The Future of Medicare:
15 Proposals You Should Know About

You’ve Earned a
Strengthening Medicare

AARP’s You’ve Earned a Say is working to make your voice heard on the future of Medicare. For more than a year, Washington has been talking behind closed doors about changes to Medicare as part of a budget deal with little discussion about how any changes would affect you and your family. You’ve spent your life paying into Medicare and you deserve to know what changes are being discussed so you can have your say.

That’s why AARP is providing you with this booklet that contains balanced information about Medicare proposals that are being debated on Capitol Hill—the pros and cons—without the political jargon and spin. You deserve to know about the major proposals on the table so you can tell Washington what you think.

For more than 50 years, AARP has been fighting to protect and improve Medicare for today’s seniors and future retirees. Now it’s time to put Medicare on stable financial ground for the future so we can guarantee future generations have affordable, quality health care.

To join the conversation about the future of Medicare, go to earnedasay.org.
What are the pros and cons of options on the table in Washington?

You’ve paid into Medicare, and you deserve to know what changes are being proposed and how each might affect you and your family.

Medicare guarantees affordable health care to more than 50 million Americans today, but it is facing long-term financial challenges.

Here are summaries of 15 options being talked about in Washington. Each summary is accompanied by two opinions that AARP commissioned from experts whose views typically represent different sides of the issues.

The experts:

Henry J. Aaron, Ph.D., of the Brookings Institution.
Stuart Butler, Ph.D., of the Heritage Foundation.

For proposals in which the experts did not provide distinctly different positions, AARP commissioned experts from Avalere Health, a leading health care consulting firm, to provide analysis.
Raise the Medicare Eligibility Age

Since Medicare’s creation in 1965, the eligibility age has been 65 for people without disabilities. Some proposals would gradually raise Medicare’s eligibility age from 65 to 67. So instead of receiving health coverage through Medicare, 65- and 66-year-olds would need to enroll in coverage through an employer plan or a government program (such as Medicaid) or purchase their own coverage on the individual market or through a health insurance exchange.

Pro: Raising the Medicare eligibility age is a good idea. Both Medicare and Social Security were intended for retired Americans. So it would make sense to set the normal eligibility age of each program at the age where we have decided as a nation that retirement typically begins. We could do so by increasing the eligibility age slowly over 10 or 15 years to at least 67—the Social Security normal retirement age—and by allowing the eligibility age of both programs to rise gradually after that as Americans live longer. This would reduce Medicare’s costs by about 5 percent over the next 20 years. Not a magic bullet, but one important step to solving the Medicare cost problem. (Stuart Butler, Heritage Foundation)

Con: Raising the age of eligibility for Medicare at this time would be a bad idea. It would save the federal government little money, raise total health care spending, impose significant financial burdens on many financially vulnerable seniors and impose new costs on businesses and state governments. Having to wait until age 65 for Medicare coverage is a serious problem even now. Raising the age of eligibility for Medicare makes the wait longer and the problem worse. Now is not the time to put at risk the health insurance coverage for millions of 65- and 66-year-olds in the mistaken belief that doing so will contribute significantly to lowering the federal deficit. (Henry J. Aaron, Brookings Institution)

“I’ve been paying into Medicare and I deserve to know what changes Washington is talking about.”
Raise Medicare Premiums for Higher-Income Beneficiaries

Most Medicare beneficiaries pay a separate monthly premium for doctor visits (Part B) and prescription drug coverage (Part D) in Medicare. The premiums people pay for parts B and D cover about 25 percent of what Medicare spends on these services. Individuals with annual incomes of more than $85,000 and couples with annual incomes above $170,000 pay higher premiums, up to three times the standard premium depending on income level. Under several proposals, these higher-income beneficiaries would be required to pay as much as 15 percent more than they currently pay.

**Pro:** The best way to generate more premium revenue to help pay for Medicare parts B and D is to raise premiums for higher-income seniors. That would improve Medicare’s finances by bringing in more premium revenue, but without imposing burdens on modest-income seniors. When Medicare was created in 1965, the vision was that the health benefits beneficiaries received should be adequate for all and should also be roughly the same for rich and poor alike. But even if that made sense at the time, the costs of Medicare are rising at a rapid clip, and we just cannot afford that vision any more. That’s why we’ve already accepted the principle that better-off beneficiaries should pay more for their parts B and D benefits. *(Stuart Butler, Heritage Foundation)*

**Con:** On the surface, it may seem reasonable to charge Medicare beneficiaries with higher incomes more for the same parts B and D coverage. However, in reality, many of these proposals will push costs on to more middle-class beneficiaries, particularly if the income level at which individuals are subject to the higher premium continues to be frozen, or even reduced. In addition, higher-income beneficiaries already pay more money into the Medicare program before retirement, and they also pay more in premiums for Medicare parts B and D—they should not have to pay even more for the same coverage as other beneficiaries.

