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Issue Brief

A Medicare Prescription Drug Benefit: Focusing on Coverage and Cost

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Introduction

Pharmaceuticals are a critical element of modern medical treatment, yet the traditional Medicare benefits package does not include coverage of outpatient prescription drugs. This omission is significant because the 38.1 million people who comprise the Medicare population are disproportionately likely to use drugs. The elderly represent 14 percent of the U.S. population but account for more than one-third of total prescription drug expenditures.[1] Almost all Medicare beneficiaries use pharmaceuticals on a regular basis and on average had 22 prescriptions filled in 1998.[2] Beneficiaries' reliance on prescription drugs is jeopardized by the high and rising cost of drugs. This rise in spending has been attributed to a number of factors, including higher utilization, drug price inflation, the proliferation of new and more expensive drugs, and the increase in direct-to-consumer marketing by drug manufacturers.

Most Medicare beneficiaries (approximately 75 percent) obtain assistance with the cost of outpatient prescription drugs, but more than one-fourth (10.2 million) lack any source of prescription drug coverage.[3] Of those with drug coverage in 1998, approximately 20 percent were covered for only part of the year.[4] Many of those with supplemental drug coverage have it as part of their retiree benefits package. Some have enrolled in Medicare+Choice managed care plans that include a prescription drug benefit. Others purchase a Medigap policy that includes drug coverage. Eligible beneficiaries can obtain state-based coverage through Medicaid (since every state currently opts to provide prescription drug benefits) or state drug assistance programs. Other public sources for those who are eligible

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The 27 percent of Medicare beneficiaries who do not, or cannot, take advantage of supplemental coverage must pay out of pocket for their prescription drugs. In 1996, average out-of-pocket spending for beneficiaries without drug coverage was 83 percent more than for those with coverage ($463 versus $253).[5] While those beneficiaries with drug coverage pay less out of pocket on average, many have only partial coverage. As a result, prescription drugs accounted for nearly one-fifth of total beneficiary out-of-pocket expenses in 1997.[6] In 2001, out-of-pocket drug spending among Medicare beneficiaries is estimated to average about $850, with 27 percent of beneficiaries expected to pay more than $1,000. Meanwhile, many existing sources of coverage (e.g., employers who offer retiree health benefits) are scaling back these benefits or dropping them altogether in response to the rising costs of prescription drugs.[7] Increasing out-of-pocket drug costs and the instability of supplemental coverage have led to calls for expanding Medicare to include coverage for prescription drugs.

Variations in Drug Coverage

As mentioned above, beneficiaries can supplement the standard fee-for-service Medicare benefits package in various ways to obtain prescription drug coverage. In 1998, 33 percent of beneficiaries received drug coverage as part of retiree benefits packages provided by former employers, 15 percent enrolled in Medicare HMOs, 10 percent purchased private Medigap policies, 12 percent qualified for Medicaid coverage (the "dually eligible" population), and 3 percent obtained supplemental coverage from other public sources, such the Departments of Veterans Affairs and Defense and state drug assistance programs. While this distribution has likely shifted over the past few years, partly because of the changing share of the Medicare population enrolled in managed care plans, the variation persists in sources of coverage for prescription drug benefits.

Along with variation in the source of coverage, there are substantial differences in beneficiaries' cost-sharing responsibilities and in the comprehensiveness of the drug benefit. Generally speaking, drug coverage offered through employer-sponsored retiree benefits and state Medicaid programs tends to be relatively generous, while in recent years many Medicare managed care plans have imposed benefit caps and increased beneficiary cost-sharing amounts. Coverage obtained through individually purchased private Medigap policies often requires high copayments and deductibles. Of the 6 million beneficiaries covered by Medigap policies in 1999, the vast majority (90 percent) had no drug coverage as only three of the 10 standardized policies provide outpatient drug coverage and at a comparatively high premium. Indeed, in some cases it appears as if the difference in premium is greater than the benefit payable under the policy even if the maximum were spent on drugs.[8]

Of the more than 10 million Medicare beneficiaries without any form of prescription drug coverage in 1998, about half had incomes below 175 percent of poverty ($14,088 for an individual in 1998), and more than 25 percent were in fair or poor health.[9] These disparities in drug coverage by income level and health status are of particular concern because beneficiaries who need but cannot afford supplemental coverage will incur out-of-pocket expenses that consume a larger share of their incomes than wealthier beneficiaries. Beneficiaries without drug coverage are also less able to purchase drugs at volume-discounted prices than those with coverage, and therefore are likely to pay more in absolute terms for prescription drugs.

