



Universal Drug Benefits for Seniors

Unnecessary, Unsustainable, and Unfair

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Executive summary

Provincial governments in Canada have special, publicly funded, programs that reimburse seniors for their spending on prescription drugs. The United States recently passed federal legislation, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA 2003), which grants universal eligibility to seniors for public funding of prescription drugs. The rationale for such programs is that after retirement many seniors lose their employer-paid drug insurance and therefore need a government program to replace it. This study argues that the age-based universal entitlement provided by seniors' drug-benefit programs is unnecessary and inefficient relative to more limited policy options, and is unfair to the rest of the population. Such policies also lead to unsustainable demand by consumers for pharmaceuticals that, in turn, provokes governments to adopt cost-control policies that reduce consumer choice, stifle pharmaceutical innovation and, by extension, harm the health of patients.

While such public programs are intended to replace private insurance coverage for risk of catastrophic drug expenses, they are often not actually designed like proper insurance plans, but instead transfer money from all taxpayers to seniors on a simple age-entitlement basis. And, while the entitlement introduced by these programs is usually justified on the basis of need, this study finds that very few people in either Canada or the United States—even among seniors—have annual drug expenses that exceed what they can easily afford. In almost all cases, prescription drug costs cannot reasonably be defined as catastrophic. The average cost of a prescription is quite low, and the annual per-capita expenditure on drugs is also low. Relative to personal income or to comparatively less important personal expenditures, drug costs appear to be a real bargain.

Moreover, a study of the prices and availability of drugs in Canada and the United States indicates that low-income seniors in both countries already have affordable generic substitutes for nearly all of the most important drugs recommended for seniors by physicians. Therefore, genuinely needy cases are not widespread and there is no justification for a universal entitlement to a publicly funded drug subsidy. To the contrary, it is because catastrophic expenses occur very infrequently among the population that drug costs for seniors (as for the rest of the population) are amenable to traditional insurance coverage. In sum, universal, publicly funded, drug coverage is unnecessarily expensive because only a few people actually need financial assistance for drugs.

Furthermore, universal public entitlements to drug benefits, which are limited to seniors as a particular age group, represent an unjustified, expensive, intergenerational wealth transfer. For example, gross annual costs to American taxpayers from expanded seniors' drug benefits under the MMA are expected to reach US\$84 billion

in the first year. These costs will be borne by the general population because the program is mostly funded by public money; but seniors are the only eligible recipients. This is inherently unfair as most of the population will be paying for, but not receiving, benefits. The unfairness is made even more acute as the baby-boomers retire, because the following generations will pay proportionally more and receive proportionally less than their numerically superior forerunners.

The expansion of public drug benefits on a universal basis will also artificially increase overall demand for pharmaceuticals because any subsidy makes the effective price for consumers much lower. The Canadian experience shows that, in the short run, this will drive drug sales and prices higher; and, in the long run, rising costs will lead governments either to abandon universality or (1) restrict consumer choice by rationing insurance coverage; (2) force the use of cheaper generic substitutes for potentially more effective new medicines; (3) slow down new drug approvals to keep them from being listed on public formularies and becoming eligible for reimbursement; and (4) impose price controls either through monopsony buying power or direct regulation. Such policies negatively affect consumer choice and incentives for future drug innovation; and might lead to higher overall public health-care expenditures and worse health outcomes for patients because potentially more effective new drug therapies are displaced by less efficient older drugs and costlier non-pharmaceutical therapies.

A more rational approach would be to focus public assistance only on those who are truly in need, that is, those with genuine, medically necessary, catastrophic expenses who do not have the means to pay—regardless of their age; and allow the rest of the population to participate in a competitive market served by private insurance. The analysis in this study shows that such an approach applied to public drug benefits in Canada would save taxpayers at least \$4 billion annually and, if applied in the United States, could save Americans taxpayers \$69 billion per year—without denying anyone access to medically necessary pharmaceuticals.

Highlights

- ◆ Public, prescription-drug benefits cost Canadians at least \$4 billion a year more than necessary because of overly generous eligibility criteria:
 - ◆ Only 3% of the general Canadian population have drug costs that exceed the catastrophic threshold established by the Romanow Commission on the Future of Health Care in Canada. Further, only a small portion of this already small population group has incomes that are low enough to justify a public subsidy for their drug consumption.

- ◆ Recent legislation expanding publicly funded drug benefits to all seniors in the United States will cost American taxpayers up to \$69 billion per year more than necessary because of overly generous eligibility criteria:
 - ◆ As of 2006, the new US Medicare drug benefit will expand drug benefits to 29 million seniors and cost American taxpayers \$84 billion annually. Yet, only 900,000 American seniors (3%) have incomes that are below 150% of the US poverty line in 2004 and also have drug costs that exceed the catastrophic threshold of the new benefit.