Also, some higher-income beneficiaries may decide it is more advantageous to drop out of parts B and D if they are able to buy less expensive private coverage or simply self-pay for the physician visits and medications. If enough higher-income beneficiaries drop out of parts B and D, the premiums for Medicare parts B and D will need to increase for beneficiaries who remain in the program, making Medicare participation more expensive for almost everyone. *(Avalere Health)*
Change Medicare to a Premium Support Plan

Under this proposal, newly eligible Medicare beneficiaries would receive their health coverage through private insurance plans, not traditional Medicare. Beneficiaries would choose among competing plans and the federal government would contribute a fixed amount to pay the premiums for the private insurance plan. If the private insurance premiums prove to be higher than the federal contribution, seniors would be required to pay the difference. If the government’s annual contribution does not increase by the same amount as the annual cost increase in premiums, beneficiaries would pay the difference, which could get larger over time.

**Pro:** It makes sense to put Medicare on a long-term budget that reduces the burden on our children and grandchildren while making health care affordable for seniors. The best way to do that is through the idea called “premium support.” This means older people would receive their own share of the Medicare budget to use toward a health insurance plan or with doctors. One way or another, older people will have to pay more for Medicare benefits. Premium support is the best way for Medicare to stay within a budget because it would give older people more control and choice over how that budget is actually spent. *(Stuart Butler, Heritage Foundation)*

**Con:** Now is not the time for premium support. All current proposals carry a threat that the vouchers will not keep pace with rising health costs, threatening the elderly and disabled with increased health care costs they cannot afford. Not until and unless we find out how to effectively enroll and pay subsidies to the working age Americans in the health insurance exchanges that are called for by the health reform legislation, will it be time to consider whether to take on the much harder job of shifting elderly and disabled Medicare beneficiaries into such new and untested organizations. *(Henry J. Aaron, Brookings Institution)*

“Medicare needs some changes but we must protect it for future generations.”
Require Drug Companies to Give Rebates or Discounts to Medicare

Under current law, drug manufacturers are required to give rebates or discounts to the Medicaid program for prescription drugs purchased by Medicaid beneficiaries. However, Medicare Part D—the optional prescription drug coverage—does not require similar manufacturer rebates or discounts. This proposal would require manufacturers to provide Medicare with the same rebates or discounts as those Medicaid receives for drugs purchased by certain low-income Part D enrollees.

**Pro:** Before 2006, drug companies provided discounts on drugs prescribed for all Medicaid beneficiaries. In 2006, legislation moved many of these beneficiaries to Medicare and ended the required discounts. As a result, the price of drugs for Medicare enrollees is higher than that under Medicaid and other government programs. Drug companies managed fine before 2006 and they can do so again. Restoring the discounts will save the Medicare program $112 billion over the next decade. This is a simple and effective way to save money for Medicare and help lower the federal budget deficit. *(Henry J. Aaron, Brookings Institution)*

**Con:** Some people think requiring drug companies to reduce the prices they charge Medicare for low-income seniors with Part D drug coverage would reduce Part D costs and be a good idea. It’s not a good idea. Prices would just go up for other Americans, and there would be less research on cures for diseases such as Alzheimer’s. This is not to say nothing is needed. Like other parts of Medicare, the revenue from Part D premiums covers only a small part of the actual cost. So today’s and tomorrow’s taxpayers will have to write bigger and bigger checks to the Internal Revenue Service if no action is taken. *(Stuart Butler, Heritage Foundation)*

“Medicare is fine for me right now but I hope it will be there for my children and my grandchildren.”
Increase Medicare Cost-Sharing for Home Health Care, Skilled Nursing Facility Care and Laboratory Services

Medicare does not charge a copay for patients whose doctors prescribe home health care or for the first 20 days in a skilled nursing facility. Several proposals would require a copay for home health care, including one that would require a payment of $100 for home health episodes with five or more home health visits and add copays for the first 20 days of care in a skilled nursing facility. Medicare does not currently require a copay for laboratory services (such as blood and diagnostic tests). A number of proposals would require beneficiaries to pay 20 percent of the cost of laboratory services.

