

[29] Shaun Matisonn, "Medical Savings Accounts in South Africa," NCPA Policy Report No. 234, June 2000, National Center for Policy Analysis.

[30] Greg Scandlen, "MSAs Can Be a Windfall for All," NCPA Policy Backgrounder No. 157, November 2, 2001, National Center for Policy Analysis.

[33] Kathleen Jaeger, "Drug Pricing & Consumer Costs," Presentation to the United States Senate Commerce Committee, April 23, 2002.

[34] 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.

[35] The material in this section and in the following section is taken largely from Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," NCPA Policy Report No. 254, August 2002, National Center for Policy Analysis.

[36] Matisonn, "Medical Savings Accounts and Prescription Drugs."

[37] John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," NCPA Policy Report No. 128, December 1991, National Center for Policy Analysis.

[38] Research suggests that 10 percent of the population consumes 72 percent of health care expenditures and 2 percent consumes 41 percent. See Donald W. Light, "Sociological Perspectives on Competition in Health Care," *Journal of Health Politics, Policy and Law*, October 2000.

[39] Dan Crippen, "Disease Management in Medicare: Data Analysis and Benefit Design Issues," Testimony before the Special Committee on Aging, United States Senate, September 19, 2002, Congressional Budget Office.

[40] Goodman and Musgrave, "Twenty Myths about National Health Insurance."

[41] John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," NCPA Policy Report No. 183, April 19, 1994, National Center for Policy Analysis.

[42] John C. Goodman, Mark Pauly and Phil K. Porter, "The Economics of Managed Competition," unpublished. Available from the National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243.

About the Authors

John C. Goodman is President of the National Center for Policy Analysis. Dr. Goodman earned his Ph.D. in economics at Columbia University and has engaged in teaching and research at six colleges and universities, including Columbia University, Stanford University, Dartmouth College, Sarah Lawrence College and Southern Methodist University. Dr. Goodman has written widely on health care, Social Security, privatization, the welfare state and other public policy issues. He is the author of seven books and numerous scholarly articles. Dr. Goodman's published works include *National Health Care in Great Britain, Regulation of Medical Care: Is the Price Too High?, Economics of Public Policy, Social Security in the United Kingdom* and, with Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis.*

Robert Goldberg is a Senior Fellow at the Manhattan Institute, researching, and writing and lecturing on health care issues. His research interests include examining the impact of price controls on biopharmaceutical innovation, Food and Drug Administration control of medical information, and the impact that government regulation of medicine has had on health care quality.

Through his writing, conferences and lectures, he has contributed to the legislative effort to reform the Food and Drug Administration. He was also instrumental in forcing reevaluations of several Clinton administration programs and proposals: the Vaccines for Children Program; the State Children's Health Insurance Program; an Environmental Protection Agency proposal to ban asthma inhalers with CFC propellants used by millions of poor children in America; and plans to have Medicare take over prescription drug coverage for seniors. His current work examines the impact of medical progress on human well-being and the use of market forces to sustain and spread medical progress in the United States and around the world.

Goldberg is the author of numerous articles and reports. He has testified before the Senate Special Committee on Aging, the Senate Small Business Committee and the House Commerce Committee. He has written on health care and social policy for *Reader's Digest*, the *Wall Street Journal*, the *Washington Post*, the *Los Angeles Times*, *Policy Review* and *National Review,* and he writes regularly for the *Weekly Standard*.

Goldberg, who received his Ph.D. in Politics from Brandeis University in 1984, is also a Senior Fellow with the National Center for Policy Analysis.

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Scandlen is a nationally recognized expert on consumer driven health care, medical savings accounts, insurance regulation and reform, employee benefits and ERISA, Medicare reform, and the uninsured. He has testified on health policy issues before congressional health committees and appeared on the *NBC Nightly News*, the *O'Reilly Factor* on Fox News, CNN, PBS and C-SPAN.

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