Drug-benefit programs for seniors

Provincial governments in Canada have special, publicly funded, programs that reimburse seniors for their expenditures on prescription drugs. The United States recently passed federal legislation, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA 2003), which granted universal eligibility to seniors for public funding of prescription drugs. The rationale for such programs is that after retirement many seniors lose their employer-paid drug insurance and therefore need to have this risk covered by the government. This study argues that the universal entitlement by age that seniors' drug-benefit programs provide is unnecessary and inefficient relative to more limited policy options and is unfair to the rest of the population. Such policies also lead to unsustainable demand by consumers for pharmaceuticals that, in turn, provokes governments to adopt cost-control policies that reduce consumer choice, stifle pharmaceutical innovation and, by extension, harm the health of patients.

Public drug-benefit programs for seniors in Canada

Public drug-benefit programs in Canada are generally the responsibility of provincial governments. Benefits specifically targeting seniors are a distinguishing feature of such programs in all provinces. Graham and Tabler [2005] compared the structure of Canada's provincial drug-benefit programs, including special provisions for seniors. They found that all provinces give some type of preferential treatment to seniors relative to the rest of the population, both in terms of criteria for eligibility and cost sharing. For instance, some provinces offer public coverage for seniors but not for the general population. Similarly, those provinces that do offer benefits to seniors as well as the rest of the population have made eligibility for seniors' benefits more universal than those offered to the general public. In fact, universality for publicly funded senior drug benefits has characterized most provincial programs at some point in their evolution. However, most significant is the policy trend occurring in all Canadian public drug-benefit programs, which is to move away from universality because of the inherent financial non-sustainability of such approaches.

For instance, until 2003, drug coverage for seniors in British Columbia was universal, regardless of income, whereas the eligibility of the rest of the population was determined by a means test. Since 2003, some means testing has been introduced for seniors. Similarly, Ontario's drug benefit for seniors was reserved only for the poor when it was introduced in 1975 but soon became a universal, age-based entitlement. However, means tests were again in use by 1996. Likewise, in Quebec, seniors enjoyed universal coverage for drugs between 1972 and 1992 but after 1992 means tests were

introduced. Means tests were also added to the provincial drug-benefit programs for seniors that began as universal entitlements in New Brunswick and Nova Scotia. Alberta is currently the only province that has universal entitlement to seniors' drug benefits. [\[Graham and Tabler, 2005\]](#)

The new US Medicare drug benefit for seniors

There are three main, publicly funded, health-insurance programs that, together, account for most of the nearly 45% of total annual, health-care expenditures paid by public funding in the United States [\[US Bureau of Labor Statistics, 2004\]](#): 1. Veterans Health Administration (VHA); 2. Medicaid; 3. Medicare.

Veterans Health Administration (VHA) provides medical benefits for US military combat veterans. Medicaid is a program that provides health-care benefits for those with low-incomes, usually welfare recipients. Medicare provides medical benefits specifically for seniors (although there are some eligible non-senior recipients like the disabled).

In 2003, the US Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to create new public drug benefits under Medicare that did not previously exist for seniors. The MMA established a basic outpatient drug benefit as "Part D" of Medicare and made it available on a voluntary basis to all Medicare beneficiaries; making eligibility for the Medicare drug benefits more universal than existing Canadian programs for seniors.

According to the US Congressional Budget Office (US CBO), the standard drug benefit specified by the MMA for calendar year 2006 will have a \$250 annual deductible; pay 75% of covered drug costs between \$250 and \$2,250; provide no further coverage until an enrollee has incurred \$3,600 in out-of-pocket drug costs for the year; and pay about 95% of covered drug costs beyond that catastrophic threshold. The catastrophic threshold is defined in terms of the actual out-of-pocket costs that enrollees incur. [\[US CBO, 2004: viii\]](#)

The US Congressional Budget Office (US CBO) estimates that 87% of current Medicare beneficiaries will participate in the drug benefit once it becomes available in 2006. Some of these would receive subsidized drug coverage through a former employer and thus would technically not be enrolled in Part D. This leaves an estimated 29 million seniors as recipients of the new benefit as of 2006. [\[Mays and Brenner, 2004\]](#)

The MMA also established subsidies for enrollees with relatively low income and countable assets. The subsidies will pay all, or a portion of, premiums and substantially reduce cost-sharing liabilities. It has been estimated that about 8.7 million people would be eligible for low-income subsidy benefits under the MMA. [\[Mays and Brenner, 2004\]](#)

Universal drug benefits for seniors are unnecessary

As described above, Canadian pharmacare programs have subsidized the elderly on a universal or preferential basis relative to the rest of the population. Though in the past this has been done regardless of the level of individual drug costs or financial ability to pay, some degree of financial means testing has begun to replace the universal eligibility that earlier characterized these programs. Additionally, the pharmacare proposals put forward by the federally appointed Romanow Commission recommended a defined catastrophic threshold as a need-test for eligibility.

