The Savings from an Efficient Medicare Prescription Drug Plan

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Executive Summary

Congress passed the Medicare Modernization Act (MMA) in 2003 in response to the difficulty that many seniors faced in paying for prescription drugs.[1] However, it was not designed in a way to maximize efficiency. Instead, Congress deliberately designed the bill in way that would ensure that private insurance companies would provide the benefit instead of the Medicare administration or a single designated provider. This design both substantially increased the cost of drugs and administrative costs in addition to making the drug program much more complicated for beneficiaries.

This paper uses data from the Congressional Budget Office (CBO) and other sources to project the savings from a drug benefit program that is centrally administered as an add-on to the traditional Medicare program. These projections show that:

- In an alternative high-cost scenario, in which the Medicare system pays as much for drugs as the highest cost country examined by CBO, the savings on drug prices during the initial 2006-2013 budget period would be $332 billion compared with the cost of the MMA. In the case of a middle cost scenario, in which Medicare paid the same prices as the lowest cost country in the CBO analysis, the savings over this budget window would be $563 billion.

- CBO projected that the marketing and the profits of the insurance industry add $38 billion to the cost of the MMA over this seven-year budget window. If Congress had instead created an add-on benefit to the existing Medicare program, this money either could have been used to create a more generous benefit or to finance federal and state spending in other areas.

- The projected combined savings from lower drug costs and lower administrative fees are large enough in the middle-cost scenario to allow for the government to fully cover the projected cost of prescription drugs for Medicare beneficiaries over this budget window, and still leave a surplus of almost $40 billion compared with the projected spending under the MMA.

Alternatively, if beneficiaries only paid the premiums projected under the MMA (with no co-payments or deductibles) the savings in the middle cost scenario would be large enough to allow the states to keep the $88.5 billion they are required to pay under the maintenance of effort provisions of the MMA, and still save the federal government $80 billion compared to its projected spending on the MMA. In short, the savings from designing a more efficient drug benefit are large enough that they could provide for substantial gains to both the federal and state governments and Medicare beneficiaries compared to the projected costs under the MMA.

The paper notes that CBO has reported to Congress that it will not be possible to incur substantial savings from having Medicare negotiate prices directly with the pharmaceutical industry, because its projections already assume that the insurance companies involved in the MMA will secure substantial price reductions from the industry. The paper points out that this assertion is contradicted by CBO's analysis showing that foreign countries, as well as the Veterans Administration, pay substantially lower prices for drugs than the prices that CBO assumed the insurers would be paying under the MMA. CBO has provided no reason for believing that Medicare, given its enormous potential market power, would be unable to negotiate the same sort of discounts with drug manufacturers.

[1] The analysis in this paper is similar to the analysis in Sager, A. and D. Socolar, 2003. "61 Percent of Medicare's New Prescription Drug Subsidy is Windfall Profit to the Pharmaceutical Industry," Boston, MA: Boston University School of Public Health [http://dcc2.bumc.bu.edu/hs/Medicare_Rx_bill_windfallprofit.pdf].

The paper also notes that CBO has occasionally made serious projection errors in the past on important public policy questions. At the time that President Bush's tax cuts were being debated in 2001, CBO apparently failed to recognize the stock bubble and the inevitable crash. As a result of this failure, CBO made projections of capital gains tax revenue that overstated collections over the budget horizon by more than $450 billion, compared with actual history and the most recent projections.

Given an overstatement of revenue projections of this magnitude, Congress would have been better served if it had found alternatives to CBO's projections when it debated tax policy in 2001. Similarly, since CBO has no obvious justification for its assertion that Medicare could not negotiate prices as low as those in other countries, or those negotiated by the Veterans Administration, Congress would be better served by alternative projections of the potential savings from having Medicare negotiate drug prices directly with the pharmaceutical industry.

Introduction

When Congress passed a Medicare prescription drug benefit in 2003, minimizing costs for the government and beneficiaries was not the primary concern. Instead, Congress structured the bill so as to ensure a role for private insurers and even added in subsidies for this purpose.[2] It also prohibited direct negotiation between Medicare and the pharmaceutical industry, which would have led to lower prices as a result of Medicare's enormous bargaining power. As a result, the combined cost of the Medicare prescription drug benefit to beneficiaries and the government is substantially greater than necessary.

