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Medicare: Prescription Drug Coverage for Beneficiaries

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ABSTRACT

Medicare has a very limited prescription drug benefit. Most beneficiaries have some form of private or public health insurance to cover expenses not met by Medicare. However, many of these plans either do not offer drug coverage or offer very limited protection for drug expenses. As a result, beneficiaries pay approximately half of their total drug expenses out-of-pocket.

The absence of an adequate prescription drug benefit has been of continuing concern to policymakers. The projected cost of such a benefit has been a major deterrent to its implementation. Recently, the issue received renewed attention as part of the overall discussion of Medicare reform. There are a number of design issues facing any development of a Medicare prescription drug benefit. These include the scope of coverage and whether the protection should be extended to all beneficiaries or just the low income. The cost of a Medicare drug benefit would depend on its design. This report will be updated if Congress takes action on the issue.

Medicare: Prescription Drug Coverage for Beneficiaries

Summary

Medicare is a nationwide health insurance program which offers health insurance protection for 39 million aged and disabled persons. The program provides broad coverage for the costs of many, primarily acute, health services. However, there are many gaps in program coverage. The most notable shortcoming is the fact that Medicare has a very limited prescription drug benefit. Most beneficiaries have some form of private or public health insurance to cover expenses not met by Medicare. However, many of these plans either do not offer drug coverage or offer very limited protection for drug expenses. As a result, beneficiaries pay approximately half of their total drug expenses out-of-pocket.

The average drug expenditure for Medicare enrollees living in the community was $600 in 1995. Total spending for persons with some drug coverage was $691 compared to $432 for those with no coverage. The average expenditure per person varied widely, depending on the type of insurance coverage. In every category, spending was significantly higher for those who had supplemental drug coverage than for those who did not. Higher spending reflects higher usage rates. In 1995, persons with coverage used 20.3 prescriptions per year compared to 15.3 for those with no supplementary drug coverage.

The absence of an adequate prescription drug benefit has been of concern to policymakers since the enactment of Medicare in 1965. On several occasions, the Congress considered adding coverage for at least a portion of beneficiaries' drug expenses. However, the projected cost of such a benefit has been the major deterrent to its implementation.

Recently, the issue received renewed attention as part of the overall discussion of Medicare reform. The National Bipartisan Commission on the Future of Medicare was charged with making recommendations concerning a number of program issues. The Commission failed to get the necessary votes for a reform proposal. However, the plan designed by Senator Breaux and Congressman Thomas is expected to be introduced as legislation in the near future. The Breaux-Thomas plan includes a drug benefit. The President has also promised to forward his Medicare plan to the Congress in the near future. This plan is also expected to include a drug benefit.

There are a number of design issues facing the development of a Medicare prescription drug benefit. First is whether coverage should be extended to the entire Medicare population or, alternatively, targeted toward the low-income. A second series of issues concerns the scope of coverage. Should the benefit be fairly comprehensive, or alternatively catastrophic in nature? A related series of issues relates to the appropriate level of beneficiary cost-sharing. Another series of issues relates to how Medicare should calculate its payments and whether and to what extent cost controls should be incorporated. There is no consensus on any of these issues. Obviously, the cost of a Medicare drug benefit would depend on its design. Total costs of a fairly comprehensive drug benefit added to the existing program are roughly estimated at upward of $30 billion annually. Net Medicare costs would be less, assuming beneficiaries paid a portion of the total in premiums.

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Medicare: Prescription Drug Coverage for Beneficiaries

Background

Medicare is a nationwide program which offers health insurance protection for 39 million aged and disabled persons. The program provides broad coverage for the costs of many, primarily acute care services. However, many observers believe that Medicare's benefit structure fails to adequately respond to beneficiaries' health care needs. The program includes cost-sharing charges for most services, provides only limited protection for some other costs (such as nursing home care) and includes no protection against the costs of some other services (such as hearing aids). Further, the program includes no upper limit ("catastrophic limit") on cost sharing charges. The most notable shortcoming is the fact that Medicare has a very limited prescription drug benefit.

Most beneficiaries have some form of private or public health insurance to cover expenses not met by Medicare. However, many of these plans either do not offer drug coverage or offer very limited protection for drug expenses. As a result, beneficiaries still pay approximately half of their total drug expenditures out-of-pocket.