Yet, in spite of the well-known problems associated with universal entitlement programs, the new US Medicare drug benefit for seniors will adopt universal age-based eligibility criteria. This section will show that universal, public, prescription drug benefits for seniors are actually unnecessary because relatively few seniors actually experience catastrophic drug costs or lack the incomes to pay for such expenses themselves. Cases of catastrophic drug costs, whether measured against other common expenditures or as a percentage of income, are few relative to the overall population. If publicly funded drug-benefit programs are justified as necessary to meet genuine hardships, then only people who reach an appropriately defined catastrophic drug expenditure threshold (assuming the drugs consumed are medically necessary) and whose incomes are insufficient to pay for such costs should be eligible for benefits.

Catastrophic need measured against expenditure thresholds

In the United States, the MMA will extend prescription drug benefits to about 29 million seniors on a universal basis as of 2006. Yet, according to the US Congressional Budget Office (US CBO), only 3.1 million of the 29 million seniors who will receive the new drug benefits will actually reach the defined total catastrophic threshold of US\$5,100 per person per year, which is equal to \$3,600 in out-of-pocket spending under the provisions of the MMA. Furthermore, it has been estimated that only 5.2 million of the 29 million eligible participants have incomes that fall below the federally defined poverty line. [US CBO, 2004; Mays and Brenner, 2004] Moreover, according to an analysis of the particular income levels of those seniors who are likely to exceed the catastrophic threshold under the MMA, only 300,000 people with personal incomes below the poverty line will exceed the catastrophic threshold for personal drug costs. In fact, even at more generous cutoff levels—incomes below 150% of the poverty line—

only 900,000 people, or 3%, of the 29 million eligible seniors will suffer catastrophic drug expenses. [1] [Mays and Brenner, 2004] This means at least 28.1 million, or 97%, of the 29 million eligible MMA participants cannot reasonably claim a catastrophic financial need that justifies a subsidy paid by taxpayers.

The same pattern is seen in Canada: genuine catastrophic need occurs among very small percentages of the population. For instance, the federal Romanow Commission on the Future of Health Care in Canada [2002] published data from Manitoba in its final report that showed only 39,878 people across all age groups or 3% of the entire general population of the province (1,155,600 in 2002) [Statistics Canada, 2004b] had annual personal drug costs in excess of Romanow's catastrophic threshold of CDN\$1,500 per person per year. According to the report:

Based on a threshold of \$1,500, the Manitoba data showed that for 2000/01:

- ◆ there were 39,878 Manitobans with drug costs in excess of \$1,500 a year;
- ◆ these people had 2,049,855 prescriptions at an average cost of \$54.53 each;
- ◆ the average cost of prescriptions for Manitobans that year was \$35.08, indicating that people with high drug needs also needed drugs that are more expensive than the average;
- ◆ the total cost to the Manitoba Pharmacare plan for these individuals was approximately \$112 million or 44% of the total cost (\$256 million) of the public plan. [Romanow, 2002: 198]

The very low frequency of genuinely needy cases implies that universal approaches to publicly funded drug benefits are unnecessary.

Catastrophic need measured against income

Similarly, when looked at as a percentage of income, drug costs do not appear to be large enough to justify a public subsidy for the average senior. For instance, in the United States, average annual drug costs (prescription and non-prescription together) equalled about 3% of the average annual per-capita income after taxes for seniors in 2002. This compares to average drug costs of about 1% of average annual per-capita income after taxes for the population aged 35 to 64 years, when earnings are highest. Moreover, while seniors had an average annual per-capita income after taxes in 2002 roughly half that of those aged 35 to 64 years, housing costs for US seniors are only 60% of the costs for those aged 35 to 64 years. [Table 1] In this context, drug costs

[1] 1.5 times the US poverty line of US\$9,310 = US\$13,965 per individual in 2004. Total household income may be higher.