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In addition, the role of competing insurers can make the plan more complicated for beneficiaries. While some beneficiaries may welcome the opportunity to choose between different plans in the hopes of finding a better deal, many beneficiaries may find this process to be quite complicated. The relative advantages and disadvantages of various plans may be difficult to recognize, especially since the insurers can change their benefits after a plan has been selected. Furthermore, beneficiaries' needs for drugs may change as well, as their health condition changes over the course of a year. In this sense, the need to choose a plan can be an additional cost for beneficiaries that would not be necessary if Medicare simply offered a basic add-on plan.

While there were clearly political and ideological reasons for designing the Medicare drug benefit in its current form, it is important that the public have an accurate assessment of the potential savings from structuring the benefit in a more efficient way. These savings could be divided between lower costs to the federal government, reducing the cost to state governments, and providing a more generous benefit.

This paper projects the financial savings that would result from having a simple add-on drug benefit to the basic Medicare package. Using data from the Congressional Budget Office (CBO) and other sources, it projects separately the savings that could potentially result from having Medicare negotiate prices directly with drug companies and the savings from having a single designated administrator of the program, instead of insurance companies. It then compares the costs of a simple Medicare add-on with the cost of the Medicare Modernization Act.

[2] The Office of Management and Budget assumed that the subsidies associated with the "Medicare Advantage" program, which facilitates entry by private insurers into the Medicare program, would total $46 billion over the original 2004-2013 budget window. CBO projected that Medicare Advantage program would lead to $14 billion in public subsidies. The main reason for the difference is that CBO assumed lower enrollment rates in the Medicare Advantage program (CBO, 2004. "Comparison of CBO and Administration Estimates of the Effect of H.R. 1 on Direct Spending," Washington, D.C.: Congressional Budget Office [http://www.cbo.gov/showdoc.cfm?index=4995&sequence=0].

Savings From Having Medicare Negotiate Prices

The most obvious potential source of savings from designing a more efficient Medicare drug benefit would stem from having Medicare, or a designated pharmacy manager, negotiate prices directly with the pharmaceutical industry. Such negotiations should in principle allow for very substantial reductions in price, because the pharmaceutical industry sells prescription drugs for prices that are typically more than 200 percent above their cost of production. This means that if a large buyer, like Medicare, were to demand substantial discounts, then the industry could still make a profit on its sales, even if it charged much lower prices than it does at present.

In surveying the prices that various countries pay for drugs, CBO found costs ranged from 35 to 55 percent less than the prices paid in the United States.

This is clearly demonstrated by the fact that other buyers, most notably foreign governments and the Veterans Administration, are able to secure prices that are much lower than what consumers pay in the United States. The pharmaceutical industry must at least cover its production costs and make a normal profit on even the lowest price drug sales to other countries or agencies, otherwise it would not make them. Therefore, if Medicare were able to bargain for drug prices collectively on behalf of its beneficiaries, it should be able to secure a price that is at least as low as the lowest price currently accepted by the industry.[3]

In surveying the prices that various countries pay for drugs, CBO found costs ranged from 35 to 55 percent less than the prices paid in the United States (CBO, 2004a, p 4).[4] This is consistent with a wide range of other studies that have found prices paid by other countries, as well as the Veterans Administration and purchases through the Federal Supply Schedule, are far lower than average drug prices in the United States.[5]

This range of prices can be used to construct projections for the discounts that Medicare could receive if it negotiated as a single buyer with the pharmaceutical industry. This range is conservative, since Medicare would be a larger buyer than any of the other countries or agencies in this group, and therefore would have more bargaining power. As CBO noted in assessing the prospect of Medicare bargaining collectively on behalf of its beneficiaries