The absence of an adequate prescription drug benefit has been of concern to policymakers since the enactment of Medicare in 1965. On several occasions, the Congress has considered adding coverage for at least a portion of beneficiaries' drug costs. However, the projected cost of such a benefit has been the major deterrent to its implementation.

Recently, the issue has received renewed attention as part of the overall discussion of Medicare reform. The National Bipartisan Commission on the Future of Medicare, established by the Balanced Budget Act of 1997 (BBA 97) was charged with making recommendations concerning a number of program issues. The Commission failed to get the necessary 11 of 17 Commissioners' votes for a reform proposal. However, the plan designed by Senator Breaux (Statutory Chairman) and Congressman Thomas (Administrative Chairman) received 10 votes and is expected to be introduced as legislation in the near future. The Breaux-Thomas plan includes a prescription drug benefit. The President has also promised to forward his Medicare plan to the Congress this year. This plan is also expected to include a drug benefit.

This report provides an overview of prescription drug coverage currently available to beneficiaries, presents information on utilization of drugs by the target population, and outlines some of the major issues that would need to be considered in the design of a Medicare drug benefit.

Sources of Existing Coverage

Proponents of expanding Medicare's coverage of prescription drugs cite the uneven coverage available to the aged and disabled populations under existing public and private programs. They also point to the fact that most medium and large employers offer prescription drug coverage for the working population under age 65. This chapter reviews the extent of Medicare coverage and the types of supplementary coverage generally available to beneficiaries.

Medicare

Medicare beneficiaries who are inpatients of hospitals or skilled nursing facilities may receive drugs as part of their treatment. Medicare payments made to the facilities cover these costs.[1] Medicare also makes payments to physicians for drugs or biologicals which *cannot be self-administered*.[2] This means that coverage is generally limited to drugs or biologicals administered by injection. However, if the injection is generally self-administered (e.g., insulin), it is not covered.

Despite the general limitation on coverage for outpatient drugs, the law specifically authorizes coverage for the following:

- *Immunosuppressive Drugs*. Drugs used in immunosuppressive therapy (such as cyclosporin) during the first 36 months following discharge from a hospital for a Medicare covered organ transplant.[3]
- *Erythropoietin (EPO)*. EPO for the treatment of anemia for persons with chronic renal failure who are on dialysis.
- *Oral Anti-Cancer Drugs*. Oral cancer drugs used in cancer chemotherapy providing they have the same active ingredients and are used for the same indications as chemotherapy drugs which would be covered if they were not self-administered and were administered as incident to a physician's professional service. Also included are oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen.

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[1] Most hospitals are paid under a prospective payment system (PPS); under PPS, a predetermined payment is made per case based on the patient's diagnosis. The prospective payment is intended to cover all services, including drugs, provided during the patient's stay. Non-PPS hospitals and skilled nursing facilities are paid on the basis of reasonable costs, subject to certain limits; reasonable costs include the costs of drugs provided during the patient's stay. A PPS payment system is currently being phased-in for skilled nursing facilities. The per diem rate that will be paid to SNFs will cover all drug costs (except EPO).

[2] Payment is made for services provided "incident to" a physician's professional service. The charge for the drug or biological must be included in the physician's bill, and the cost of the drug or biological must represent an expense to the physician. Drugs or biologicals furnished by other health professionals may also meet these requirements.

[3] BBA 97 authorizes the National Academy of Sciences to conduct a study on preventive and enhanced Medicare benefits. The report is to include specific findings with respect to several benefit categories including the "elimination of the time limitation for coverage of immunosuppressive drugs for transplant patients." The law requires submission of the study by August 5, 1999; however, the study has not begun.

- *Hemophilia clotting factors.* Hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.[4]

The program also covers the following immunizations:

- *Pneumococcal pneumonia vaccine*. The vaccine and its administration to a beneficiary if ordered by a physician.
- *Hepatitis B vaccine*. The vaccine and its administration to a beneficiary who is at high or intermediate risk of contracting hepatitis B.
- *Influenza virus vaccine.* The vaccine and its administration when furnished in compliance with any applicable state law. The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Payments for these drugs and immunizations are made under Medicare Part B. The program generally pays 80% of Medicare's recognized payment amount after the beneficiary has met the $100 Part B deductible. The beneficiary is liable for the remaining 20% coinsurance charges. These Part B cost sharing charges do not apply for pneumococcal pneumonia or influenza vaccines.