Table 1: Average annual US spending on prescription and non-prescription drugs relative to other expenditures, by age group, 2002

Age range (years)	Average annual personal Rx spending (US\$)	Average annual per-capita income after taxes (US\$)	Rx spending as percent of annual income	Average annual housing costs (US\$)	Percentage within age range without a mortgage
35 to 64	\$484	\$56,562	1%	\$15,219	23%
65 +	\$955	\$28,674	3%	\$9,176	62%

Source: [US Bureau of Labor Statistics, 2004](#).

averaging 3% of income for the average senior do not appear to justify universal public programs to subsidize personal pharmaceutical consumption. [[US Bureau of Labour Statistics, 2004](#)]

In Canada, data is not readily available on average drug spending by age group. However, averaged over the entire population, per-capita total drug costs (prescription and non-prescription, public and privately funded) in 2002 were estimated to be CDN\$578 (or US\$486 @ 2002 US\$ PPP). [[CIHI, 2004](#)] This is equal to only 2% of the 2002 average Canadian's after-tax income of CDN\$25,900. [[Statistics Canada, 2004c](#)] Health Canada also recently published a report, summarizing data on household prescription drug spending as a percentage of household income. As [Table 2](#) shows, according to Health Canada's analysis, only 3% of Canadian households spend more than 5% of their income annually on prescription drugs.

These examples illustrate that universal approaches to public drug benefits are unnecessary because relatively few people actually experience drug costs that can reasonably be defined as catastrophic relative to income.

Table 2: Percent of households in Canada by household prescription drug spending as a percentage of household income, 1997–2002

Spending on prescription drugs (percentage)	Percentage of all households in each category					
	1997	1998	1999	2000	2001	2002
> 0% of Income	67%	65%	66%	65%	65%	65%
> 1% of Income	18%	18%	19%	19%	19%	19%
> 2% of Income	9%	9%	10%	10%	10%	11%
> 3% of Income	6%	6%	6%	6%	6%	7%
> 4% of Income	4%	4%	4%	4%	4%	5%
> 5% of Income	3%	3%	3%	3%	3%	3%

Source: [Health Canada, 2004](#), citing [Statistics Canada, Survey of Household Spending, 1997, 1998, 1999, 2000, 2001, 2002](#).

Drug costs compared to other expenditures

Furthermore, in the context of comparably less important expenditures, average drug costs do not appear to be very burdensome. For instance, in 2002 Canadian households spent an average of CDN\$3,537 on recreation, \$1,478 on tobacco and alcohol, \$313 on games of chance, \$1,444 on charitable donations, and only \$1,210 on prescription medicines annually. These expenditures are shown in [Table 3](#) as percentages of household income by various definitions of family unit. Again, in the context of overall income or other less important expenditures, average drug costs do not appear to justify a universal public subsidy. [[Statistics Canada, 2004d](#)] Similarly, drug costs in the United States also seem like a real bargain when compared to other far less important expenditures. For instance, as shown in [Table 4](#), US seniors spent an average of only US\$955 on drugs in 2002 but an average of \$1,139 on entertainment in the same year. [[US Bureau of Labour Statistics, 2004](#)] These examples illustrate that universal approaches to public drug benefits are unnecessary because relatively few people actually experience drug costs that can reasonably be defined as catastrophic relative to other less important, discretionary expenses.

Canadian and US Prices for drugs that are important to seniors

Another fallacy used to support justifications for universal, age-based, entitlements in the United States can be illustrated by a quick cross-border comparison of drug prices faced by low-income seniors in the United States and Canada. American proponents of expanding Medicare's drug benefits to seniors often cite higher drug prices that are higher in the United States than in Canada as a justification for a public subsidy.

However, data referenced by this study show that, in general, US generic drug prices are dramatically lower than Canadian prices and that 95% of the most commonly recommended drugs for seniors have generic substitutes. Therefore, American seniors—especially low-income seniors—already have options south of the border that are more affordable relative to Canadian generic drug prices, even without the expanded public drug coverage that will become available under US Medicare in 2006.

Specifically, the data used in this study indicate that Canadian seniors pay much more than American seniors for the same generic drugs (64% more on average) but pay much less than American seniors for the same brand-name drugs (36% less on average) [[Figure 1](#)]. [[Skinner, 2005b](#)] By comparison, the general price data used for this study show that Canadian prices for generic drugs over all of the 100 top-selling products available in both markets in 2003 averaged 78% higher than US prices for the same drugs. In contrast, Canadian prices for brand-name drugs over all of the 100 top-selling products available in both markets in 2003 averaged 43% lower than US

Table 3: Comparison of selected average annual household expenditures to average annual after-tax household income by family type, Canada 2002