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[3] There is an important issue about whether the industry would still have enough money to finance research into the development of new drugs if its profit margins were substantially reduced in the United States. This is a very important question, but the question of how best to finance drug research is a different issue from asking how much money can be saved if a single Medicare selected agent was allowed to negotiate collectively on behalf of Medicare beneficiaries. It is worth noting here that there is considerable evidence that the current system of patent supported research is becoming increasingly inefficient through time (e.g. Dimasi J. R. Hansen, and H. Grabowski, 2003. "The Price of Innovation: New Estimates of Drug Development Costs." Journal of Health Economics, 22: 151-185.). Baker, 2006[forthcoming]. ("The Growing Inefficiency of Patent Monopolies as a Mechanism for Supporting Prescription Drug Research," Washington, D.C.: Center for Economic and Policy Research).

[4] CBO, 2004a, "Would Prescription Drug Importation Reduce U.S. Drug Spending?" Washington, D.C.: Congressional Budget Office [http://www.cbo.gov/ftpdocs/54xx/doc5406/04-29-PrescriptionDrugs.pdf].

[5] Similar analyses of relative prices in other countries can be found in U.S. Department of Commerce, International Trade Commission, 2004. "Pharmaceutical Price Controls in OECD Countries," Washington, D.C.: U.S. Department of Commerce [http://www.ita.doc.gov/td/health/DrugPricingStudy.pdf] and Australian Productivity Commission. 2001. *International Pharmaceutical Price Differences*, Australian Productivity Commission, Commonwealth of Australia, [http://www.pc.gov.au/research/commres/pbsprices/finalreport/pbsprices.pdf].

"exclusion from the Medicare market could threaten the profitability –and even the survival – of some drug manufacturers."[6]

In fact, the floor on the prices that Medicare could conceivably set would be even lower than the range of discounts currently being received by other countries or agencies. In principle, as long as drug companies can cover their production costs and earn a normal profit on their sales, they would profit by selling their drugs to Medicare rather than being excluded from this huge market. The price of generic drugs gives a reasonable basis for estimating the minimum price that would still be high enough for the industry to earn a profit, since obviously generic companies are able to produce and market their drugs at these prices and still earn a normal profit. According to the Commerce Department the average price of a generic prescription is approximately 30 percent of the price of an average brand drug prescription.[7] Assuming that the brand drug manufacturers are as efficient in producing and distributing their drugs as the generic manufacturers, then they should also be able to make a profit at this price.

The second key question is the rate of growth of drug prices. The CBO assumed that baseline per capita drug spending would rise at an average annual rate of 9.0 percent over the ten-year projection period.[8] If Medicare were to negotiate on behalf of its beneficiaries, it would be able to substantially reduce this growth rate. The bulk of this projected growth in average prescription prices is not attributable to higher production costs, but rather a growing gap between prices and production costs.[9] If Medicare acted as a collective buyer of drugs, it could negotiate prices that reflected actual production costs. For purposes of this analysis, it is assumed that the average prescription price negotiated by Medicare would rise in step with the overall rate of inflation. This means that real drug spending would increase only as a result of an increase in the number of prescriptions per person or an increase in the size of the Medicare population.

Table 1 shows the projected cost of drugs to the Medicare population, assuming that all drugs are purchased at a price negotiated by Medicare or another agent acting as a single buyer compared with the baseline projected by CBO in 2004.[10]

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[6] CBO, 2002. "Issues in Designing a Prescription Drug Benefit for Medicare," Washington, D.C.: Congressional Budget Office [http://www.cbo.gov/showdoc.cfm?index=3960&sequence=0]. The statement goes on to warn that exclusion of manufacturers from formularies "might be difficult to sustain politically."

[7] The average price for a prescription of a brand drug cost $95.86 in 2004, compared to a price of $28.71 for an average generic prescription (U.S. Commerce Department, Census Bureau, 2006, *Statistical Abstract of the United States*, Washington, D.C.: U.S. Department of Commerce, Table 126). Even this number is likely to be somewhat inflated, since it includes generic drugs that are sold during periods of "market exclusivity." This is the six-month period after the first generic drug equivalent to a brand drug enters the market. During this period, no other generics are allowed to enter the market, which means that the first generic will be able to set higher than normal prices since it must only compete with the brand version of the drug.