Supplementary Coverage

Most beneficiaries have some form of private or public health insurance coverage to supplement Medicare. In 1996, only 11.3% of beneficiaries relied solely on the traditional fee-for-service program; an additional 8% relied exclusively on coverage through their Medicare managed care organization. The remaining 80.7% had some form of private or public supplementary coverage.[5] However, many persons with supplementary coverage have either limited or no protection against prescription drug costs.

Medicare Managed Care Organizations. Since the early 1980s Medicare beneficiaries have been able to enroll in health maintenance organizations (HMOs). Beneficiaries get all their Medicare services through the HMO and Medicare makes a monthly capitation payment to the plan in their behalf. The new Medicare+Choice program, which became effective January 1, 1999, expanded the options available to beneficiaries to include additional managed care arrangements. An entity operating as

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[4] Medicare also pays for the following drug categories: (1) an injectable osteoporosis drug approved for treatment of post-menopausal osteoporosis provided by a home health agency to a homebound individual whose attending physician has certified suffers from a bone fracture related to post-menopausal osteoporosis and the individual is unable to self-administer the drug; and (2) supplies (including drugs) that are necessary for the effective use of covered durable medical equipment, including those which must be put directly into the equipment (e.g., tumor chemotherapy agents used with an infusion pump).

[5] A CRS analysis of 1994 data showed that there are considerable differences in the types of supplemental coverage held by the aged and disabled. The disabled were much more likely to have Medicaid coverage while the elderly were much more likely to have either employer-based coverage or individually purchased "Medigap" protection.

a Medicare HMO in 1998, had to convert to Medicare+Choice status in order to continue to provide Medicare services, effective January 1, 1999.

Traditionally, Medicare payments to HMOs have varied considerably throughout the country. In areas where payment rates have been high, HMOs have typically been able (and have often been required) to offer services in addition to those covered under the basic Medicare program. Of particular importance has been the ability of a number of plans to offer prescription drug coverage *at little or no additional cost to beneficiaries*. Conversely, in lower payment areas, plans typically have not offered a similar scope of additional benefits.

Under Medicare+Choice, the variation in payment rates across the country is being reduced. As a result, capitation payments in many previously high payment areas will see relatively small year to year increases. Thus, some HMOs may need to reduce benefits. Of particular concern to plan operators and beneficiaries are potential reductions in drug benefits. Many plans are questioning whether they can continue to be competitive if they drop prescription drug coverage or alternatively institute significant cost-sharing requirements for the coverage.

Prescription drug benefits may be offered by a Medicare+Choice plan as part of the basic package or included in a high option package. As of January 1999, the Health Care Financing Administration (HCFA) reports that three-quarters of Medicare+Choice packages that were offered to beneficiaries contained prescription drug benefits (though the actual percentage of beneficiaries enrolling in plans with drug coverage is not known). Ninety percent of plans with drug coverage contain a cap on spending. Some plans apply the cap to all drugs while others limit the cap to brand name drugs. (See **Table 1**)

Table 1. Caps on Prescription Drug Benefits Under Medicare HMOs, 1999

Amount of cap	Cap on brand name drugs — no cap on generic drugs	Cap on all drugs — generic and brand name drugs
$500 or less	3%	16%
$501 - $1,000	10%	26%
$1,001 - $2,000	12%	16%
$2,001 - $3,000	4%	2%
$3,001 - $5,000	1%	1%
Total	29%	61%

Source: CRS analysis of HCFA's 1999 Compare Data.

Note: Based on 513 plans that reported data; excludes 194 plans for which data were not reported. Includes only risk-based plans.

Packages Without Cap: 10%

Private Supplementary Coverage. The majority of the Medicare population (62.5% in 1996) have private supplemental coverage. This private insurance protection may be obtained through a current or former employer (29.9% had such

coverage in 1996). It may also be obtained through an individually purchased policy, commonly referred to as a "Medigap policy (28.4% had these plans in 1996). Some persons (4.2% in 1996) have both employer-sponsored plans and Medigap coverage.

