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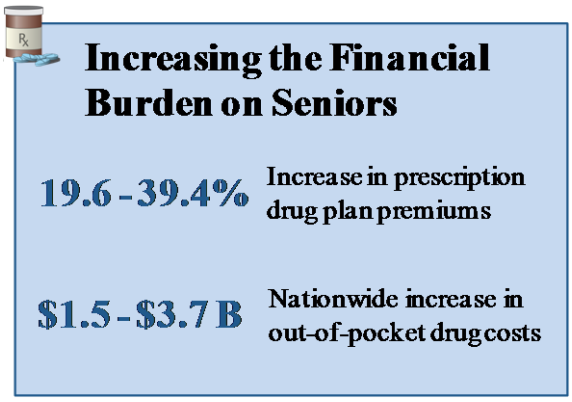
July 21, 2011

Cost Shifting Debt Reduction to America's Seniors

Medicare Part D Rebates Would Dramatically Increase Drug Premiums

*By Douglas Holtz-Eakin and Michael Ramlet**

The United States faces a daunting budgetary outlook. To avert an impending debt crisis, policymakers must tackle the unsustainble growth in entitlments in general, and Medicare spending in particular. Imposing mandatory prescription drug rebates in Medicare Part D has been proposed as a solution. In this report, beneficiary data is used to evaluate the impact of introducing Medicaid-style rebates into the Medicare Part D program. Despite any cosmetic appeal, such rebates would dramatically raise, not lower, the premiums paid by America's seniors and seriously undermine proven success in harnessing competition in entitlement programs.



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MEDICARE PART D: A DRAMATIC SUCCESS STORY

The Medicare Part D prescription drug program marked a significant change to Medicare. Part D created a competitive market for prescription drug plans, and has proven to be a dramatic success in controlling prescription drug costs. Actual Part D benefit costs have been in the vicinity of 40 percent below the Congressional Budget Office's initial ten-year estimate.[1] As a result, America's seniors have benefitted from lower prescription drug premiums.

The voluntary outpatient drug benefit is delivered through stand-alone prescription drug plans (PDPs) and drug plans sponsored by Medicare Advantage plans (MA-PDs) that compete head-to-head in each geographic region, without a government-prescribed benchmark or price-setting mechanism. Every Part D plan participates in the annual bidding process that determines the federal subsidy to enrollees, which averages 74.5 percent of the cost of a standard benefit.

Prior to the availability of Medicare Part D, beneficiaries eligible for both Medicare and Medicaid (commonly referred to as "dual eligibles") received hospital and physician services from Medicare while Medicaid covered their outpatient prescription drug costs. When the Medicare Part D program was implemented in 2006, however, Medicare became the source of prescription drug coverage for dually eligible beneficiaries.

Medicaid requires that pharmaceutical manufacturers pay a minimum federal rebate on prescription drugs purchased by Medicaid beneficiaries. The Part D program was designed to rely on private rebates

*Douglas Holtz-Eakin (dholtzeakin@americanactionforum.org) is President of the American Action Forum and Michael Ramlet (mramlet@americanactionforum.org) is Director of the Forum's Operation Healthcare Choice.

negotiated directly between prescription drug plans and manufacturers. Part D plans negotiate rebates for all enrolled beneficiaries, and the Medicare Trustees report that brand-name prescription drugs may carry rebates of 20 to 30 percent.[2] On average the rebates paid for medicines used by the dual eligible population are lower than the Medicaid statutory rebate, leading some policymakers to propose applying Medicaid-like rebate provisions to both the dual-eligible and low-income populations in the Medicare program.[3] However, a closer look reveals that only a subset of the Part D population and some, but not all, of the discounts provided in Part D yield distorted results.

The mandate to pay Medicaid statutory rebates is composed of several parts, including a minimum rebate equal to a percentage of the average manufacturer price (AMP), and an additional rebate if prices have increased more than inflation.[4] Additional requirements ensure that the final Medicaid price approximates the "best price" that a manufacturer is offering to *any* commercial payer. Congressional Budget Office (CBO) has estimated that as a result, "in 2003, the average rebate received by Medicaid for brand-name prescription drugs was 31.4 percent of the AMP."[5] Changes included in the Affordable Care Act increased the minimum rebate percentage from 15.1 to 23.1 percent of AMP. Taking these changes into account, together with data on pharmacy rebate collections reported by CMS in 2009[6], it is estimated that the average rebate for brand-name drugs in Medicaid is roughly 40.0 percent in 2011.