[8] CBO, 2004b, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit." Washington, D.C.: Congressional Budget Office [http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0], p 6.

[9] The industry has justified this growing gap by noting the rapid rise in its costs for developing new drugs.

[10] The numbers are adjusted to exclude drug spending that is covered through the Veterans Administration (VA) drug program. The CBO assumed that the VA would continue its current drug program and that Medicare beneficiaries who qualify for VA drug benefits would stay in the VA program. This accounted for 15.5 percent of baseline spending according to the CBO (CBO, 2004b, 6).

Table 1
Projected Spending on Drugs by Medicare Beneficiaries

	2006	2007	2008	2009	2010	2011	2012	2013	Total 2006-2013
Baseline	134	150	167	186	206	229	255	284	**1611**
Baseline minus Veterans Administration Drug Purchases	113	127	141	157	174	193	215	240	**1361**
High Cost	85	90	95	101	106	112	119	126	**834**
Middle Cost	61	65	69	73	77	81	86	91	**602**
Low Cost	42	45	48	51	53	56	60	63	**418**

Source: CBO and author's calculations, see appendix.

The table uses three alternative assumptions. In the high-cost case, it is assumed that the cost of drugs falls by 35 percent from the baseline path projected by the CBO in the absence of the MMA – effectively that Medicare negotiates prices that are comparable to those in the highest cost country evaluated by CBO. The mid-cost scenario assumed that Medicare or the buying agent negotiates a price that is 55 percent lower than the baseline cost projected by CBO. This is equivalent to assuming that Medicare negotiates prices that are comparable to the lowest prices in the countries examined by CBO. The low-cost scenario assumes that Medicare negotiates prices that are comparable to the prices that brand drugs would sell at if they were marketed as generics. In each case the growth path assumes that prices would rise by an amount equal to the projected growth rate of the Medicare population, plus CBO's projected inflation rate, plus 1.5 percent annually to allow for additional per person use of prescription drugs.

These projections are adjusted to reflect the fact that lower drug prices will lead to some increase in usage. The CBO projections assume that the lowered cost of drugs to beneficiaries under the MMA leads to a 10 percent increase in usage. The projection for the high-cost, middle-cost, and low-cost scenarios assume that lower drug prices will lead to a 15 percent, 20 percent, and 25 percent increases in drug usage, respectively.[11]

Table 2 shows the gross savings from this path compared to the spending path CBO projected for drugs under the MMA. In addition to being considerably larger than the 20-25 percent gross savings path projected by CBO from the 2003 Medicare Modernization Act (CBO 2004, pp 11-14), this projection also is constructed somewhat differently. The CBO projection includes savings that would result from insurers requiring beneficiaries to switch to lower cost drugs and also from restricting their use of drugs. While savings of this sort would

[11] These are very crude projections. Without a more precise design, it is not possible to determine how much the price reductions will be for different beneficiaries. Also, it is not clear how much can be said about the impact of very large changes in price on usage. Presumably, price ceases to be a major factor in determining the use for most drugs for many people, once it has already fallen to a low level.

still be possible even with a system where there was a single buyer, the potential gains from shifting to lower cost drugs would be considerably smaller if drug prices were pushed down closer to production costs. Similarly, there would be less cost savings associated with restricting beneficiaries' access to medically useful drugs. CBO does not break-down the extent to which these restrictions, as opposed to lower drug prices obtained by insurers, account for their projected savings, so it is not possible to directly determine how much of the reductions in drug costs attributable to the MMA are due to these forms of cost control.

Table 2
Gross Savings Under MMA and Alternative Scenarios

	2006	2007	2008	2009	2010	2011	2012	2013	Total 2006-2013
MMA	14	16	19	22	25	29	33	38	195
High Cost	29	37	46	56	68	81	97	114	527
Middle Cost	52	62	72	84	97	112	130	149	758
Low Cost	71	82	93	107	121	137	156	177	942

Source: CBO and author's calculations, see appendix.

