Bad Ideas

A series examining proposals that could move health care coverage in the wrong direction

Private Gain and Public Pain in Medicare

Health care costs are on the rise, and conservative lawmakers have proposed to bring them down by turning health care consumers into savvy buyers. They want Americans to have more "skin in the game," meaning that consumers must pay more out of their own pockets for their medical care. Theoretically, consumers will then shop around for the best bargains on health care services ranging from checkups to bypass surgery.

Ironically, the same conservatives who promote the notion of smart shopping when it comes to health care passed the Medicare Modernization Act (MMA). The MMA created the new Medicare Part D prescription drug program, and it prohibits Medicare from bargaining for the best prices on prescription drugs. What's more, it provides remarkably wasteful subsidies to private insurance plans. Against powerful evidence to the contrary, proponents of the MMA argued that strengthening the role of the private market in Medicare would reduce expenditures. However, the push to privatize Medicare has resulted in landmark profits for the drug and insurance industries—profits that come at a high cost to taxpayers and to the senior citizens and people with disabilities who depend on Medicare.

Medicare Part D— When Government Is Prohibited from Being a Smart Shopper

The legislation that created Part D strictly prohibits Medicare from playing any part in negotiating drug prices with pharmaceutical companies. Instead, it relies solely on the power of the private market to secure lower prices. This stands in stark contrast with other government agencies, such as the Department of Veterans Affairs (VA), which uses the leverage it derives from the millions of veterans it serves, to negotiate lower drug prices.

Families USA tracked the prices of the 20 drugs most frequently prescribed to seniors between November 2005 and April 2006. We compared the lowest price for these drugs available from any Part D plan to the lowest price secured by the VA.

- For all of the top 20 drugs prescribed to seniors, the lowest price charged by any Part D plan was higher than the lowest price secured by the VA.
- The median price difference between the lowest Part D plan price and the lowest VA price was 46 percent.
- The lowest Part D prices were up to 418 percent higher than the lowest VA prices.

- ### How Much Money Is Wasted?
  - According to Congressional Budget Office estimates from March 2005, the Medicare drug program will cost $593 billion from 2004 until 2013.[1]
  - If Medicare could negotiate drug prices, it is estimated that the federal government could save at least $370 billion between 2004 and 2013.[2]

- ### Who Pays?

  Taxpayers are picking up a hefty portion of the tab for the Part D program, as Medicare uses tax revenues to pay for roughly 75 percent of Part D. Higher prices also affect the seniors and people with disabilities covered under Part D, who must pay a considerable portion of their drug costs out of pocket. In addition, Part D is designed with a coverage gap known as the "doughnut hole" during which beneficiaries continue to pay monthly premiums but receive no prescription drug coverage.
  - Seniors whose total annual drug costs are between $1,000 and $3,000 are responsible for about 43 percent of their prescription drug costs.
  - Beneficiaries with greater drug needs, spending between $4,000 and $6,000 annually, for example, must pay about 65 percent of their drug costs.[3]

Medicare Advantage Managed Care Plans—Whose Advantage?

Since 1983, when private managed care plans were introduced, proponents have asserted that the plans would bring down Medicare costs and help beneficiaries by coordinating their care.[4] Despite promised savings, Medicare's privatized managed care program, dubbed Medicare Advantage by the MMA, has never provided a better bargain than traditional fee-for-service Medicare.

Medicare pays private insurance companies a flat amount for each beneficiary who joins their managed care plans. In theory, plans could develop cost-effective treatment strategies and coordinate care to reduce expenses. In reality, however, private plans reduce costs by recruiting the youngest and healthiest beneficiaries, a practice known as "cherry-picking." The result is extreme overpayments to the private managed care plans.

- A 1995 analysis by the U.S. General Accounting Office (GAO, now the Government Accountability Office) found that the payment system for these private plans was seriously flawed, with excess payments running into billions of dollars.[5]
- In 2003, the MMA increased payments to private managed care plans even further. A 2004 Medicare Payment Advisory Commission (MedPAC) analysis found that payments to managed care plans represented 107 percent of per capita costs for traditional Medicare—a 7 percent overpayment.[6] In 2006, MedPAC estimates that this overpayment to private plans has risen to 11 percent.[7]

- ### How Much Money Is Wasted?

