CONSERVATIVE REFORM NETWORK
PRINCIPLED. PRACTICAL. SOLUTIONS.

THE MEDICARE PRESCRIPTION DRUG PROGRAM
A MODEL FOR BROADER HEALTH CARE REFORM
INTRODUCTION

In 2010, a jubilant President Obama signed the Affordable Care Act into law. Liberals had finally achieved their long-sought policy goal of a national health care system established and controlled by the federal government. Almost six years later, the American people have registered their verdict: polling consistently demonstrates that more people disapprove of the law than approve – by 8 points according to an average of recent public polls. Yet, when asked whom they think would do a better job handling the issue of health care, Americans say they trust Democrats over Republicans by an average of eight points.

What is going on here? Logically, one would think that we tried it the liberals’ way and the American people didn’t like it; so shouldn't they turn to conservatives for a better alternative? The problem is that, while conservatives have succeeded in pointing out Obamacare’s many problems, we have failed to convince the American people that we can be trusted to enact better reforms. This is a particularly disturbing failure when you consider that the last major health care reform enacted prior to Obamacare was pushed by conservatives, is overwhelmingly popular, has made medical treatment accessible for millions, and has come in under budget.

ABSTRACT

In 2003, conservatives, utilizing principles of competition and choice, created a prescription drug benefit program that has simultaneously given millions of seniors access to life-prolonging medicines, controlled costs, come in under budget, and proven wildly popular. These same principles can be applied to reforming the overall health insurance system and replacing Obamacare. A wider understanding of how Part D functions and what it has achieved, can help conservatives advance the cause of market-oriented health care reform.
As the debate over replacing Obamacare heats up, policymakers would be well served by understanding why the Medicare prescription drug program has worked so well and how that success can be replicated for the larger health care system.

**THE MEDICARE PRESCRIPTION DRUG PROGRAM**

Enacted in 2003, the Medicare Modernization Act (MMA) created a new prescription drug benefit under Medicare. For the first time, seniors had an option of getting prescription drug coverage, either as part of a comprehensive Medicare Advantage Plan or through the new Part D program which supports both stand-alone prescription drug plans and employer-only group plans.

The current Part D prescription drug program is built around a model of competition and choice. Under the system, each year private plan providers submit competitive bids to the Centers for Medicare and Medicaid Services (CMS) to provide a basic prescription drug benefit. The government then calculates its share of the subsidy based on the average of the bids submitted. Beneficiaries then choose among the competing plans in their area. If a plan submitted a bid that was above the average, then the beneficiary will have to pay the higher cost if they choose to stay with that plan rather than pick an alternative plan. Because beneficiaries can change plans once a year, providers have a strong incentive to keep plan prices low to attract more customers. But price is not the only consideration for many beneficiaries; plans also compete for customers by offering different benefit designs and some beneficiaries may choose to pay a higher premium for enhanced benefits.

**SUCCESS OF THE MEDICARE PART D PROGRAM**

**Coverage:** In 2015, more than 39 million Medicare beneficiaries were enrolled in a Medicare prescription drug plan, including employer-only group plans. Of this total, 61 percent are enrolled in a stand-alone prescription drug plan. Prior to the creation of Part D in 2003, more than 25 percent of seniors had no prescription drug coverage.³

**Access and Choice:** In 2016, beneficiaries will continue to have a choice among multiple prescription drug plans. The number of competing plans will range from 19 in Alaska to 29 in Pennsylvania and West Virginia. These plans compete for business on cost and by offering
different cost-sharing structures, drug formularies, and utilization management tools. In this way, beneficiaries are able to choose a plan that best fits their needs.

**Affordability:** In 2016, the average base beneficiary premium will be $32.50 per month. Thanks to the downward pressure on price created by competition, for the past five years (2011 to 2015) the average premium has remained steady at between $30 and $32 a month. While not entirely comparable, for reference, during this same period, total premiums for employer-sponsored health insurance for a single beneficiary increased by 15 percent ($5,429 a year to $6,251). Worker contributions for the same coverage increased by 16 percent ($921 a year to $1,071) over the same period.