Table 3 shows the savings that would result from having a single administrator of the drug program as opposed to having a group of private insurers, as provided for in the MMA. CBO directly estimated the costs attributable to having private insurers administer the program (2004, p 17). These are costs associated with marketing, member acquisition, and member retention in addition to the profit earned by the insurers. There may also be additional savings to providers from only having to deal with a single insurer for drug reimbursements, but such savings would be difficult to measure and are not included in this projection. CBO projected these administrative costs over the original 2006-2013 planning horizon to total approximately $38.0 billion. This is the amount that could be saved if Medicare used a single administrator for the prescription drug benefit.

Table 3
Savings on Administrative Costs

	2006	2007	2008	2009	2010	2011	2012	2013	Total 2006-2013
Savings on Administrative Costs	4.6	4.6	4.7	4.7	4.8	4.8	4.9	4.9	38

Source: CBO, see appendix.

Table 4 combines the savings shown in Tables 2 and 3 to show projections for the total potential savings from having the drug plan administered by a single administrator who would negotiate prices directly with the pharmaceutical industry.

Table 4
Total Savings Under Alternative Scenarios Relative to the MMA

	2006	2007	2008	2009	2010	2011	2012	2013	Total 2006-2013
High Cost	19	25	32	39	48	57	69	81	370
Middle Cost	42	50	58	67	77	89	102	116	601
Low Cost	61	70	79	89	101	113	128	144	785

Source: CBO and author's calculations, see appendix.

In the high-cost case, the total projected savings would be $370 billion over the original 2006-2013 period. In the middle-cost scenario the projected savings would be more than $600 billion, and in the low-cost case the projected savings would be $785 billion. It is important to realize that these are gross savings on purchases of drugs by the Medicare population compared with the program put in place by the Medicare Modernization Act; they are not savings to the federal government alone.

The Cost of an Efficient Medicare Drug Benefit

Savings of the magnitude projected above would have allowed for a qualitatively different benefit. The CBO projected that the MMA would cost just under $400 billion in the original 2004-2013 budget window. The savings from designing the benefit in a more efficient manner could have been divided between beneficiaries and state governments, which still must meet maintenance of efforts requirements that offset their savings on Medicaid expenditures, or allowed for a substantial reduction in the cost of the benefit to the federal government.

Table 5 shows total federal and state expenditures for prescription drugs over the years 2006-2013 with the passage of the MMA (CBO 2004, table 1). The combined levels of state and federal spending would be large enough to fully cover the costs of beneficiaries' drug spending in the middle-cost scenario. This means that if the federal and state government followed the spending path projected by CBO and the drug costs were in line with the projections in the middle scenario, then beneficiaries could have their drug expenditures fully paid by Medicare, with no insurance premiums, deductibles or co-payments.

Table 5
The Cost of An Efficient Medicare Drug Benefit
(billions of dollars)

	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**Total 2006 -2013**
Gross Federal Payments (includes previous Medicaid payments)	34.1	54.4	59.6	65.3	72.2	79.1	88	98.4	551.1
State Payments	5.7	9.1	10	10.8	11.7	12.6	13.7	14.9	88.5
Total Government Payments	**39.8**	**63.5**	**69.6**	**76.1**	**83.9**	**91.7**	**101.7**	**113.3**	**639.6**
Total Drug Costs									
High Cost	84.6	90.0	95.2	100.9	106.2	112.3	118.9	125.9	834.0
Middle Cost	61.1	65.0	68.8	72.9	76.7	81.1	85.9	91.0	602.5
Low Cost	42.4	45.2	47.8	50.6	53.3	56.3	59.6	63.2	418.4
Beneficiaries' Premiums	9.1	12.8	14.3	15.5	17	18.5	20.6	22.9	130.7

Source: CBO and author's calculations, see appendix.

Alternatively, it would be possible to design a benefit that would allow for substantial reductions in state payments, coupled with modest insurance premiums or co-payments. If costs followed the path described in the middle scenario, the premium schedule in the MMA would be sufficient to allow the states to cut their contribution in half, and still save the federal government more than $100 billion of its projected spending on the MMA over the ten-year horizon. This would reduce its net expenditure on the MMA by more than one-fourth.

