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Issue Brief

A Medicare Prescription Drug Benefit: Issues and Options

JULIETTE CUBANSKI, JOHN F. KENNEDY
SCHOOL OF GOVERNMENT

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For more information, please contact:

Mary Mahon
Public Information Officer
The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Tel 212.606.3853
Fax 212.606.3500

E-mail mm@cmwf.org

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Introduction

Pharmaceuticals are an integral part of modern medical treatment, often improving quality of life and reducing the need for hospitalization, yet the traditional Medicare benefits package does not include coverage of outpatient prescription drugs. When Medicare was created in 1965, insurance coverage for prescription drugs was not standard and fewer effective pharmaceutical treatments were available. Yet, the practice of medicine has changed dramatically since that time and prescription drug coverage is now a common feature of private insurance. Almost every one of Medicare's 40 million beneficiaries uses pharmaceuticals regularly, filling an average of 30 prescriptions in 1999.¹ The elderly are disproportionately likely to use drugs, representing less than 15 percent of population but accounting for 40 percent of prescription drug expenditures.² While most Medicare beneficiaries have assistance paying for outpatient prescription drugs, four of 10 (38 percent) had no drug coverage in the fall of 1999, while 25 percent lacked coverage for the entire year.^{3,4} 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 low-income beneficiaries can obtain state-based coverage through Medicaid (since every state currently opts to provide prescription drug benefits) or some states' pharmacy assistance programs. Other public sources for those who are eligible include the Department of Veterans Affairs and Department of Defense. Medicare beneficiaries without drug coverage fill fewer prescriptions and face higher out-of-pocket drug costs than those with coverage. In 1999, those without drug cover-

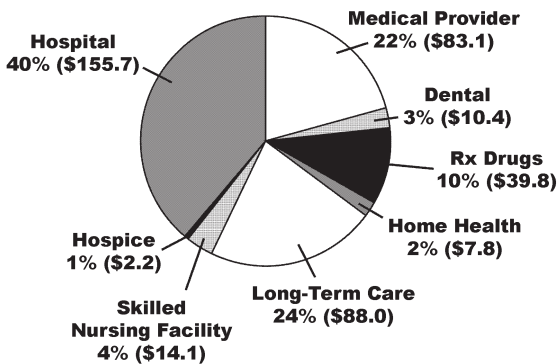
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age filled an average of seven fewer prescriptions than did those with coverage (25 versus 32).⁵

While lack of coverage is a major policy concern, the rising cost of drugs jeopardizes the reliance on prescription drugs by all beneficiaries. According to the Congressional Budget Office (CBO), total drug spending by Medicare beneficiaries will grow from \$87 billion in 2002 to \$278 billion in 2012, totaling \$1.8 trillion over the 2003–2012 period. CBO estimates that prescription drug spending per enrollee will increase from \$2,439 in 2003 to \$5,816 in 2012, an annual rate of increase of 10.1 percent.⁶ Over that same period, spending for current Medicare benefits per enrollee is expected to rise by only 5.3 percent. The rise in drug 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. As drug expenditures rise, some existing sources of coverage (e.g., employers who offer retiree health benefits) are scaling back drug coverage benefits or dropping them altogether in response to rising costs.⁷ Increasing total and out-of-pocket drug spending and the instability of supplemental coverage have led to calls for expanding Medicare to include coverage for prescription drugs.

Figure 1. Total Health Care Expenditures for Medicare Beneficiaries, 1999

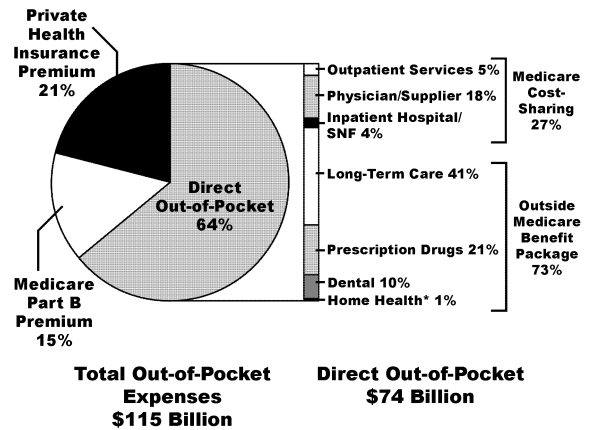
Total Health Care Expenditures = \$385.2 Billion



