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State Savings with an Efficient Medicare Prescription Drug Benefit

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Americans pay far higher prices for prescription drugs than do people in other wealthy countries. This is true for the Medicare prescription drug program also. The reason that other countries spend so much less on drugs is that their governments negotiate prices with the pharmaceutical industry. While they grant patent monopolies to the industry that prevent competitors from selling the same drugs at lower prices, these governments use their large market shares to prevent the drug companies from charging exorbitant prices.

The United States government could adopt the same approach with Medicare, which also provides a huge market, actually far larger than many other countries. Medicare could use its market leverage to negotiate the same, or even lower, prices as are paid by other wealthy nations. The potential savings would be enormous.

Recently CEPR estimated that the federal government could save from $230 billion to $541 billion over the next ten years if Congress and the President were to enable Medicare to negotiate prescription drug prices, as is done in other wealthy countries.[1]

These estimates are based on the projection that the United States would spend $883 per person on prescription drugs in 2012.[2] This is nearly twice as high as in other wealthy countries. For example, Canada spends a bit over 70 cents for each dollar spent in the United States per person on prescription drugs. The United Kingdom spends just under 40 cents, and Denmark only about 35 cents.[3]

State governments pay into the Medicare drug program as well, to cover a portion of foregone drug costs for those beneficiaries who are dually-eligible for Medicaid and Medicare.[4] In the low savings case, where the United States spends as much on drugs as Canada, the cumulative savings to state governments would be $31 billion. In the high saving case, where we paid the same amount for our drugs as people in Denmark, the savings to the states would be $73 billion.

How much could each state expect to save individually? **Table 1** shows projected savings to individual state governments if Medicare were allowed to negotiate prescription drug prices.[5]

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TABLE 1: **State Government Savings from Negotiated Medicare Prescription Drug Prices, by State, 2013-2022**

State	Low Savings (Canadian Prices), in millions of dollars	High Savings (Danish Prices), in millions of dollars
AK	$ 36	$ 85
AL	526	1,240
AR	305	718
AZ	553	1,303
CA	3,311	7,804
CO	344	810
CT	405	954
DC	56	132
DE	99	233
FL	2,560	6,033
GA	768	1,811
HI	100	236
IA	283	668
ID	114	270
IL	1,255	2,957
IN	634	1,495
KS	262	618
KY	469	1,105
LA	514	1,211
MA	767	1,808
MD	572	1,349
ME	150	352
MI	1,154	2,720
MN	449	1,057
MO	627	1,478
MS	341	803
MT	82	192
NC	923	2,175
ND	56	132
NE	165	388
NH	125	294
NJ	1,016	2,394
NM	161	380
NV	218	513
NY	2,230	5,256
OH	1,261	2,971
OK	387	913
OR	325	766
PA	1,556	3,666
RI	119	281
SC	472	1,112
SD	72	169
TN	676	1,594
TX	2,178	5,134
UT	149	352
VA	637	1,502
VT	62	145
WA	522	1,229
WI	520	1,225
WV	230	543
WY	42	99
Total	**$ 30,838**	**$ 72,679**

Source: Authors' calculations, OECD, Centers for Medicare & Medicaid Services, Medicare Trustees' Report, and Congressional Budget Office. See Appendix for details and methodology.

California leads the way, with potential savings between $3.3 and $7.8 billion over ten years. The next 6 top-saving states are Florida, New York, Texas, Pennsylvania, Ohio and Illinois, all with projected savings of at least $1 billion. Even those states with the least potential savings, such as Wyoming, North Dakota and Vermont, would still save tens of millions of dollars over a decade.

While lower drug prices would reduce revenues and incentives for research and development of new drugs, they would also disincentivize improper marketing of medications and misrepresentation of their safety and efficacy. Policy makers could focus on developing a more efficient mechanism for financing drug research, which would reduce the extent of corruption that inevitably results from government-granted drug patent monopolies.

Appendix

Table 1 utilizes the ratios of individual state spending in 2009 as listed in "Medicare State Estimates by State of Residence – Personal Health Care, Health expenditures by state of residence: Summary Tables, 1991-2009," National Health Expenditure Data, Centers for Medicare& Medicaid Services, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf

To calculate individual state savings estimate, these ratios are then applied to projected cumulative savings to state governments as listed in Table 2 of "Reducing Waste with an Efficient Medicare Prescription Drug Benefit." Washington, DC: Center for Economic and Policy Research, available at http://www.cepr.net/index.php/publications/reports/reducing-waste-with-an-efficient-medicare-prescription-drug-benefit.

That table uses the projected sources of revenues from the 2012 Medicare Trustees Report, Table III.D3. The 2022 numbers are taken by projecting the growth rate from each source of revenue from 2020 to 2021 on the 2021 numbers. The savings are calculated by applying the ratio of drug spending in Canada (low savings) and Denmark (high savings) to actual spending on drugs in Part D. To get spending on drugs, the direct administrative costs of the Medicare program were subtracted from total spending (found in Table III.D3) as were the administrative costs of the insurers providing the benefit. The latter were projected as 6 percent of the cost of the program by the Congressional Budget Office. Together, the projected cost of the drugs purchased under the program was assumed to be 93.5 percent of spending. The saving from lower cost drugs are assumed to be proportional to what beneficiaries, the federal government and state governments paid into the program.

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1 Baker, Dean. 2013. "Reducing Waste with an Efficient Medicare Prescription Drug Benefit." Washington, DC: Center for Economic and Policy Research. http://www.cepr.net/index.php/publications/reports/reducing-waste-with-an-efficient-medicare-prescription-drug-benefit

2 Centers for Medicare & Medicaid Services. National Health Expenditure Projections 2011-2021, Table 11. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

3 OECD's Health Care Statistics. 2012. http://stats.oecd.org/Index.aspx?DataSetCode=SHA

4 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2012.pdf

5 See Appendix for details and methodology.