Income unit	After-tax income	Selected expenditures as a percent of household income				
		Recreation (\$3,537)	Tobacco & alcohol (\$1,478)	Games of chance (\$313)	Charitable donations (\$1,444)	Prescription drugs (\$1,210)
Economic families [1]	\$60,500	6%	2%	1%	2%	2%
<i>Elderly families [2]</i>	\$43,400	8%	3%	1%	3%	3%
<i>Married couples only</i>	\$42,000	8%	4%	1%	3%	3%
<i>All other elderly families</i>	\$48,400	7%	3%	1%	3%	3%
<i>Non-elderly families [3]</i>	\$63,200	6%	2%	0%	2%	2%
<i>Married couples only</i>	\$59,000	6%	3%	1%	2%	2%
<i>No earner</i>	\$28,800	12%	5%	1%	5%	4%
<i>One earner</i>	\$45,800	8%	3%	1%	3%	3%
<i>Two earners</i>	\$65,700	5%	2%	0%	2%	2%
<i>Two parent families with children [4]</i>	\$67,700	5%	2%	0%	2%	2%
<i>No earner</i>	\$24,200	15%	6%	1%	6%	5%
<i>One earner</i>	\$49,900	7%	3%	1%	3%	2%
<i>Two earners</i>	\$67,200	5%	2%	0%	2%	2%
<i>Three or more earners</i>	\$83,800	4%	2%	0%	2%	1%
<i>Married couples with other relatives</i>	\$82,700	4%	2%	0%	2%	1%
<i>Lone-parent families [4]</i>	\$33,000	11%	4%	1%	4%	4%
<i>Male lone-parent families</i>	\$42,100	8%	4%	1%	3%	3%
<i>Female lone-parent families</i>	\$30,800	11%	5%	1%	5%	4%
<i>No earner</i>	\$15,800	22%	9%	2%	9%	8%
<i>One earner</i>	\$30,400	12%	5%	1%	5%	4%
<i>Two or more earners</i>	\$44,400	8%	3%	1%	3%	3%
<i>All other non-elderly families</i>	\$58,000	6%	3%	1%	2%	2%
Unattached individuals	\$25,900	14%	6%	1%	6%	5%
<i>Elderly male</i>	\$24,600	14%	6%	1%	6%	5%
<i>Non-earner</i>	\$22,500	16%	7%	1%	6%	5%
<i>Earner</i>	\$32,400	11%	5%	1%	4%	4%
<i>Elderly female</i>	\$21,900	16%	7%	1%	7%	6%
<i>Non-earner</i>	\$21,500	16%	7%	1%	7%	6%
<i>Earner</i>	\$26,800	13%	6%	1%	5%	5%
<i>Non-elderly male</i>	\$28,400	12%	5%	1%	5%	4%
<i>Non-earner</i>	\$10,100	35%	15%	3%	14%	12%
<i>Earner</i>	\$31,300	11%	5%	1%	5%	4%
<i>Non-elderly female</i>	\$25,200	14%	6%	1%	6%	5%
<i>Non-earner</i>	\$11,300	31%	13%	3%	13%	11%
<i>Earner</i>	\$28,300	12%	5%	1%	5%	4%

Source: [Statistics Canada, 2004](#).

Notes: Average income after tax is total income, which includes government transfers, less income tax. Expenditures by average household. [1] An economic family is two or more individuals sharing a common dwelling who are related by blood, marriage (including common-law), or adoption. [2] Families in which the major income earner is 65 years of age and over. [3] Families in which the major income earner is less than 65 years of age. [4] Children less than 18 years of age.

prices for the same drugs. [Skinner, 2005a] These findings are consistent with previous studies of differences between drug prices in Canada and those in the United States. [See Graham, 2000; PMPRB, 2003; US FDA, 2003, 2004; Skinner, 2004]

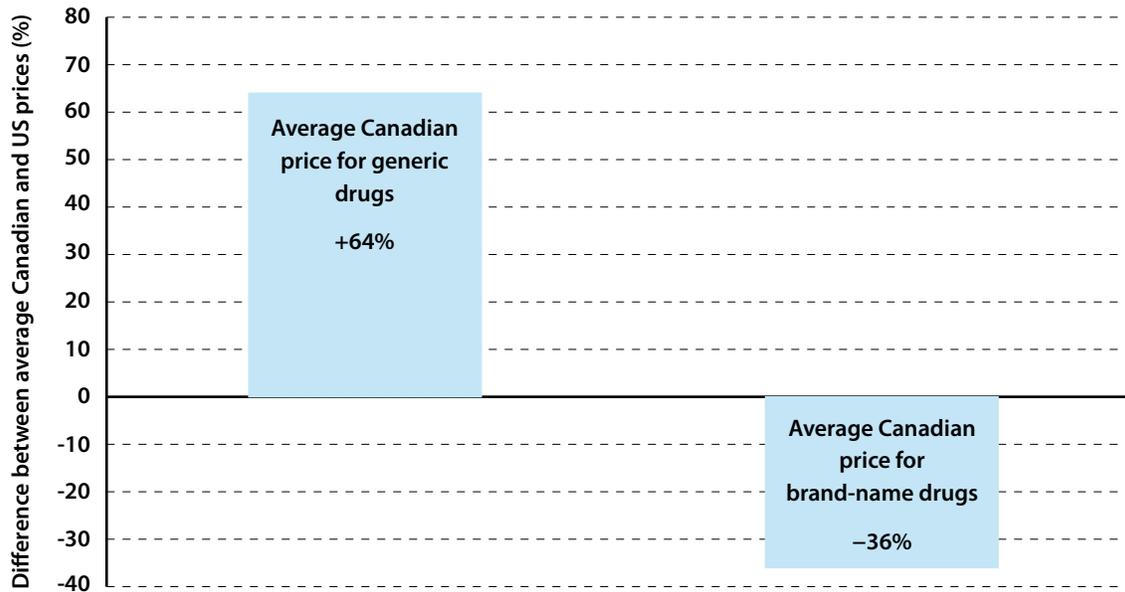
Significantly, the data for this study also indicate that 95 of the 100 drugs most commonly recommended for seniors had generic versions available in Canada. [Skinner, 2005b] Therefore, seniors living on low incomes in Canada already have affordable alternatives to more expensive brand-name versions for almost all of the most important medicines recommended for them by doctors. Differences between US and Canadian drug prices also indicate that low-income Canadian seniors would do better if they enjoyed the much lower prices available in the United States for generic drugs.