THE PROPOSAL: APPLY MEDICAID-LIKE REBATES TO MEDICARE PART D

The ongoing debt ceiling negotiations between President Obama and Congress have sought to identify potential budget solutions to address runaway entitlement spending. Among the many proposals is the idea of extending Medicaid drug rebates to dual eligibles, or also to those who qualify for a low-income subsidy (LIS) in the Medicare Part D program. Building on earlier proposals by U.S. Representative Henry Waxman to create a duals rebate, Rep. Waxman and Senator Jay Rockefeller recently introduced legislation, the Medicare Drug Savings Act of 2011. The Waxman-Rockefeller proposal goes beyond earlier proposals by extending it to low income beneficiaries as well and targets $120 billion in pharmaceutical rebates over the next decade.[7]

The introduction of Medicaid rebates into the Medicare Part D program has been portrayed as painless to America's seniors. According to Rep. Waxman, the Medicare Drug Savings Act of 2011 would "[eliminate] drug manufacturer windfalls instead of hurting seniors." While it is easy to understand the political appeal of the rebate proposal and claims of "windfall" based on a fragmentary view of how Part D works, the policy foundations deserve closer scrutiny. In the end, the cost of a new government rebate, like any tax[8], will not only be borne somewhere else in the economy, this analysis shows that seniors will be forced to pay much higher premiums for their prescription drug plans.

THE BILLION DOLLAR QUESTION: WHO PAYS FOR THE REBATES?

Healthcare Cost-Shifting

Even a cursory inspection reveals that the U.S. healthcare system is plagued by a tangled web of cost shifting and misaligned incentives. Adding additional rebates paid to the government on top those already paid to plans for those who qualify for a low-income subsidy (LIS) in the Medicare Part D program raises the potential that they will only worsen market conditions. As America's healthcare providers and private insurance companies can attest, the Medicaid system forces privately insured individuals to cross-subsidize the delivery of medical care. The dramatic difference between private insurance and Medicaid and Medicare reimbursements has created a tiered medical system with reduced access and lower quality care for government beneficiaries.

Reports by CBO[9] as well as other researchers[10] indicate that the Medicaid rebate program has already shown a similar track record of increasing prescription drug costs in private sector markets. A new federal rebate in Medicare Part D is likely to do the same, but because the Medicare program is much larger, the impact would be more significant. Such an impact would likely be felt in the employer-based insurance market, as well as in government programs including Part D. That is, to the extent that deeper discounts are paid to the government, a share of manufacturers' added costs for these discounts could ultimately be borne by consumers, either within Part D or in other markets.[11]

Rebates Help Keep Premiums Low

Since the inception of the Part D program, health plans have negotiated rebates with prescription drug manufacturers. The law requires that the value of these rebates be passed through to beneficiaries to reduce costs. The Trustees' annual reports show that rebates have risen each year as a share of total drug spending, an indication of the stiff competition among plans to get the best deals and maximize potential savings. [12]

In practice, most health plans have used their negotiated rebates to lower the beneficiary premium. Furthermore, because the beneficiary premium represents a modest share of the total drug costs covered by the plan, changes in the negotiated rebate level can drive surprisingly large changes in the premium. To illustrate with round numbers, imagine a plan in which the member drug cost is $300 per member, per month, and the plan bid is $120 (reinsurance and member cost sharing account for roughly 60 percent of the total plan drug spending). If negotiated rebates are $60 per member per month across all spending (generics do not pay rebates), the plan bid would be lowered from $120 to $60. But if rebates are reduced by 2 percent, or $6, so that they are now $54, the bid would $66. Because on average, Centers for Medicare and Medicaid Services (CMS) picks up 75 percent of the cost, the beneficiary premium would increase from $15.00 to $16.50, or 10 percent.