Note: Premium payments are excluded.
Source: CMS, Office of Research, Development, and Information. Data from Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Figure 2. Medicare Beneficiary Out-of-Pocket Spending, 1999

The majority of beneficiary out-of-pocket spending is for Medicare cost-sharing and payment for non-covered services



* Home health services not covered by Medicare.
Notes: 1) Data are for all beneficiaries, both fee-for-service and Medicare+Choice enrollees.
2) Total per capita direct out-of-pocket spending is \$1,825.
Source: CMS, Office of Research, Development, and Information. Data from Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Medicare Prescription Drug Coverage and Spending

Beneficiaries can supplement the standard fee-for-service Medicare benefits package in various ways to obtain prescription drug coverage. In 1999, 32 percent of beneficiaries received coverage as part of retiree benefits packages provided by former employers, 16.8 percent had coverage through Medicare HMOs, 12 percent purchased private Medigap policies, 12 percent qualified for Medicaid coverage (the “dually eligible” population), and 4 percent obtained supplemental coverage from other public sources, such as the Departments of Veterans Affairs and Defense and state pharmaceutical assistance programs.⁸

The prevalence of drug coverage varies by demographic and socioeconomic characteristics such as age and income.⁹ Lack of drug coverage disproportionately affects beneficiaries living in rural areas, the near-poor (those just above income eligibility for Medicaid), and the oldest of the elderly. Differences in coverage rates by self-reported health status are not statistically significant, but almost four of 10 of those in any health status category lack coverage. Lack of drug coverage is higher for Medicare beneficiaries with no chronic conditions than for those with five or more chronic conditions (42.6 percent versus 32.2 percent).¹⁰

While most Medicare beneficiaries receive some assistance paying for prescription drugs, this coverage may be incomplete or unstable. Depending on their source of coverage, beneficiaries may face potentially substantial up-front costs, including high premiums, copayments, and deductibles, and spending caps that limit the extent of their protection from catastrophic (or even moderate) drug expenses. Generally speaking, drug coverage offered through employer-sponsored retiree benefits and state Medicaid programs tends to be relatively generous, while coverage obtained through individually purchased private Medigap policies tends to be less generous. Although all state Medicaid programs cover prescription drugs for Medicare beneficiaries whose income and assets fall below certain thresholds, there is considerable variation in the drug benefits they offer. Also, while 10.7 million Medicare beneficiaries had one of 10 standard Medigap policies in 1999, only about 25 percent have purchased drug coverage through Medigap.^{11,12} Only three of the 10 plans provide outpatient drug coverage, and these provide these benefits at comparatively high premiums that vary widely within and across markets.¹³ Indeed, in some cases it appears as if the premium is greater than the benefit payable under the policy even if the maximum were spent on drugs.¹⁴

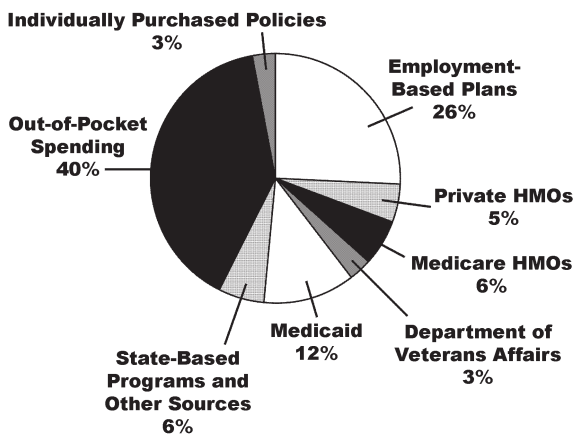
The Balanced Budget Act of 1997 established the Medicare+Choice program, broadening the array of managed care products available to the Medicare population. Prescription drug coverage has been a standard benefit offered by Medicare HMOs, but is increasingly less common.¹⁵ Among the 5 million beneficiaries (13 percent of the Medicare population) enrolled in Medicare+Choice plans, 71 percent were offered at least some coverage for prescription drugs in 2002—down from 84 percent in 1999.¹⁶ In recent years reimbursement increases for Medicare+Choice managed care plans have been limited to 2 to 3 percent, which, given the more rapid rate of increase in prescription drug spending, has led many plans to impose benefit caps and increase beneficiary cost-sharing amounts. Also, drug benefits offered by Medicare managed care plans vary dramatically across plans, managed care products, and market areas.¹⁷ In 2002, only 2 percent of Medicare+Choice enrollees with drug coverage faced no annual cap, while nearly 60 percent were subject to a cap of \$750