Table 4: Average US spending on drugs compared to spending on entertainment, by age group, 2002

Age Range	Average annual personal Rx spending (US\$)	Average annual expenditure on entertainment (US\$)
35 to 64	\$484	\$2,516
65 +	\$955	\$1,139

Source: US Bureau of Labor Statistics, 2004.

Figure 1: Differences between average Canadian and US drug prices for the 100 drugs most recommended for seniors by Canadian physicians—percent average Canadian price (2003 US\$PPP) differs from US Price for generics and brand-name drugs (US price = 0)



Source: IMS Health, 2004.

However, lower US prices for generic drugs make this argument even stronger for US seniors. Recall that this study showed that 95% of the top 100 drugs recommended by physicians for seniors in Canada have generic versions. We know that the state of medical science and availability of drug products is fairly similar in Canada and the United States; therefore, there is no reason to believe that recommendations by Canadian and American physicians would differ dramatically. We also know that the rate of generic substitution is much higher in the United States than in Canada. [Skinner, 2005a] Therefore, it seems safe to assume that the United States follows the Canadian pattern for the percentage of the most recommended drugs for seniors that are available in generic form. Further, recall that this study determined that Canadian prices for the generic drugs most important to seniors were 64% higher on average than United States prices for the same drugs. If, as this study has shown, these are priced significantly lower on average in the United States than in Canada, then low-income US seniors are already better off under current US drug policy than they would be under Canadian drug policies, which have been shown in previous studies to discourage competition over time in the generic industry and lead to much higher overall generic drug prices. [Skinner, 2004; 2005a] This also exposes the error in arguing for universal, publicly funded, drug benefits for US seniors on the basis of differences in American and Canadian drug prices and weakens needs-based justifications for the newly expanded Medicare coverage.

Universal drug benefits for seniors are not economically sustainable

The expansion of public drug-benefit programs will also increase overall demand for pharmaceuticals along an unsustainable trajectory. The effect of third-party payment (e.g. insurance; entitlements) on consumer demand for goods or services is well documented. Research shows that the higher the percentage of the total price of a good or service is covered by third-party payment, the more likely that consumers will demand more of it. [Pauly, 2003] This is the case because, as third-party payment increases, the effective price of a good or service falls to the direct consumer. As the effective price to consumers falls, they become less sensitive to price as a factor in their decisions to consume. This lack of sensitivity to price can also lead to a general rise in prices overall. [Newhouse et al., 1993]

In fact, the US Congressional Budget Office (US CBO) expects both an increase in demand for drugs and an increase in drug prices to occur with the introduction of the new US Medicare drug benefit. The US CBO estimated that the expansion of Medicare coverage of drug costs will have the following effects:

- ◆ “price effect”: the likelihood that average drug prices will be higher because beneficiaries who currently lack drug coverage (about 25% of the Medicare population) will become partially insulated from those prices
- ◆ “use effect”: changes in demand for drugs resulting from changes in beneficiaries’ cost-sharing liabilities (assumption that beneficiaries’ total drug use will increase if their own out-of-pocket costs fall). [US CBO, 2004: ix]

Expanding publicly funded, universal drug benefits to seniors and heavily subsidizing drug consumption even for those who do not need such assistance will increase the overall demand for pharmaceuticals and permit drug-makers to charge higher prices than could be obtained if financially able consumers were directly responsible for the costs of their own personal consumption of medicines. In part, this may explain support by many in the US pharmaceutical industry for the new Medicare provisions. However, where it exists, industry’s support for the expansion of Medicare drug benefits is shortsighted.