If the government imposes its own mandatory rebates and the market responds in ways that reduce privately negotiated rebates (as CBO has suggested it will), the impact could be significant. It is important to note that in addition to driving up premiums, the changed market incentives resulting from mandatory government rebates in Part D could also trigger other market responses. For example, as others have suggested,[13] this change could drive changes in plan availability and a reduced incentive for health plans to enroll low income beneficiaries. In addition, it could result in tightened plan formularies and fewer plans with enhanced benefits (such as a reduced deductible). These market reactions are more difficult to quantify than the clear potential impact on premiums.

Modeling the Premium Impacts

To quantify the potential financial impact of a new mandatory federal rebate on Part D premiums, we utilized an independent Medicare actuary to develop scenarios illustrative of the impact of introducing rebates.[14] For illustrative purposes, we assume conservatively that privately negotiated rebates for drugs used by the non-LIS population in Part D are reduced by 50 percent of the expected value of the rebate dollars that would be paid to the federal government under the new policy. Put another way, this scenario assumes that 50 percent of the value of the additional government rebate is either absorbed by pharmaceutical companies (for example, in reduced investments in research) or leads to changes in prescription drug spending outside of Part D.

To simplify the analysis, we first calculate the value of the rebates that manufacturers would be required to pay directly to the Treasury for all drugs sold to dual eligible and LIS beneficiaries if the policy were applied in contract year 2012. The federal rebate was calculated as the difference between the average rebates manufacturers are currently paying to private Part D drug plans (per CBO[15]) and the current Medicaid rebate. Then, we estimate the National Average Bid (or "benchmark") so that the member premium could be calculated for the LIS and non-LIS populations.

The impact of a change in premiums will be felt most directly by beneficiaries that do not receive a low income subsidy, as these beneficiaries pay the full premium themselves. To understand the impact for this group, we calculated the premium in two ways, representing a low and high impact. First, we calculated the premium as if the market were to respond to the new rebate paid by the government by uniformly reducing a portion of rebates across all Part D plans, regardless of a plan's mix of low income and other beneficiaries. To do this, we calculated the premium with the assumption that privately negotiated rebates are reduced by 50 percent of the value of the new federal rebate. In this approach, a portion of the cost of the new federal rebate becomes higher government costs in Part D, and a portion is borne by non-subsidy beneficiaries, who pay higher premiums out-of-pocket.

This calculation represents a lower bound estimate of the premium increase (again, assuming 50 percent of the policy's "impact" is felt in Part D) because in effect it assumes that every plan has the same mix of subsidy and non-subsidy beneficiaries. However, currently that is the not the case. CMS reports that 88 percent of beneficiaries enrolled in enhanced benefit plans (for example, plans which eliminate the deductible, or offer more generous coverage) are non-subsidy beneficiaries. The reason for this is that the low income subsidy is tied to the basic benefit, and many beneficiaries not receiving a subsidy opt to "buy up" to more generous coverage. This "low impact" calculation effectively assumes that the impact of the new policy does not drive further segmentation of the market and differentiation among plans serving these two populations, and actually reduces the differentiation that currently exists.

Alternatively, we calculate a high impact scenario in which existing differences among Part D plans are magnified by the policy. To do this, we calculated the premium as if a plan were composed only of non-subsidy beneficiaries, and again, reduced the rebates by 50 percent of the value of the new federal rebate. This represents a more realistic representation of market impact should the policy drive further differentiation in the market in response to the policy, which applies differently to the subsidy and non-subsidy populations. If 50 percent of the cost of the policy is borne in Part D, this represents an upper bound estimate of the policy's impact for this group. Of course, if a higher share of the policy's cost is ultimately felt in Part D, the impact on premiums could be higher.