Coverage Under Medicare Managed Care

The Balanced Budget Act of 1997 established the Medicare+Choice program, broadening the array of managed care products available to the Medicare population. Prescription drug coverage is relatively common among the 5.6 million beneficiaries (14 percent of the Medicare population) enrolled in some type of managed care plan. Two-thirds of Medicare+Choice enrollees are offered at least some coverage for prescription drugs; this share has declined from 84 percent in 1999.[10]

The generosity of prescription drug benefits offered by Medicare managed care plans varies dramatically across plans, managed care products, and market areas. The proportion of enrollees with drug coverage under Medicare+Choice is declining, while copayments, limits on the comprehensiveness of benefits, and overall premiums for these plans are increasing.[11] Thus, having drug coverage through Medicare+Choice

does not necessarily protect enrollees from shouldering substantial out-of-pocket costs. For example, in 2001 only a small share of enrollees (11 percent) faced no annual cap on drug benefits, while 38 percent were subject to a cap of $750 or less, up from 21 percent in 1999. More than 90 percent of beneficiaries were enrolled in plans that use a formulary (a list of preferred drugs that may be prescribed), while more than one-quarter paid a copayment of $20 or more for brand-name drugs. Despite these growing limitations on the extent of drug coverage under Medicare+Choice, increasing the share of beneficiaries who enroll in managed care plans has figured centrally in proposals to expand prescription drug coverage and in the broader attempts to reform the Medicare program.

Federal Proposals for Adding Drug Coverage to Medicare

Recent attempts to add prescription drug coverage to the Medicare program are not without historic precedent. Proposals for including prescription drug coverage in the Medicare benefits package were considered during the program's initial design, but the idea was ultimately shelved, only to be raised again amid debate over the Social Security Amendments of 1972, over national health insurance in the 1970s, over the Medicare Catastrophic Coverage Act (MCCA) of 1988, and again over the Clinton Health Security Act in 1993-1994. While the MCCA succeeded in enacting a drug benefit for Medicare beneficiaries, it was never implemented. The legislation was repealed in 1989 as a result of opposition by the elderly and various interest groups to the financing of the benefit.

In Congress, there is broad bipartisan support for covering prescription drugs for Medicare beneficiaries on a voluntary basis, but disagreement over the details of how to provide coverage. Proposals have differed in terms of what the benefit would include and whom it would cover. For instance, determining eligibility for prescription drug assistance through Medicare could be based solely upon a beneficiary's income in relation to the federal poverty level.[12] However, using such a criterion to define need could exclude those beneficiaries who lack access to affordable or stable drug coverage, who incur high out-of-pocket drug costs, or who are older or in poor health. Other differences include how the benefit would be structured and financed. While some have proposed folding a drug benefit into Medicare's Part B, others have advocated the creation of a Medicare Part D for prescription drug coverage alone. Still others have proposed that, in lieu of creating a separate financing mechanism altogether, beneficiaries and/or pharmacies serving them be allowed to purchase drugs at the same discounts offered to the federal government and to managed care plans that receive volume discounts for prescription drugs. Choices about financing also have to be made, including the extent to which beneficiaries should be liable in terms of premiums, deductibles, and copayments, and whether the requisite additional public dollars should come from payroll taxes or general revenues or from both.

Major legislative proposals assign responsibility for administering the drug benefit to pharmacy benefit managers (PBMs). PBMs are commonly used in the private sector to process pharmaceutical claims on behalf of health plans and employers, and to manage drug utilization and negotiate price discounts with drug manufacturers and retail pharmacies.[13] By performing these functions, it has been argued, PBMs can limit the cost and enhance the quality of a Medicare prescription drug benefit. Many Medicare beneficiaries who are enrolled in a managed care plan or who have drug coverage through a retiree plan already have their drug benefits managed by PBMs.[14] Techniques for managing drug costs include designing closed or limited formularies, performing drug utilization review, and steering patients to generic, less expensive, or more cost-effective drugs. The application of these techniques would result in a less expensive Medicare prescription drug benefit than if there is less control imposed on drug use. However, the feasibility and appropriateness of applying these private sector cost-control techniques to elderly and disabled Medicare beneficiaries, whose demand for prescription drugs has not been constrained previously, are difficult to determine.