Employer-Sponsored Plans. Employers may offer their retirees health benefits, though the number offering such plans has declined in recent years. A 1997 survey of retiree health plans shows that over a 5-year period (1993-1997) the number of employers offering health plan coverage to retirees under age 65 fell from 46% to 38%, while the number providing coverage to Medicare-eligible retirees fell from 40% to 31%. Coverage by large employers (over 5,000 employees) of Medicare-eligible retirees dropped from 63% to 48% over the same period.[6]

The scope of benefits offered to retirees varies by plan. Of those offering retiree medical coverage for Medicare-eligible enrollees in 1997, two-thirds provided some drug coverage. The percentage increases to approximately 90% for large employers. Two-fifths offered a mail-order plan.

Medigap. Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals who first purchase a Medigap policy on or after July 30, 1992, select from 1 of 10 basic standardized plans, though not all 10 plans are covered in all states. The 10 plans are known as Plans A through Plan J. Plan A covers a basic package of benefits. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits. Plan J is the most comprehensive. A change authorized by the BBA 97 added two high deductible plans to the list of 10 standardized plans. With the exception of the high deductible feature, the benefit package under the high deductible plans will be the same as under Plan F or Plan J.[7]

Only three of the standardized plans, Plans H-J, offer prescription drug coverage. All three plans impose a $250 deductible. Plans H and I cover 50% of the charges up to a maximum benefit of $1,250. Plan J covers 50% of the charges up to a maximum benefit of $3,000. The premiums for these plans are higher than those for the other seven Medigap plans, in large measure due to the drug coverage. A number of observers have concluded that only those persons who expect to actually utilize a significant quantity of prescriptions actually purchase drug coverage. This adverse selection tends to drive up the per capita cost of coverage.

Medicaid. Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. Persons entitled to *full* Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles" Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare. Perhaps

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[6] Mercer/Foster Higgins. *National Survey of Employer-Sponsored Health Plans, Report 1997.*

[7] For further information on Medigap see: CRS Report RL30094, *Medicare: Supplementary "Medigap" Coverage*, by Jennifer O'Sullivan.

the most important service for the majority of dual eligibles is prescription drugs.[8] All states offer this service under their Medicaid plans.

Several population groups are entitled to more *limited* Medicaid protection. These are qualified Medicare beneficiaries (QMBs), specified low income beneficiaries (SLIMBs), and certain qualified individuals. The following are the four coverage groups:

- **Qualified Medicare Beneficiaries (QMBs)**. QMBs are aged or disabled persons with incomes at or below the federal poverty line ($8,240 for a single and $11,060 for a couple in 1999[9]) and assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the federal-state Medicaid program. Medicaid protection is limited to payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.
- **Specified Low-Income Medicare Beneficiaries (SLIMBs).** These are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLIMB limit is 120% of the federal poverty level. Medicaid protection is limited to payment of the Medicare Part B premium (i.e., the Medicare beneficiary is *not* entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.
- **Qualifying Individuals (QI-1)**. These are persons who meet the QMB criteria, except that their income is between 120% and 135% of poverty. Further, they are *not* otherwise eligible for Medicaid. Medicaid protection is limited to payment of the Medicare Part B premium.[10]
- **Qualifying Individuals (QI-2)**. These are persons who meet the QMB criteria, except that their income is between 135% and 175% of poverty. Further, they are *not* otherwise eligible for Medicaid. Medicaid protection is limited to payment of that portion of the Part B premium attributable to the gradual transfer of some home health visits from Medicare Part A to Medicare Part B. ($1.07 in 1998; $2.23 in 1999).

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[8] Medicaid also offers coverage for long-term care — a potentially very costly item for the population needing these services.

[9] The levels are actually higher since $20 per month of unearned income is disregarded in the calculation.

[10] In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 and QI-2 programs are paid for 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. Any expenditures beyond that level are paid by the state. Total allocations are $200 million in FY1998, $250 million for FY1999, $300 million for FY2000, $350 million for FY2001, and $450 million for FY2002. Assistance under the QI-1 and QI-2 programs is available for the period January 1, 1998 to December 31, 2002.