In the short run, drug-makers will benefit from higher sales and prices due to the expanded drug-benefit coverage of a universal, publicly funded program. However, as the Canadian experience with public drug-benefit programs indicates, in the long run, cost pressures will lead governments to:

- 1 severely restrict consumer choice by rationing coverage by public insurance
- 2 force generic substitution for newer and potentially more effective medicines
- 3 slow down approvals of new drugs to keep them from being listed on public formularies and becoming eligible for reimbursement, and
- 4 impose price controls either through monopsony buying power or direct regulation.

These are the kinds of tactics used increasingly by provincial governments in Canada to reduce the costs of public drug-benefit programs in Canada. [Graham and Tabler, 2005; Graham 2005, 2002; Lindsey and West, 1998] In the United States, such policies will have a negative effect upon consumer choice, the health of patients, and incentives for future drug innovation; and may lead to higher overall public health-care expenditures as potentially more effective, new drug therapies are displaced by less efficient older drugs and costlier non-pharmaceutical therapies.

Meanwhile, once universality is entrenched, political pressures and demands make it very difficult for governments to reverse policies. Therefore, the long-term costs—even to the industry—outweigh any short-term gains from expanding publicly funded drug benefits.

Universal drug benefits for seniors are expensive and unfair

Providing universal drug benefits for seniors is also expensive and unfair because it requires the transfer of wealth (via taxation) from the general population to provide a benefit enjoyed by only a few. For instance, it is currently estimated that the new US Medicare drug benefit will cost taxpayers nearly \$84 billion annually beginning in 2006. [Mays and Brenner, 2004] The minimum net additional cost to taxpayers between 2006 and 2013 totals almost \$400 billion. [US CBO, 2004] This estimate will likely be revised upwards as the population ages. Therefore, the new US Medicare benefit represents a government-imposed intergenerational transfer of wealth that will make the population younger than 65 years old (266 million people in 2004 [US Census Bureau, 2004]) worse off, in order to benefit 29 million seniors, 97% of whom do not have incomes low enough to justify a public subsidy.

Additionally, it is important to note that expanding the coverage of publicly funded drug benefits will not just affect prices for sales to Medicare recipients as described above but will also inflate the average price for drugs in the market overall; meaning that prices will also rise for drugs sold to non-Medicare recipients. [Duggan and Morton, 2004] Therefore, taxpayers who are not also Medicare recipients will suffer twice: first, from paying for a drug benefit they do not receive themselves; and, second, by paying higher drug prices because of the artificial boost to consumer demand caused by expanded public funding of drug purchases for seniors.

Less costly ways to help those with low incomes and medically necessary catastrophic drug costs

Public prescription-drug benefits provided through universal programs are unnecessary, unfair, and unsustainable in the long run. A more rational approach is to provide public assistance only to those who are truly in need—those who face genuine, medically necessary, catastrophic expenses but do not have the means to buy private insurance or pay out-of-pocket—regardless of their age. According to the Romanow Commission’s data presented earlier in this paper, only 3% of the Canadian population faces drug expenditures above the Commission’s annual threshold of \$1,500. Furthermore, the total drug costs for this group, all of which were covered publicly by the province of Manitoba, amounted to 44% of the entire public expenditure on drug benefits. Extrapolating this to the nearly \$7 billion dollars spent by public drug-benefit programs across Canada in 2002 [CIHI, 2004], means that focusing a public drug benefit on this specific population group based on Romanow’s catastrophic threshold would save at least 56% of the costs of current public drug-benefit programs, about \$3.9 billion annually (in 2002 dollars).

Additionally, many of the people in this group do not require a public subsidy because their incomes are likely to be high enough to cover such expenses on their own or to purchase private insurance. Therefore, the overall savings from focusing public assistance only on those with genuine, medically necessary, catastrophic expenses who also do not have the means to pay would increase the savings well above the 56% calculated above.

This sample calculation serves to illustrate the unnecessary costliness associated with universal approaches to public drug benefits. This particular calculation applies to the general Canadian population but the lesson is also applicable to universal drug benefits for specific age groups, like seniors.

Similarly, the same calculation can be done for the United States. Fortunately, more detailed data was readily available and a more accurate analysis of costs and savings can be produced for the US case. Table 5 shows the total spending on drug benefits and the number of senior participants expected in 2006 when the new seniors’ drug benefits under Part D of the MMA come into force. This is broken down according to the annual level of spending by participants categorized in two groups: those over the initial MMA coverage limit of US\$2250; and those with annual drug spending above the MMA defined catastrophic level of US\$5100. Both cases include only those with incomes below 150% of the poverty line defined by the US government.

As Table 7 indicates, the cost of covering only the seniors in these two groups is dramatically lower than the cost of providing drug benefits for all seniors on a

Table 5: Calculation of annual unnecessary costs to US taxpayers from extending universal eligibility to seniors under the new Medicare Drug Benefit, 2006.