  As managed care enrollment has expanded, so has the size of the subsidies going to private plans.

  - Enrollment in Medicare Advantage has grown by more than 1 million members in the past year, to 6.04 million as of June 2006. Based on MedPAC's estimates, Medicare is paying a at least $4.6 billion in excess funds to private Medicare Advantage companies in 2006.
  - A recent independent study estimates that overpayments to Medicare Advantage plans will cost more than $23.5 billion over the next five years (2007-2011).[8] Over the next 10 years, overpayments could easily total more than $50 billion.

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  Congress has given an artificial advantage to private Medicare Advantage plans, an advantage that is driving up Medicare costs. This added cost burdens taxpayers and leads to increased premiums for seniors and people with disabilities who need Medicare. In 2005 alone, taxpayers lost $2.7 billion in overpayments to private Medicare Advantage plans and their parent insurance companies.

Who Gains from These Changes?

Medicare Part D and Medicare Advantage are a financial burden for both consumers and taxpayers, so who truly benefits from these programs? Drug manufacturers and insurance companies have emerged as the undeniable winners.

Insurance companies that sell Medicare Advantage plans are substantially overpaid to market their plans and bring in beneficiaries. These plans typically restrict access to providers and services and therefore usually appeal to younger and healthier beneficiaries who use fewer medical services. Yet despite the fact that they serve healthier—and cheaper—enrollees, they have generally been paid as if they serve the same mix of older, sicker enrollees as traditional Medicare.

What's more, the three largest providers of Part D prescription drug and Medicare Advantage plans, United Health Care, Humana, and WellPoint, have all seen substantial growth in both revenues and earnings in the last year.

- United Health Care and Humana report that second quarter 2006 revenues are up by more than 50 percent compared to the same time last year, and WellPoint's revenues have increased by more than 25 percent.[9]
- These companies' profits have also increased substantially. WellPoint's profits are up by more than 33 percent, United Health Care's profits are up by more than 25 percent, and Humana's profits have grown by nearly 10 percent.[10]

Conclusion

Any smart shopper would look at the price tags attached to privatized Medicare programs and keep right on walking. However, proponents of privatization have seen to it that Medicare is not allowed to use its considerable leverage, forbidding it from negotiating to secure lower drug prices while overpaying private plans that fail to save money. The result is windfall profits for drug and insurance companies—and lighter wallets for American taxpayers, seniors, and people with disabilities.

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[1] Congressional Budget Office, *Comparison of CBO's March 2005 Medicare Prescription Drug Baseline and the CBO Estimate for the MMA* (Washington: Congressional Budget Office, March 2005), available online at http://www.cbo.gov/showdoc.cfm?index=6139&sequence=0.

[2] Dean Baker, *The Savings from an Efficient Medicare Prescription Drug Plan* (Washington: The Center for Economic and Policy Research, January 2006), p. 10.

[3] Marilyn Moon, *Medicare: A Policy Primer* (Washington: The Urban Institute Press, 2006), p. 90.

[4] Ibid, p. 68. A small number of managed care plans participate in Medicare on a cost basis rather than a risk basis. These cost plans are not discussed in this report.

[5] See, for example, U.S. General Accounting Office, *Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem* (Washington : U.S. General Accounting Office, November 1995); U.S. General Accounting Office, *Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (Washington: U.S. General Accounting Office, April 1997).

[6] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington: Medicare Payment Advisory Commission, March 2004), p. 211.

[7] Brian Biles, Lauren Hersch Nicholas, and Barbara S. Cooper, *The Costs of Privatization: Extra Payments to Medicare Advantage Plans – 2005 Update* (New York: The Commonwealth Fund, December 2004). Biles et al. base their estimate on a 7.8 percent overpayment rate.

[8] Brian Biles and Emily Adrion, *Payments to Medicare Advantage Plans Exceed Fee-for-Service Costs: Options for Medicare Savings from 2007 to 2011* (Washington: George Washington University School of Public Health & Health Services, September 15, 2006), available online at http://www.gwumc.edu/sphhs/healthpolicy/chsrp/downloads/Extra_Payments_2007-11_GW_Briefing_Paper_FINAL_9-15-06.pdf.

[9] UnitedHealth Group, (Minneapolis, MN: UnitedHealth Group, July 19, 2006); Humana Inc., 2006 and 2005 SEC