or less—up from 21 percent in 1999.¹⁸ Nine of 10 beneficiaries were enrolled in plans that use a formulary (a list of preferred drugs that may be prescribed), 20 percent paid a copayment of \$10 or more for generic drugs, and 80 percent paid a copayment of \$20 or more for brand-name drugs.¹⁹ The use of formularies and copayments is not restricted to Medicare+Choice plans, however. For example, Medigap plans that include drug coverage have an annual deductible of \$250, require cost-sharing of 50 percent, and limit yearly benefits to either \$1,250 or \$3,000.

CBO estimates that in 1999, total out-of-pocket spending by Medicare beneficiaries on outpatient prescription drugs was \$19.4 billion—or roughly 20 percent of total out-of-pocket expenses for all Medicare beneficiaries.^{20,21} (It is important to note that there is some uncertainty associated with out-of-pocket spending estimates, primarily because of underreporting of drug use and spending in the survey data.) Having a supplementary source of drug coverage does not necessarily protect enrollees from shouldering substantial out-of-pocket costs.²² On average, 40 percent of Medicare beneficiaries' total drug expenditures came from their own pockets in 1999; employment-based plans covered the next largest share (26 percent), followed by Medicaid (12 percent).^{23,24}

Medicare beneficiaries who do not, or cannot, take advantage of supplemental coverage

Figure 3. Sources of Payment for Medicare Beneficiaries' Prescription Drugs, 1999



Source: Congressional Budget Office based on data from Medicare Current Beneficiary Survey.

must pay out-of-pocket for their prescription drugs. In 1999, total drug spending for beneficiaries without coverage was half of what people with some form of drug coverage spent (\$617 versus \$1,131). Non-covered beneficiaries pay substantially more out-of-pocket costs—on average, 75 percent more than those with coverage (\$617 versus \$352).²⁵ Beneficiaries without coverage pay more in absolute terms for prescriptions (\$33 versus \$13 per prescription), because they are less able to purchase drugs at volume-discounted prices than those with coverage. The growing burden of out-of-pocket drug spending and the increasingly limited nature of supplemental drug coverage have led to a variety of proposals to add outpatient prescription drug coverage to Medicare.

Proposals for Adding Outpatient Prescription Drug Coverage to Medicare

Attempts to add prescription drug coverage to the Medicare program are not without precedent. Proposals for including drug coverage 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 how the benefit was financed.

In the 107th Congress (2001–2002), there was broad bipartisan support for covering outpatient prescription drugs for Medicare beneficiaries, but disagreement over the details. The major proposals that were considered all established a voluntary drug benefit under a new Part D of Medicare. Beneficiaries would assume specified costs of the new benefit in the form of premiums and cost-sharing charges, with subsidies available to those with low incomes.

In June 2002, the House voted on and passed a Republican-sponsored proposal, H.R. 4954 (the Medicare Modernization and Prescription Drug Act of 2002). A House Democratic bill, H.R. 5019 (the Medicare Rx Drug Benefit and Discount Act of 2002), was

not debated. The House-passed bill would add voluntary drug coverage to Medicare as a drug-only benefit provided by private insurance companies. Plan sponsors would establish a monthly premium to be paid by beneficiaries, which would be subject to approval by HHS. After paying a \$250 deductible, beneficiaries would pay 20 percent of total drug expenses up to \$1,000, 50 percent of costs between \$1,000 and \$2,000, and 100 percent of costs between \$2,000 and \$3,700. After reaching this out-of-pocket spending threshold, the insurance plan would cover 100 percent of drug costs. The House-passed bill also included a full premium subsidy and reduced coinsurance for elderly with incomes up to 150 percent of poverty. The benefit would be administered by a new Medicare Benefits Administration.