Not only has the prescription drug program contained costs relative to other insurance programs, but also the per-beneficiary costs are far below what was initially predicted when the program was created. In 2004, it was estimated that by 2013 monthly premiums prescription drug coverage would average $61 per month; instead, premiums were half that amount.

**Support for Low-Income Beneficiaries:** Approximately 12 million low-income beneficiaries, who otherwise could not afford prescription drug coverage, receive subsidies.

**Satisfaction:** A 2014 survey conducted for the Conservative Reform Network of likely voters age 65 and older found that 49 percent of respondents with a Medicare prescription drug plan were very satisfied and 39 percent were somewhat satisfied; only 12 percent expressed any dissatisfaction.
**Taxpayer Costs:** A decade after it was enacted, Part D is one of those rare government programs that comes in under budget – in this case, substantially under budget, with costs about 50 percent lower than originally estimated by the Congressional Budget Office (CBO). While lower overall drug spending, driven in part by increased utilization of generics, and differences between expected and actual enrollment account for much of the difference, the program has also worked as intended with competition keeping costs lower. A 2014 CBO study found not only that competition resulted in lower premiums for seniors, but also that additional competition from even one new nationwide plan saved the government between $7 and $17 million a year.

As the nearby chart demonstrates, while the CBO frequently reduced its estimates of projected future costs, the Part D program still came in under budget in 2014.

![Net Part D Spending Estimates Vs Actual for 2014](chart)

**COMPETING MODELS**

Despite the success of the Part D prescription drug program, at the time of its creation some policymakers wanted a very different model. For example, Democratic Leader Nancy Pelosi argued for a system where the government itself would negotiate prices for prescription drugs. In fact, some continue to advocate for a different model. Today, Hillary Clinton is campaigning on her plan to undo the current prescription drug program and instead have the government negotiate prices. Proponents of this approach suggest that the federal government could use its position as the negotiator on behalf of millions of seniors to force a reduction in prices. They often point to Medicaid as a model they would like Medicare to emulate.
If the government replaced the current Part D system of private sector competition and negotiation with a Medicaid-style government-negotiated rebate model, it could have a negligible impact on short-term prices. But at what cost?

Under a government-negotiated rebate model:

- Beneficiaries would likely have fewer choices among plans and less ability to select a plan that best meets their needs.

- As the CBO has noted, “the decline in the expected return from drug development, greater uncertainty about those returns, and the higher cost of funding such development would reduce the creation of new drugs...”¹² In particular, a reduction in the development of new drugs that target ailments impacting seniors is likely – in short, fewer cures.

- Drug companies likely will raise initial prices for their new drugs. In addition to raising the costs of new drugs for everyone outside of the Medicare prescription drug program, over time it is estimated that these higher initial prices would wipe out most of the savings to the government.¹³

In summary, government-negotiated prices lead to fewer choices for seniors, fewer life-saving and life-improving drugs, and no savings over time.

**KEY ELEMENTS OF THE PRESCRIPTION DRUG PROGRAM**

As noted above, policymakers designed the Medicare prescription drug program to use competition and choice to both lower costs and provide better benefits. The key elements of the Part D program include:

**Competitive Bidding to Determine a Fixed Subsidy Amount:** Each year insurers to bid on the price for offering a standard prescription drug benefit. In 2016, the standard benefit consists of a plan with a $360 deductible, 25 percent coinsurance up to $3,310, with a catastrophic out-of-pocket threshold kicking in at $4,850. The government then pays a set subsidy equal to 74.5 percent of the national average bid, and beneficiaries pay the remainder in monthly premiums. Once a plan submits a bid, its bid is binding for the year. If an insurer’s bid is above the national average, its enrollees will pay the additional costs through higher premiums. This structure incentivizes insurers to keep costs low in order to attract customers. Seniors have shown they are
smart shoppers and will find the plans that suit them best, both in providing the medications they need and offering the lowest-priced plan. Indeed, while the government used a standard benefit for bidding purposes, very few seniors – 2 percent in 2014 – enroll in a standard benefit plan.\(^4\)

**Flexible Benefit Design and Choice:** While insurers bid on and the government subsidy is based on a standard benefit, insurers are free to offer both policies with actuarially-equivalent alternative structures and policies with enhanced benefits. For example, about one-third of plans in 2016 won’t include a deductible, and only about half will include the full $360 deductible. Most plans will replace the 25 percent coinsurance in the standard plan with tiered copayments.\(^5\)

While beneficiaries can choose to pay more for an enhanced benefit plan, the government subsidy remains the same.