The Part D population assumptions in this analysis are based on estimates from CBO and the Medicare Trustees.[16] According to the Medicare Trustees, 10.6 million LIS beneficiaries are currently enrolled in Part D, which includes 6.4 million dual eligible beneficiaries.[17,18] CBO estimates that "LIS beneficiaries account for about 40 percent of Part D enrollees."[19] Thus, it is assumed that the LIS population is estimated to account for about 40 percent of Part D enrollees. (Further information about the detailed assumptions underlying the models is provided in a supplemental technical paper.[20])

RESULTS: MEDICAID STYLE DRUG REBATES IN PART D INCREASE PREMIUMS

We present the key results of our analysis in Figures 1 and 2. As shown in the first line of Figure 1, if premium pressures are applied evenly across the Medicare population then we estimate that a new federal rebate in Medicare Part D would drive up premiums up by 19.6 percent. Alternatively, if it were possible to entirely focus the upward pressure among the non-LIS beneficiaries we estimate that the impact would be a rise of 39.4 percent. Clearly the actual impact would likely lie between the boundaries.

Figure 1: Annual Increase in Prescription Drug Premiums for Seniors

	%
If Applied to All Seniors	↑ 19.6 %
If Applied Only to Seniors Above Low Income Status	↑ 39.4 %

Higher costs in Part D are far from a theoretical matter. We estimate that nationwide the higher costs would translate into a $1.5 to $3.7 billion increase in out-of-pocket drug costs for America's seniors, depending on the actual rise in premiums (Figure 2).

Figure 2: Nationwide Increase in Out-of Pocket Drug Costs for Seniors

	$
If Applied to All Seniors	$1.5 B
If Applied Only to Seniors Above Low Income Status	$3.7 B

CONCLUSION: REBATES ARE NOT A REAL SOLUTION

Proposals to impose a Medicaid-style rebate in the Medicare Part D program may be popular with some public officials, but would likely raise monthly premiums for seniors by between 20 to 40 percent. To date, the Medicare Part D program has been successful because it has harnessed competition for the benefit of Medicare beneficiaries. Imposing a Medicaid-style approach to Medicare Part D would put the popular program at risk. While Congress and the Administration look at ways to reduce the budget deficit, this proposal would ultimately do so at the expense of senior citizens.

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References

[1] In the interest of full disclosure, Douglas Holtz-Eakin had a significant role in developing those initial estimates while serving as the Director of the Congressional Budget Office.

[2] 2011 Medicare Trustees Report, p. 183. Part D plans negotiate rebates based on drug sales to all of their members, not just dual eligibles. Thus, the negotiated rebates include rebates on drugs sold to individuals who previously had no prescription drug insurance and no purchaser negotiating rebates on their behalf, and indivudals who previously had public or private prescription drug insurance.

[3] Report of the House of Representatives Committee on Oversight and Government Reform, July 2008.

[4] Congressional Budget Office, The Rebate Medicaid Receives on Brand-Name Prescription Drugs, Letter to the Hon. Charles M. Grassley, June 2005

[5] Op cit, page 5.

[6] 2009 CMS-64 Medicaid expenditure reports

[7] Rep. H. Waxman and S. Levin, Dear Colleague letter in connection with H.R. 2190

[8] Joe Antos, "When Is a Rebate Not a Rebate?" July 8, 2011

[9] Op cit, pages 7-8

[10] Testimony of Fiona Scott Morton, Yale University before the House Oversight and Government Reform Committee, July 24, 2008.

[11] Because dual-eliglble and LIS beneficiaries generally do not pay a premium and have significantly reduced cost sharing, we did not attempt to assess the financial impact of the policy on these beneficiaries.

[12] Medicare Trustees Report, 2007 through 2011.

[13] Joe Antos and Guy King, "Tampering with Part D Will Not Solve Our Debt Crisis," June 29, 2011
[14] A technical report of the Part D actuarial analysis is available upon request. Please email the American Action Forum's Michael Ramlet (mramlet@americanactionforum.org) or visit the American Action Forum website (www.americanactoinforum.org) to access the report.

[15] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options." March 2011.

[16] 2011 Medicare Trustees Report.

[17] 2011 Medicare Trustees Report.

[18] There were 5.7 million dual eligibles enrolled in Part D in 2006, the first year Medicare Part D was available and dual eligible beneficiaries were enrolled.

[19] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options." March 2011.

[20] A technical report of the Part D actuarial analysis is available upon request. Please email the American Action Forum's Michael Ramlet (mramlet@americanactionforum.org) or visit the American Action Forum website (www.americanactoinforum.org) to access the report.