Following passage of H.R. 4954 in the House, the Senate debated and voted on a number of proposals during July 2002, but did not reach agreement. Three proposals to add a prescription drug benefit to Medicare were considered:

- S. 2625, the Medicare Outpatient Prescription Drug Act of 2002 (also introduced as S.Amdt. 4309 to S. 812, and sometimes referred to as the Graham amendment)
- S. 2729, the 21st Century Medicare Act (sometimes referred to as the “tripartisan bill”)
- Medicare Prescription Drug Cost Protection Act of 2002 (S.Amdt. 4345 to S. 812, also known as the Graham-Smith amendment)

The Senate also voted on a bill to create a prescription drug discount card program (S. 2736, the Medicare Rx Drug Discount and Security Act of 2002). This measure also failed to pass.

There are major differences among the House and Senate bills. A key issue is the degree of reliance and financial risk placed on the private sector. The House-passed bill (H.R. 4954) and the S. 2729 would rely on private entities to provide benefits and would require plans to assume some of the financial risk for the cost of covered benefits. Under H.R. 5019 (the House Democratic alternative) and the Graham and Graham-Smith amendments in the Senate, the benefit would be administered by the federal government as part of the Medicare program and the government would bear most of the financial risk of coverage. Other differences

include the definition and scope of benefits, the way in which the benefit would be administered, the amount of drug spending the government would subsidize, the required amounts for beneficiary cost-sharing, and the level and implementation of subsidies for low-income beneficiaries.

The growing costs, availability, and use of prescription drugs make any proposal to offer a Medicare drug benefit increasingly expensive. The Congressional Budget Office estimates that a basic Medicare drug benefit would cost \$1.8 trillion over the period 2003–2012.²⁶ According to CBO, major plans debated in the 107th Congress would have required from \$309 billion to \$594 billion in direct federal spending between 2005 and 2012.²⁷ The final cost ultimately depends on such details as how the benefit is structured and administered, how generous the coverage is, and how the benefit is financed.

Current Federal and State Prescription Drug Coverage Initiatives

While the congressional debate regarding a prescription drug benefit to Medicare continues, efforts are under way at the federal and state levels and in the private sector to increase the affordability and accessibility of prescription drugs for Medicare beneficiaries. In September 2002, the Bush administration issued a final regulation establishing the Medicare-Endorsed Prescription Drug Card Assistance Initiative, a discount program for beneficiaries. Under this program, the Department of Health and Human Services (HHS) would endorse private discount card programs that meet certain federal qualifications, including the negotiation of discounts with drug manufacturers on at least one drug in each of 119 medical categories. The administration projects that up to 10 million beneficiaries would enroll, and realize average savings of 10 to 13 percent on their drug spending (an average of \$170 per year). However, in September 2001, a federal judge ruled that HHS did not have authority to implement the program without first obtaining congressional approval or issuing a specific regulation. Pharmacy groups that opposed the program when it was first announced in July 2001 are expected to continue their legal challenge. The Bush administration is pursuing implementation of the program, and says it expects Medicare-endorsed card programs to begin operating as soon as possible.²⁸

STATE INITIATIVES

At the state level, policymakers are taking steps to address gaps in prescription drug coverage among low-income, elderly populations. State pharmaceutical assistance programs are a small but important source of drug coverage for the Medicare population, primarily for low-income beneficiaries who are not eligible for Medicaid and lack other coverage. However, not all states have such programs. As of November 2002, 34 states had established or authorized prescription drug subsidy or discount programs, 27 of which have programs currently in operation.^{29,30} Most of these programs (26) use state funds to provide for a direct subsidy of a portion of drug purchases for eligible recipients, while eight states offer only a discount on the price of prescription drugs for eligible or enrolled seniors. In 2001, states appropriated \$1.5 billion for state pharmaceutical assistance programs. The National Conference of State Legislatures reports that in the 2001–2002 legislative sessions, at least 34 states introduced more than 300 bills that create, expand, or amend such assistance programs.³¹