**Pro:** Imposing a copayment for home health, skilled nursing facility and laboratory services will discourage unnecessary use of these services. Shifting more of the cost for these services to Medicare beneficiaries will also reduce Medicare costs and help to improve the long-term stability of the program. Most Medicare supplemental insurance plans (such as Medigap) would cover at least a portion of the cost-sharing, which would lessen the financial burden of these proposals on the majority of beneficiaries who have supplemental coverage. *(Avalere Health)*

**Con:** Many Medicare beneficiaries—particularly those who are low income and do not qualify for any additional assistance—will have trouble affording new copayments for home health, skilled nursing facility and laboratory services. These individuals may end up not receiving needed care or services. Even Medicare beneficiaries with supplemental policies could face higher out-of-pocket costs, as premiums would likely rise to offset the higher copays. State governments would also pay more, as Medicaid would be responsible for the copayments of low-income Medicare beneficiaries who receive assistance from Medicaid. *(Avalere Health)*
Generate New Revenue by Increasing the Payroll Tax Rate

The primary source of funding for Medicare hospital services (Part A) comes from the payroll tax. Workers and their employers each contribute 1.45 percent of earnings for a total contribution of 2.9 percent. Medicare also offers coverage for physician services (Part B) and prescription drugs (Part D), but these services are not funded by the payroll tax. It’s estimated that beginning in 2024 Medicare will not have enough money to pay for all of the expected hospital expenses. Increasing the payroll tax rate by 0.5 percent to 3.9 percent (or to 1.95 percent each for workers and employers) would raise additional revenue for Medicare’s inpatient hospital expenses. For an individual earning about $50,000 a year in wages, this increase would amount to an extra $250 in Medicare payroll taxes per year.

**Pro:** The Affordable Care Act health reform legislation includes important measures that promise to slow the growth of spending under Medicare hospital insurance (Part A). However, even with these cost-control measures, Medicare hospital insurance faces a small long-term deficit. That gap can, and should, be closed by a modest increase in payroll taxes. In addition, some changes in benefits are in order to improve protections against extended or repeated hospitalizations. There is no reason to perpetuate the myth that Medicare hospital insurance is in crisis. It isn’t. Vigorous enforcement of the health care law together with this modest tax increase will secure hospital insurance for current and future Medicare beneficiaries. *(Henry J. Aaron, Brookings Institution)*

**Con:** Addressing Medicare’s long-term financial problems by raising payroll taxes on working Americans is not the answer. Doing so will make the situation worse for the economy and for our children and grandchildren, and it will erode the political will to undertake needed reforms. We need to make sure that programs like Medicare don’t take such a large share of the economy in the future that there is not enough for other critical goals like education, rebuilding our roads and bridges, and defending America. We’ve got to get the future costs of Medicare down, not tax Americans more. *(Stuart Butler, Heritage Foundation)*
Increase Supplemental Plan Costs and Reduce Coverage

Even with Medicare coverage, seniors are often left with significant health care costs, so many people purchase supplemental private insurance coverage (such as Medigap plans) to reduce their out-of-pocket expenses. One proposal would charge more for certain types of supplemental plans, such as those that cover all costs so seniors incur no out-of-pocket expenses themselves. Other proposals would limit what Medigap supplemental insurance plans will cover. For instance, they could prevent Medigap from covering the first $500 of a Medicare beneficiary’s out-of-pocket costs, and only cover 50 percent of the remaining charges. Some proposals may also include a cap to limit overall out-of-pocket expenses.

**Pro:** Current Medigap plans are complicated. They cover some routine costs most Medicare beneficiaries could pay themselves, and they raise the cost of Medicare itself by increasing the use of Medicare-covered services while only paying part of the cost of this service use. Taxpayers pay the rest. Medigap plans should be changed to improve the coverage for serious illnesses and cover fewer small expenses. That change would lower Medigap premiums and Medicare costs, and improve the insurance protection Medicare beneficiaries need. *(Henry J. Aaron, Brookings Institution)*

**Con:** It would be unwise to increase the premium amounts for Medicare supplemental insurance, such as Medigap, or to decrease the amount of coverage available to enrollees under these policies. There is no evidence that these reforms would deter the use of unnecessary health care services. Rather, these Medigap proposals would simply raise costs for Medicare beneficiaries and have an unfair effect on lower-income Medicare enrollees and those in poor health. *(Avalere Health)*