In the low cost scenario there would be a surplus of more than $220 billion, which the government could devote to some other purpose. Even in the high cost scenario, the combination of government funding and insurance premiums would leave a relatively small gap to be picked up by either modest beneficiary co-payments (an average of approximately $5 per prescription should be sufficient to fill the gap) or small deductibles on drug expenses.

The CBO Estimates of Medicare Negotiated Prices

Douglas Holtz-Eakin, testifying in his capacity as head of the CBO, has stated that he believed that any savings from having Medicare negotiate prices directly with the pharmaceutical industry would be minimal.[12] He stated that the CBO projections already assumed that the private insurers in the plan had secured large price reductions, so that there would be little possible gain from having Medicare negotiate directly with its considerably larger market power.

…it is important to be clear if CBO believes that the obstacle impeding a low cost drug plan is the political power of the industry, rather than any inherent economic obstacles.

This claim from CBO seems directly at odds with evidence that it has produced, showing that other countries (as well as the Veterans Administration) pay far lower prices for prescription drugs than the discounts that it assumed that private insurers could secure. Also, as noted earlier, CBO recognized that Medicare could exert enough market power, when acting as a collective buyer on behalf of Medicare beneficiaries, that it could conceivably put a manufacturer out of business, if it excluded it from its formulary.

In making this statement, CBO did warn that political pressures may make it impossible for a single Medicare buyer to exert this much power. While the political power of the pharmaceutical industry is indeed an important factor counteracting efforts to restrict costs, it is important to be clear if CBO believes that the obstacle impeding a low cost drug plan is the political power of the industry, rather than any inherent economic obstacles.

While CBO does an outstanding job in presenting non-partisan analysis on important policy issues, it is worth noting that it has occasionally been wrong on major issues in the past. One important example is its projections for capital gains tax revenue at the time when Congress was debating President Bush's tax cuts in 2001. Table 6 shows the projections of capital gains revenue from the *Budget and Economic Outlook: Fiscal Years 2002-2011*, which CBO issued in January of 2001 compared with the projections and actual tax receipts reported in the *Budget and Economic Outlook: Fiscal Years 2006-2015*.

[12] CBO, 2004c. "Estimate of the Effect of Striking the "Noninterference" Provision as Added by P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," Washington, D.C. Congressional Budget Office, ["http://www.cbo.gov/showdoc.cfm?index=4986&sequence=0].

Table 6
CBO Projections of Capital Gains tax Revenue

(billions of current dollars)

	2001 projection	2005 projection	Difference
2001	$129	$100	$29
2002	125	58	67
2003	119	51	68
2004	114	48	66
2005	110	56	54
2006	107	60	47
2007	106	65	41
2008	106	89	17
2009	106	82	24
2010	108	84	24
2011	110	97	13
Total	**$1240**	**$790**	**$450**

Source: CBO and authors calculations, see appendix.

CBO projected a total of $1,240 billion in capital gains tax revenue for the years from 2001 to 2011. In its most recent projections (CBO 2005), CBO projects that total capital gains revenue over this period will be $790 billion, a difference of more than $450 billion. (If the impact of higher interest payments was included, this difference would rise to almost $600 billion over this 10-year budget window). If CBO had provided Congress with more accurate projections at the time, it is possible that Congress would have acted differently in voting on tax cuts that year.[13]

In the case of its projections on the potential savings from having a single buyer negotiate for Medicare, CBO cites no evidence to support its assertion that no substantial savings are possible.

It is worth noting this failure to accurately project capital gains tax revenue in order to keep CBO's projections on a Medicare drug benefit in perspective. CBO is a tremendously valuable resource in policy debates; however, it is fallible. In the case of its projections on the potential savings from having a single buyer negotiate for Medicare, CBO cites no evidence to support its assertion that no substantial savings are possible. To the contrary, its own research suggests that there is a potential for very large savings. In the absence of any evidence to support its assessment, CBO's judgment on this issue should not be accepted as the final word. Unless CBO can provide some reason as to why Medicare would not be able to accrue the same sort of savings as the Canadian government, the Australian government, or the Veterans Administration, those involved in the debate over designing a Medicare prescription drug benefit should turn to projections that are more firmly grounded in evidence.