While a comprehensive approach to reforming the Medicare program and adding a prescription drug benefit may have to await a more favorable economic and political climate, efforts are underway at the federal and state levels and in the private sector to increase the affordability and accessibility of prescription

drugs. President Bush has proposed creating a pharmacy discount card program for Medicare beneficiaries, using PBMs to administer the discounts. Under this plan, PBMs would negotiate discounts with pharmaceutical manufacturers of 15 percent to 25 percent off retail prices. These savings would be passed on to Medicare beneficiaries who purchase a discount card from a PBM at a cost of no more than $25. However, a lawsuit was filed by pharmacy groups in July 2001 to block implementation of the program, alleging that the administration lacks authority to execute the plan without first obtaining congressional approval. The Bush administration responded by filing a motion to stay all court proceedings related to the drug program, while it initiates the federal notice and comment process. A federal injunction that prevented the start of the program was lifted in November. Centers for Medicare and Medicaid Services (CMS) received 28 applications from pharmacy benefit managers to implement the program and can continue with the process now that the injunction has been lifted.[15]

State-Based Prescription Drug Programs

At the state level, prescription drug subsidy or discount programs have been implemented in 31 states to date.[16] The majority of these programs (26) use state funds to provide for a direct subsidy of a portion of drug purchases for eligible recipients, while the remainder offer only a discount on the purchase price of prescription drugs for eligible or enrolled seniors. The National Conference of State Legislatures reports that, as of April 2001, more than 290 individual bills had been filed to create, expand, or amend such assistance programs.[17]

States have taken different approaches to the design of these programs. Some have organized statewide and regional buying clubs and purchasing cooperatives, while others have negotiated bulk purchasing agreements that obtain price discounts from pharmacies and drug manufacturers. Some states extend discounted Medicaid prescription drug prices to Medicare beneficiaries, or extend the lowest market rate to seniors based on the federal ceiling prices for drugs listed in the Federal Supply Schedule (which mandated minimum drug discounts for specified federal agencies).[18] While state drug assistance programs fill a gap in the Medicare program by enhancing the accessibility and affordability of prescription drugs, the overall effects of these programs are difficult to assess and may be limited, given the cross-state variation in program design and eligibility requirements.

The Role of the Pharmaceutical Industry

The pharmaceutical industry is concerned about seniors' inability to afford outpatient prescription drugs and supports expanding drug coverage for Medicare beneficiaries. The industry endorses federal legislation that relies on private entities to deliver the prescription drug benefit.[19] The primary concern with a benefit that does not involve competition and choice in the private market is that the federal government would implement price controls to limit the cost of the benefit. The industry argues that price controls could reduce the funding available for research and development of new drugs.[20] The industry also opposes allowing wholesalers and pharmacists to reimport less expensive, U.S.-made drugs from abroad, arguing that drug companies could not verify the safety or purity of reimported drugs.[21]

While the legislative debate continues over the drug benefit, the pharmaceutical industry has implemented some programs to improve the accessibility and affordability of drug coverage for Medicare beneficiaries. Many manufacturers established patient drug assistance programs to provide their medications free of charge to physicians whose patients could not afford them. Eligibility rules vary from one company to another. Drug makers GlaxoSmithKline and Novartis created drug discount card plans similar to what President Bush proposed. The GSK program lets low-income beneficiaries without drug coverage purchase most of the company's drugs at discounts of at least 25 percent. Under Novartis's program, seniors who have low incomes and no other drug coverage will qualify for a 25 percent discount on the wholesale price of Novartis drugs. Depending on the experience of GSK and Novartis, other manufacturers say they may create similar programs.[22] However, there is some concern about the extent to which these voluntary private-sector programs can expand drug access among the elderly.[23]

The Cost of a Prescription Drug Benefit

Medicare beneficiaries are increasingly reliant on pharmaceuticals, as indicated by the fact that prescription drug spending per enrollee is estimated

to increase from $1,989 in 2002 to $4,818 in 2011, an annual rate of change of 10.3 percent.[24] Over that same period, spending for Medicare benefits per enrollee is expected to rise by only 5.7 percent. The growing costs, availability, and use of prescription drugs make any proposal to offer a Medicare drug benefit increasingly expensive. According to the Congressional Budget Office (CBO), major plans debated in the 106th Congress would have required from $138 billion to $405 billion in direct federal spending between 2004 and 2011.[25] CBO estimates that a basic Medicare drug benefit would cost $1.5 trillion over the period 2001-2010.[26] The final cost ultimately depends on such details as how the benefit is structured and administered, the generosity of the coverage, and how the benefit is financed.

Conclusion

Designing an effective and politically popular Medicare prescription drug benefit remains a significant policy challenge. A viable prescription drug benefit would provide meaningful levels of coverage for Medicare beneficiaries across a range of health care needs and income levels. It also would balance public- and private-sector entities' responsibilities for delivering and administering these benefits, and accommodate the existing patchwork of benefits, funding sources, and service-delivery mechanisms. As the passage and subsequent repeal of the MCCA demonstrated, building and maintaining popular support for the addition of a benefit from which only some individuals gain, and for which all may have to pay in one form or another, requires substantial effort.

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