“Washington needs to listen to what we think.”
Raise Medicare Premiums for Everyone

Most Medicare beneficiaries pay a monthly premium for doctor visits (Part B) and prescription drug coverage (Part D). The premiums people pay for parts B and D covers about 25 percent of what Medicare spends on these services. Individuals with annual incomes of more than $85,000 and couples with annual income above $170,000 pay higher premiums, which cover more than 25 percent of Medicare spending. Some proposals would increase premiums for everyone in Medicare to cover a larger portion of the program’s costs. Under one proposal, the standard Medicare premiums would go up from 25 to 35 percent of program costs. If that proposal were to go into effect in 2012, the current $99.90 monthly premium for Medicare Part B paid by the typical beneficiary would cost 40 percent more, or an additional $40 per month. Part D premiums, which vary widely by plan and region, would increase similarly.

Pro: Increasing the basic premiums for Medicare Part B and Part D makes sense. It would help Medicare’s finances and can be done while protecting lower-income seniors. Parts B and D are voluntary “add-ons” to the Medicare coverage seniors receive for hospital services (also known as Part A), which Americans pay for through the payroll tax. A retired couple with, say, $120,000 of annual income from investments is certainly better able to pay a higher proportion of B and D costs than their $50,000-a-year working-age neighbor can pay in taxes, so it would make sense to raise premiums for many older people with incomes below the level where Medicare currently charges higher premiums. (Stuart Butler, Heritage Foundation)

Con: Some upper income Medicare beneficiaries can afford—and already pay—more than the normal premium. But for too many seniors, even current premiums are burdensome. Across-the-board premium increases would hit elderly and disabled single persons with incomes barely above $15,000 and couples with incomes above $23,000 who can ill afford higher charges. Raising premiums across-the-board is a terrible idea. (Henry J. Aaron, Brookings Institution)
Strengthen the Independent Payment Advisory Board (IPAB)

The IPAB is a group of 15 health experts (generally appointed by the president and approved by the Senate) who are required to recommend ways to hold down Medicare spending growth if that growth exceeds a certain limit. The IPAB has the authority to reduce payments to some Medicare providers (e.g., hospitals, doctors), but it cannot raise beneficiary premiums or reduce their benefits. Some proposals would change the law to give the IPAB more authority so it could also reduce benefits, while other proposals would further limit the amount of Medicare spending growth, which could require the IPAB to further reduce spending on doctors, hospitals and other health care providers. Some would eliminate the IPAB altogether.

**Pro:** The IPAB is a promising way to limit the growth of Medicare spending without rationing care or cutting access to care by the elderly and disabled. It should be retained and strengthened so it can improve incentives for doctors, hospitals and other providers to deliver higher-quality care at reasonable cost. Some members of Congress want to kill the IPAB even before it goes to work because of a mistaken belief that it usurps Congressional authority. It does not. Congress remains free to reverse any recommendations that the IPAB makes. It could even kill the IPAB with new legislation. But the creation of the IPAB expresses a Congressional commitment to an important goal—slowing the growth of health care spending. *(Henry J. Aaron, Brookings Institution)*

**Con:** The IPAB was created in the new health law to cap total Medicare spending so it grows only a little more each year than the economy grows. To accomplish this, the 15 unelected board members will be able to cut payments each year to your physicians, hospitals or Medicare plan provider by however much it takes to stay under the spending cap. If Congress can’t agree on its own package of cuts, the board’s cuts will go into place automatically and nobody—not the courts or even Congress itself—can stop them. This board should not be strengthened. It should be dismantled. *(Stuart Butler, Heritage Foundation)*
Redesign Medicare’s Copays and Deductibles

Medicare Part A pays for inpatient hospital, skilled nursing facility, hospice and home health care. Part B pays for physician and outpatient services (excluding prescription drugs). Part A and Part B have different cost-sharing and deductibles. Under Part A, beneficiaries who receive inpatient hospital services pay a deductible ($1,156 in 2012) in each benefit period, and there is no initial cost-sharing for hospital stays under 60 days. In contrast, the annual deductible for Part B services is $140, and beneficiaries must pay 20 percent of their costs after meeting their deductible. Some proposals would combine the Part A and Part B programs to have only one deductible (for example, $550) and one coinsurance (for example, 20 percent) for all Part A and Part B services. Currently, there is no annual upper limit on out-of-pocket expenses for Part A or Part B. Some proposals would set an out-of-pocket limit.