[13] It was possible to recognize that the government was unlikely to see these tax revenues. The stock market was clearly experiencing a bubble, which was almost certain to deflate within the ten-year horizon (see Baker, D. 2002, "Letter to Dan Crippen," [http://www.cepr.net/letters/crippen_2002_02_26.htm] and Baker, D. 2000, "Double Bubble: The Implications of the Over-Valuation of the Stock Market and the Dollar," Washington, D.C.: Center for Economic and Policy Research [http://www.cepr.net/publications/double_bubble.pdf]).

Conclusion

The Medicare Modernization Act approved by Congress in 2003 was not designed to create the most efficient possible prescription drug insurance for Medicare beneficiaries. As a result, it costs the government and beneficiaries considerably more than is necessary. If Medicare were allowed to negotiate directly with the drug industry, or to allow a single agent to negotiate on its behalf, it could purchase drugs at prices that are far lower than CBO projected that private insurers would pay under the system put in place in the MMA. In addition, a single provider of prescription drug insurance would save tens of billions of dollars in administrative fees that result from having private insurers with marketing costs and profits.

An efficient Medicare drug benefit could allow for substantial savings for both the federal and state governments, in addition to lower cost insurance for beneficiaries.

An efficient Medicare drug benefit could allow for substantial savings for both the federal and state governments, in addition to lower cost insurance for beneficiaries. It could also allow for a much simpler benefit, since beneficiaries would not be forced to wade through details of various prescription drug plans in order to determine the best one. In this way, a more efficient Medicare drug benefit could allow for substantial gains all around.

Appendix

Table 1 -- The baseline projection for prescription drug spending is taken from CBO (2004b). It uses the projection that Medicare beneficiaries would spend $1.61 trillion on prescription drugs over the years 2006-2013, with $1.36 trillion spent by those not covered by the VHA (p. 5). The growth in per capita spending is assumed to be 9.0 percent annually, with the Medicare population growing at approximately 2 percent annually. The top row shows total drug spending, while the second role shows spending minus the costs covered by the VHA.

The lines for high cost, middle cost, and low cost project spending assume that drug prices are reduced by 35 percent, 55 percent, and 70 percent respectively, as discussed in the text. The numbers are adjusted in accordance with the assumption that these price reductions, respectively, lead to 15 percent, 20 percent, and 25 percent, increases in drug usage.

Table 2 – This table shows the difference between spending on drugs under the baseline scenario and the spending path projected for high cost, middle cost and low-cost scenarios shown in Table 1. The projected savings for the MMA are derived from the CBO assumptions shown in CBO (2004b) Table 3. This table shows gross savings rising from an average of just under 20 percent in 2006 to 25 percent in 2013. In addition, the table shows additional savings of between 1.6 percent and 2.5 percent due to the rule that discounts need not apply to Medicaid's Best-Price Provision. These savings are offset by projections of countervailing "price" and "use" effects, which increase spending on drugs. The projections incorporate these assumptions, interpolating the years between 2006 and 2013.

Table 3 – This table shows the amount of annual administrative expenses attributable to marketing and profits as described in CBO 2004b, p 17 and also in CBO (2004b) Table 3. This number is calculated by multiplying the assumed ratios for administrative expenses in CBO (2004b) Table 3 (10.7 percent in 2006 and 5.6 percent in 2013), interpolating the years in between.

Table 4 – This table sums the savings shown in Tables 2 and 3.

Table 5 – This table uses the projections for state payments and beneficiaries' premiums found in CBO (2004b) Table 1. The projection for "gross federal payments" combines net new spending on MMA with the prior federal drug spending commitments shown in CBO (2004b) Table 1. The projected payments for drugs are taken from Table 1 above.

Table 6 – This table shows projected capital gains tax revenue for the 2001-2011 budget horizon from the *Budget and Economic Outlook: 2002-2011*, Table 3-6 and from the *Budget and Economic Outlook: 2006-2015*, Table 4-3.