Total number of part-D participants in 2006	29,000,000
Total expected annual drug spending in 2006 accounted for by part-D participants: including out-of-pocket and subsidy spending	\$83,500,000,000
Total number of part-D participants with drug spending over the catastrophic threshold of \$5100	3,100,000
Percent of total part-D drug spending accounted for by those with drug spending above \$5100	61%
Total spending by part-D participants with drug spending above \$5100*	\$50,935,000,000
Average spending by part-D participants with drug spending above \$5100*	\$16,430
Total number of part-D participants with drug spending over the initial spending limit of \$2250	6,900,000
Percent of total part-D drug spending accounted for by those with drug spending above \$2250	85%
Total spending by part-D participants with drug spending above \$2250*	\$70,975,000,000
Average spending by part-D participants with drug spending above \$2250*	\$10,286
Number of part-D participants with drug spending above \$5100 and incomes below 150% of the defined US poverty line	900,000
Total spending by part-D participants with drug spending above \$5100 and incomes below 150% of the defined US poverty line*	\$14,787,580,645
Savings to US taxpayers from covering only those with annual drug spending above \$5100 and incomes below 150% of the defined US poverty line	\$84b – \$15b = \$69b
Number of part-D participants with drug spending over \$2250 and incomes below 150% of the defined US poverty line	1,900,000
Total spending by part-D participants with drug spending above \$2250 and incomes below 150% of the defined US poverty line*	\$19,543,840,580
Savings to US taxpayers from covering only those with annual drug spending above \$2250 and incomes below 150% of the defined US poverty line	\$84b – \$20b = \$64b

Source: [Mays and Brenner, 2004](#), citing data from the Congressional Budget Office's estimates of spending under the Medicare Modernization Act, 2003.

Notes: * Calculation by author based on source data shown.

universal basis. The analysis of this data shows that expanding publicly funded drug benefits to all seniors in the United States will cost American taxpayers up to \$69 billion per year more than necessary because of overly generous eligibility criteria.

Limited public benefits and private insurance

The rationale for publicly funded, universal, age-based drug-benefit programs is that after retirement many seniors lose their employer-paid drug insurance and therefore need to have this risk-coverage provided by government. However, as this paper has shown, genuine need for government assistance cannot adequately be demonstrated in the case of almost all seniors. Therefore, the bulk of the seniors' population should be able to afford private insurance coverage for the risks of suffering catastrophic drug expenses in the market or pay out-of-pocket for their drug costs.

Nonetheless, some may argue that private insurers have not offered such coverage for seniors and that, as the market has failed, government assistance is justified. Such a claim is doubtful and is a matter for empirical verification but, even if this were the case, there could be a number of explanations for the market's failure to provide insurance for seniors after retirement. First, it may mean that most seniors do not perceive the risk of catastrophic drug expenditures to be very great and therefore simply do not demand insurance protection—at least, not if they have to pay for it themselves. If seniors are not demanding insurance in the market, then by definition there can be no need-based justification for government provision. Second, insurers may find it difficult to organize seniors into insurance pools and to assess accurately the risk posed by individual members, so that the insurance fund is at risk of adverse selection problems. Still, regulation is a more efficient way of dealing with this type of problem. Third, any absence of insurance availability in private markets may simply mean that the very existence of public programs precludes market opportunities to provide insurance in the first place.

Nonetheless, if the market fails to provide appropriate insurance options to retired seniors, government assistance should be focused on providing any redistributive, publicly funded, benefits only to those with genuine, medically necessary, catastrophic expenses who also do not have the means to pay. This could be accomplished through a retroactive, means-tested, partial reimbursement for low-income seniors (which could be fairly extended to any low-income person regardless of age) for catastrophic drug expenditures. The remainder of the senior population could be served by a properly designed public insurance plan that directly links 100% of insurance costs to the insured through voluntary participation, community-based premiums, and consumer co-payments rather than redistributive general taxes.

Alternatively, where the market provides health insurance opportunities for retired seniors, it may be appropriate for the state to provide an income subsidy for poorer people—where eligibility is determined by a means test—allowing them to buy private drug insurance. [Skinner, 2002] This could be accompanied by a retroactive partial reimbursement—again where eligibility is determined by a means test—for the catastrophic drug expenses of the chronically ill who may be excluded from coverage by market insurance. Medical Savings Accounts (MSAs) are also an optional way of pre-funding drug expenditures for low-income people while retaining incentives for responsible consumption. [Skinner, 2002]

Ultimately, governments should reject both age-based and universal approaches to drug coverage. Instead, eligibility for public assistance should be restricted to people with catastrophic medically necessary expenses—regardless of age—who also lack the income to pay for such costs themselves or to buy private insurance.

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