

NEW STRATEGIES CAN FINANCE AN AFFORDABLE AND COMPREHENSIVE MEDICARE DRUG BENEFIT

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The Medicare prescription drug debate in Congress has long been artificially boxed in by high drug prices. Congress therefore struggles to choose between a meager benefit for around \$400 billion in new federal costs and a broader plan that seems unaffordable to many. Both leave many patients with urgent needs unmet and would still risk explosive costs.

Yet new cost-cutting and financing methods can make a truly comprehensive Medicare prescription drug plan affordable for both patients and the federal treasury, while protecting drug makers' ability to finance research.

Covering *all* drugs, with modest co-payments of \$5 or \$10 per prescription, is possible, our analyses indicate, even while holding new federal costs around \$400 billion over a decade.

The estimates shown here, outlined last year in testimony to a Congressional veterans affairs subcommittee, reflect the cost of benefits for 2002-2011. Though a later start would mean some rise in the cost estimates, these figures reflect 10 full years of benefits—unlike the June House and Senate bills, where the \$400+ billion plans specify a slow start-up, so their ostensible 10-year budgets buy only 6-7 full years of Medicare coverage.

Pay for new volume at actual cost: With comprehensive drug coverage, Medicare patients could fill many prescriptions that they are currently unable to afford. Fortunately, manufacturing that added volume of pills would cost far less than today's high prices suggest. Instead of paying high list prices, we urge that Medicare cover drug makers' actual cost of manufacturing the increased volume of pills. We estimate that this measure would save over \$400 billion in 10 years. Drug manufacturers' actual added costs would be covered. They would earn no windfall profit on the new volume, but their profits would not fall below current levels either. Their ability to finance research would be unchanged.

Evidence on which drugs work: A related initiative would facilitate further savings. The federal government should launch a large-scale effort to develop and distribute reliable and comparative evidence on drug effectiveness, safety, and cost. This would encourage quick adoption of breakthrough drugs and discourage use of costly drugs that lack added benefits.

Slash marketing and advertising: With drug makers' profits protected, they would not need to waste a projected \$410 billion over a decade on marketing and advertising. Re-directing that money would help finance both the drug coverage and the new drug information initiative.

Low monthly cost – full protection: For the drug benefit, premiums would average about \$20 per month, on a sliding scale based on individuals' Social Security checks. Patients' only costs would be premiums and co-payments, and both would be scaled to income.

Freedom of choice: Patients would not be forced to choose among costly and inadequate benefit packages with varying restrictive formularies. Instead, they would pay little for one benefit package that provides comprehensive coverage and lets caregivers and patients (rather than insurers) decide what medications are appropriate. Especially until better comparative data are developed, winning lower prices from drug makers is a safer and more effective way to contain cost than is restricting use of drugs.

Pharmacies protected: On the pharmacy side, our cost estimates prepared last year include \$27 billion over the decade 2002-2011 for the added cost of dispensing the increased volume of medications. They also include \$5 billion in one-time expenses to increase pharmacy capacity to handle the higher volume.

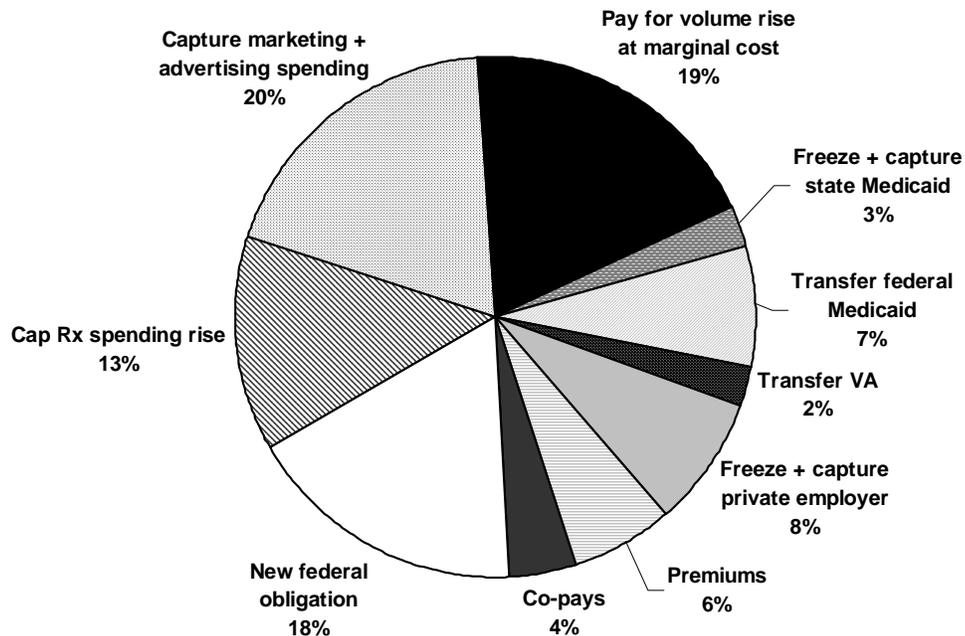
Maintenance of effort: Such a Medicare program's design must both cover newly-provided drugs and address costs of prescriptions that patients and private and public insurers now buy. An important financing strategy is maintenance of effort. Our proposal aims to *capture and pool some existing spending* for drugs for Medicare patients. This would freeze contributions of state Medicaid plans and private employer retiree plans at current levels, relieving them of future soaring costs while helping finance the new benefit. The program would also receive federal funds that would otherwise be financing drugs for those Medicare patients covered by Medicaid and the VA. Instead of leaving some seniors in Medicaid, as in the June Senate bill, pooling these funding streams permits giving the same comprehensive benefits to all at an affordable public cost.

Limit spending increases: To contain costs, the plan would allow for an 8.5 percent annual rise in Medicare prescription drug spending—before counting the cost of the increase in medication use when patients gain coverage. Such a limit is essential to make drugs affordable. It can be achieved while assuring access to all needed medications, while preserving manufacturers' returns on equity and funding for research.

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The authors' reports on drug cost and coverage problems, including the 22 July 2002 Congressional testimony on which this article is based, are available at www.healthreformprogram.org. Go to the US Health Reform page. For a related analysis, see Sager and Socolar, "Prescription Drug Peace Treaty," PPSI Newsletter, January 2002.

Financing Medicare's New Part Rx, 2002-2011



The above chart illustrates where funds would come from for Socolar and Sager's proposal for Medicare's prescription drug coverage over the first decade. They say: "Covering *all* drugs, with modest co-payments of \$5 of \$10 per prescription, is possible, our analysis indicates, even while holding new federal costs around \$400 billion over a decade."