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 discounts from pharmacies and manufacturers. Some states extend discounted Medicaid 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).³² While state pharmacy assistance programs fill a gap in the Medicare program by enhancing the accessibility and affordability of drugs, the overall effects of these programs are difficult to assess, given the cross-state variation in program design and eligibility requirements. In states with pharmacy assistance programs, enrollment in 2001 varied from less than 1 percent to more than 27 percent of a state's Medicare beneficiaries.³³ Enrollment is currently concentrated in three states (New York, New Jersey, and Pennsylvania).³⁴

In January 2002, the Bush administration announced a new federal initiative, Pharmacy Plus, designed to make it easier for states to use section 1115 waiver authority to expand Medicaid prescription drug coverage to low-income

Medicare beneficiaries. The initiative is targeted at beneficiaries with family incomes up to 200 percent of the federal poverty level (\$17,720 for an individual in 2002). The purpose of the Pharmacy Plus demonstration, according to HHS, is to provide a subsidized benefit that helps individuals maintain good health and avoid “spending down” to Medicaid eligibility.^{35,36} As with other types of section 1115 waivers, the expansion must be budget-neutral to the federal government; i.e., states must derive savings somewhere in their existing Medicaid program budget to pay for expansions in drug coverage. States that have existing senior pharmaceutical assistance programs and are willing to revise these programs to adhere to the Pharmacy Plus requirements can qualify for federal matching funds.³⁷ According to a recent survey, 18 states report that they are seeking or considering waivers for the Pharmacy Plus initiative.³⁸ As of December 2002, HHS had approved waiver programs in Florida, Illinois, Maryland, South Carolina, and Wisconsin. Applications from Arkansas, Connecticut, Indiana, Maine, Massachusetts, New Jersey, and Rhode Island were pending approval.³⁹

The Role of the Pharmaceutical Industry

Leaders of the pharmaceutical industry have stated that they support expanding drug coverage for Medicare beneficiaries. The industry endorses federal legislation that relies on competing, private insurance plans to deliver the benefit.⁴⁰ The industry’s stated 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. The industry argues that price controls could reduce the funding available for research and development of new drugs.⁴¹ The industry also opposes allowing wholesalers and pharmacists to reimport less expensive, American-made drugs from abroad, arguing that drug companies could not verify the safety or purity of reimported drugs.⁴²

The pharmaceutical industry has implemented some programs to improve the accessibility and affordability of drug coverage for Medicare beneficiaries. Many manufacturers established programs to provide medications free of charge to physicians whose patients could not afford them. Eligibility rules vary from one com-

pany to another. Some drug makers have created drug discount card plans similar to what has been proposed in the Medicare-Endorsed Prescription Drug Card Assistance Initiative. The Together Rx pharmacy discount card program was established by seven brand-name pharmaceutical companies in April 2002. Under Together Rx, Medicare beneficiaries who do not have drug coverage and have annual incomes up to \$28,000 for an individual and \$38,000 for a couple could receive discounts of 20 to 40 percent on their drug purchases. Approximately 380,000 beneficiaries have signed up for the Together Rx program.⁴³ Discount card programs also have been established by Eli Lilly and Pfizer, as well as by drugstore chains, including Eckerd, CVS, and Longs Drugs. However, there is some concern about the extent to which these voluntary, private-sector programs can expand drug access among the elderly, as well as decrease drug costs. Critics of the discount card approach are concerned that if discounts are not passed on to consumers or do not apply to all drugs, the benefit to users could be minimal. Moreover, drug cards are not a substitute for insurance coverage and do not offer the same level of risk protection that is currently available to many beneficiaries with drug coverage.

Conclusion

A growing number of beneficiaries have limited or no access to prescription drug coverage. As prescription drug spending and use have escalated, and the burden of paying for drugs has intensified, adding a drug benefit to Medicare has become a dominant focus of policymaking. Designing a Medicare prescription drug benefit that is both effective and fiscally sustainable has been a significant policy challenge. A viable prescription drug benefit would provide meaningful levels of coverage for 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.

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