**Pro:** Redesigning Medicare copayments and deductibles could simplify and streamline benefits for beneficiaries. If an annual out-of-pocket spending cap were included in this redesign, Medicare beneficiaries—particularly those with high utilization—would have more financial protection from expenses caused by severe and often unexpected illnesses. This could also reduce the need for supplemental insurance, such as Medigap. While most beneficiaries likely will not reach the out-of-pocket limit in a given year, knowing that the limit exists could give them a greater sense of financial security. Redesigning Medicare cost-sharing could also create savings for the federal government by making beneficiaries more price-sensitive in using health care services, resulting in lower utilization and greater Medicare savings. *(Avalere Health)*

**Con:** Many Medicare beneficiaries would end up paying more out of their own pocket if Medicare cost-sharing is combined across parts A and B. Seniors with higher hospital utilization could be adversely affected by proposals that apply coinsurance to the first 60 days of a hospital stay. In addition, Medicare beneficiaries with modest incomes or no supplemental coverage could find it difficult to afford these cost-sharing requirements. These seniors may decide not to get the medical care they need in order to avoid paying coinsurance or deductible amounts, which could lead to poorer health outcomes and, in the long run, higher Medicare costs. *(Avalere Health)*
Address the Sustainable Growth Rate (Physician Payment) Formula

In 1997, the law established a new formula for paying Medicare doctors. The goal of the “Sustainable Growth Rate” (or SGR) was to reduce health care costs by setting limits on how much doctors who treat Medicare patients could be paid. Fees have not been reduced in recent years, as the SGR formula calls for, because Congress has repeatedly intervened to prevent payment reductions. There are several proposals to reform the Medicare doctor payment system. Some proposals include freezing payments for primary care physicians while temporarily decreasing rates for specialists. Maintaining current payment rates for Medicare doctors would cost $316 billion over 10 years, according to the Congressional Budget Office.

Opinion: The SGR formula was flawed from the beginning. The physician fee cuts that it calls for cannot be implemented. That formula should be replaced with payment rules that encourage more doctors to provide primary care. *(Henry J. Aaron, Brookings Institution)*

Opinion: Doctors who take Medicare patients rightly complain bitterly about a government payment rule that is designed to cut their fees automatically every year to keep Medicare spending on doctors within a budget. This rule needs to be eliminated and other steps taken to prevent the future cost of Medicare from skyrocketing. *(Stuart Butler, Heritage Foundation)*

“I want Medicare to be there for my kids.”
Increase Penalties for Health Care Fraud

Estimates show that waste and fraud in the health care system cost taxpayers tens of billions of dollars every year. Proposals to reduce fraud include increasing the penalties for fraudulent activities, such as the illegal distribution of Medicare patient and provider information.

**Pro:** Increasing penalties on providers and others who commit fraud can reduce such behavior and lead to substantial savings. Dollar for dollar, addressing fraud in this way is an effective strategy compared to other approaches. For every dollar spent on such activities over the past three years, the federal government has collected more than seven dollars in return. *(Avalere Health)*

**Con:** There is little evidence that fraud is deterred by harsher sanctions. People who commit fraud may not care about sanctions or may gamble that the payoff is worth the risk—even if the penalty for fraud is substantially increased. In addition, the threat of harsher sanctions may intimidate physicians and other providers who fear they may be prosecuted for innocent mistakes. Some providers may stop participating in Medicare or other health care programs to avoid the hassle and expense of an audit. *(Avalere Health)*

“I’m counting on Medicare being there when I retire.”
Allow Faster Market Access to Generic Versions of Biologic Drugs

Expensive biologic drugs (medications made from living organisms) are used to treat conditions like cancer, rheumatoid arthritis and multiple sclerosis. These types of drugs currently provide manufacturers with 12 years of exclusive market access before generic versions (known as biosimilars) can enter the market. This proposal would reduce the exclusivity period to seven years. Because generic medications have a lower retail cost, this would save money for Medicare and its beneficiaries.