**Private Rather than Government Negotiation:** To keep costs under control, insurance plans negotiate with drug companies for discounts on the drugs their enrollees use. These negotiations have been demonstrated to result in significant cost savings.\(^6\) The fact that multiple plans, which have to compete with each other for customers, are the ones negotiating discounts with drug companies ensures that such negotiations do not result in a loss of access to treatments for patients. In other words, insurers have an incentive to get the best price, but they do not have the ability or incentive to force prices so low that they result in a lack of access or a reduction in the development of new drugs, as the government could with its monopoly buying power.

**Targeted Government Support:** While the Medicare prescription drug program is designed to cover the bulk of the cost of the program, for many low-income seniors the monthly premium – estimated at 25.5 percent of the cost of a standard benefit – is still beyond their means. For beneficiaries with income up to 150 percent of the federal poverty level, the government provides an additional low-income subsidy (LIS). The subsidy covers some or all of their monthly premium as well as out-of-pocket expenses, i.e. the deductible and copayments.

It is important to note that rather than creating a separate program for low-income beneficiaries which, like the Medicaid program, relies on government cost controls, the Medicare prescription drug plan offers the same program to seniors of all incomes. The program utilizes competition to keep costs low for all seniors and then utilizes targeted subsidies to help low-income beneficiaries.

In contrast, the Obama administration has proposed amending the LIS portion of Part D to double the required copayments for brand-name drugs and to impose Medicaid-style rebates, i.e. government-negotiated prices, for drugs LIS beneficiaries use.\(^7\) These changes would create a sub-standard prescription drug program, including fewer choices and reduced access to treatments, for low-income beneficiaries. No wonder nearly 60 patient groups publicly voiced their strong opposition.\(^8\)
While the government pays for a large portion of the costs of the prescription drug program regardless of the beneficiaries’ income, the program includes a special premium surcharge for those with income above certain thresholds – $85,000 for an individual and $170,000 for a couple. The upper-income surcharge not only offsets a portion of the cost of the program, but also ensures that government assistance is targeted to those who need it most.

**REPLACING OBAMACARE**

While the Medicare prescription drug program provides a specific benefit to a discrete population, the basic program structure can be applied to the overall health insurance system. The following table highlights the key elements to creating a workable Obamacare replacement.

<table>
<thead>
<tr>
<th>Program Design Element</th>
<th>Application in Medicare Part D</th>
<th>Application in an Obamacare Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted Population</td>
<td>Seniors and disabled individuals enrolled in Medicare.</td>
<td>Individuals without access to employer-provided health insurance.</td>
</tr>
<tr>
<td>Targeted Assistance</td>
<td>Low-income beneficiaries receive an additional subsidy.</td>
<td>Subsidies should be targeted to those in need of assistance, e.g. through a refundable tax credit.</td>
</tr>
<tr>
<td>Competitive Bidding / Fixed Subsidy</td>
<td>A bidding process determines a fixed government subsidy.</td>
<td>There are multiple ways the government could create a maximum, fixed-amount subsidy, e.g. setting it based on the average cost of competing plans or linking it to the cost of a basic high-deductible insurance plan.</td>
</tr>
<tr>
<td>Flexible Benefit Design / Choice</td>
<td>Insurers design a variety of drug plans and compete on both cost and benefits to attract customers.</td>
<td>Insurers should be free to design a wide variety of health insurance plans and compete for customers on both costs and benefits without overbearing government mandates or regulations.</td>
</tr>
<tr>
<td>Private Sector Rather than Government Negotiation</td>
<td>Insurers negotiate with drug companies to help control costs.</td>
<td>Insurers negotiate with health care providers to help control costs.</td>
</tr>
</tbody>
</table>
CONCLUSION

The public is astonished when a government program works at all. It is unheard of for a new program to work better than its proponents promised. But that is the story of the Medicare Part D Prescription Drug Program. And it is a story that can and should be replicated by applying the same principles and structures to replace Obamacare.

ENDNOTES


13 Ibid.