**Pro:** Under the new health care law, brand-name biologic drug manufacturers are allowed to sell their products without any competition for 12 years. This period is excessive and should be shortened in order to encourage lower prices and maximize savings for consumers and Medicare. Allowing seven years of market exclusivity is more than enough time to give manufacturers a monopoly to recoup their development costs. *(Avalere Health)*

**Con:** Drug companies have raised concerns that reducing the market exclusivity period could slow the development of new biologic drugs because it will reduce the number of years that the manufacturer is able to make money from the product to recover its research and development costs. If drug companies believe they won’t be able to recoup their costs, it may reduce their incentive to develop biologics that could be used to treat many of the diseases faced by Medicare enrollees. *(Avalere Health)*

Enroll All Beneficiaries Covered by Both Medicaid and Medicare in Managed Care

Approximately 9 million low-income older and disabled people are covered by both Medicaid (a federal-state program that provides assistance to low-income people) and Medicare. These people are referred to as “dual eligibles.” Because Medicare and Medicaid have different coverage rules and provider access, and dual eligibles are generally a less healthy population, there are higher costs and greater challenges in providing health care for this population. Proposals include requiring all low-income older people to enroll in a managed care plan, which means the care they receive would need to come from doctors and hospitals in the provider network for that managed care plan.
**Pro:** All low-income seniors should be required to enroll in a managed care plan to reduce confusion for beneficiaries about what is covered, improve the care they receive through better coordination among their many doctors and providers, and lower costs for the Medicare and Medicaid programs. Currently, people with both Medicare and Medicaid receive their health care through two programs, with different rules and different networks of doctors and providers. Better management of care could reduce wasteful or unnecessary use of health services and could reduce medical complications that can lead to more expensive care and treatment. By some estimates, these savings could amount to well over $100 billion for Medicare and Medicaid. With these savings, some managed care plans may even be able to offer additional patient services and support, such as free dental services or access to nurse help telephone lines. *(Avalere Health)*

**Con:** It is wrong to force low-income Medicare beneficiaries into managed care plans while those with higher incomes are allowed to keep their current doctors and other health care providers in the traditional Medicare program. In addition, it is unclear whether managed care will even reduce costs. In fact, some studies even show that federal costs go up when Medicare beneficiaries are enrolled in managed care. There are other ways to improve care and reduce costs for people with both Medicaid and Medicare that do not require enrollment into a managed care plan. For example, some states allow beneficiaries to remain in traditional Medicare but pay a primary care physician an extra fee to coordinate and manage the patient’s care. These programs have demonstrated some success in improving care and reducing costs for individuals with Medicare and Medicaid. Such options—which do not require giving up one’s doctor—are better alternatives to mandatory enrollment into managed care. *(Avalere Health)*

“**Medicare needs to be strengthened for the future.**”
Prohibit Pay-for-Delay Agreements

Brand-name pharmaceutical companies can delay generic entry into the marketplace by compensating a generic competitor for holding its competing product off the market for a certain period of time. Some proposals would prohibit brand-name and generic pharmaceutical manufacturers from entering into these “pay-for-delay” agreements.

**Pro:** Prohibiting drug companies from entering into pay-for-delay agreements will help get less expensive generic drugs to the market more quickly, leading to substantial savings for consumers and government programs like Medicare and Medicaid, as generic drugs can cost up to 90 percent less than their brand-name counterparts. Prohibiting pay-for-delay agreements could also improve patient health. Access to generic drugs has been shown to increase medication adherence, which is particularly important for individuals with chronic health problems who rely on multiple medications to help stabilize and manage their conditions. Medicare beneficiaries who fail to take their medications as prescribed are more likely to have costly health complications, creating additional costs for patients and the Medicare program. *Avalere Health*

**Con:** Pay-for-delay agreements are an efficient and cost-effective way for pharmaceutical companies to resolve expensive patent lawsuits. If pay-for-delay agreements are prohibited, generic drugs could actually be kept off the market for a longer period of time, since it can take years to resolve patent litigation through the court system. In addition, prohibiting pay-for-delay agreements could also affect generic manufacturers’ willingness to challenge brand-name drug patents, reducing the number of generic drugs that become available before their brand-name counterparts go off patent. There is little proof that pay-for-delay agreements prevent generic competition. In fact, a majority of pay-for-delay agreements allow generic drugs to enter the market before the brand-name patent has expired. It is also important to ensure that the innovations of brand-name drug manufacturers are adequately protected by patents. Without this security, pharmaceutical companies may be less likely to invest money in the research and development of new drugs. *Avalere Health*
To join the conversation about the future of Medicare, go to **earnedasay.org**.