Thus, QMBs and SLIMBs are not entitled to Medicaid's prescription drug benefit unless they are also entitled to full Medicaid coverage under their state's Medicaid program. QI-1s and QI-2s are *never* entitled to Medicaid drug coverage (because, by definition, they are not eligible for full Medicaid benefits).

Other Public Sources.[11] Some beneficiaries with a military service connection may receive drug coverage through Department of Defense or Department of Veterans Affairs programs.

Some beneficiaries also have coverage through state pharmaceutical assistance programs. As of 1997, 10 states had implemented programs which provide pharmaceutical assistance coverage for low-income aged persons who do not qualify for Medicaid.[12] Six of these states also extended such coverage to some low-income disabled persons not qualifying for Medicaid.[13,14]

Extent of Coverage for Prescription Drug Costs

Despite the variety of potential sources of coverage for prescription drug costs, beneficiaries still pay out-of-pocket for a significant portion of the total. A recent analysis by HCFA[15] reports that in 1995, 65% (23.9 million) of the 36.7 million beneficiaries had some drug insurance coverage. This is an increase over previously published estimates which were approximately 50%. However, the estimate of out-of-pocket spending by beneficiaries has remained relatively unchanged; it is still estimated to be about half of total spending.

Extent of Supplementary Prescription Drug Coverage

There is some discrepancy between various data sources on the extent of prescription drug coverage for the Medicare population. The HCFA analysis is based on 1995 Medicare Current Beneficiary Survey data.[16] The analysis reviews the distribution of noninstitutionalized Medicare beneficiaries by type of supplemental

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[11] Some pharmaceutical companies have patient assistance programs that provide free prescriptions for low-income persons without other assistance. The programs are reportedly not well publicized; further, the application process for many programs can be difficult and time consuming. See: Drugs: Drug Industry Veteran Dispenses New Remedy. *Wall Street Journal*, February 19, 1999.

[12] Connecticut, Delaware, Illinois, Maine, Maryland, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

[13] Connecticut, Illinois, Maine, Maryland, New Jersey, and Rhode Island.

[14] National Pharmaceutical Council. *Pharmaceutical Benefits Under State Medical Assistance Programs*. Reston, Virginia, November 1997.

[15] Davis, Margaret, et al. Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries. *Health Affairs*, January/February 1999.

[16] The authors utilized various strategies which were designed to correct for what they identified as previous underreporting of data.

insurance and presence of drug coverage. The review looks at coverage available both through an individual's primary source of supplementary health insurance coverage and their secondary source of such coverage.

The HCFA analysis reports that 95% of those enrolled in Medicare HMOs had primary drug coverage in 1995; the percentage was 88% for those with Medicaid, 84% for those with employer-sponsored plans and 29% for those with Medigap. (See **Table 2).** Several considerations should be kept in mind when reviewing these data.

- *HMOs*. It should be noted that the HMO number is a 1995 number. This percentage may have subsequently changed. As noted earlier, the percentage may drop under the Medicare+Choice program
- *Medicaid*. The Medicaid number reflects the percentage of all persons on the Medicaid rolls, including the QMB-only and SLIMB-only populations (who do not have drug coverage). If just the population with full Medicaid coverage is taken into account, the percentage should be closer to 100%.
- *Employer-sponsored plans*. As noted earlier, the 1997 Mercer/Foster Higgins study on employer sponsored health plans reports that employers are continuing to drop retiree health plan coverage. This will affect the percentage of retirees with prescription drug coverage.
- *Individually-purchased Medigap*. A 1997 report of 1995 data by the Physician Payment Review Commission reported that only 14.1% of persons purchasing 1 of the 10 standardized policies purchased one of the three policies with drug protection (Plans H-J). It is possible that the higher HCFA percentage represents drug coverage available to people still covered under non-standardized plans first purchased before July 30, 1992.

Table 2. Distribution of Noninstitutionalized Medicare Beneficiaries, by Type of Supplemental Insurance and Presence of Drug Coverage, 1995
(in percent)

Type of coverage	With primary drug coverage	With secondary drug coverage	No drug coverage
All persons	61.7	3.4	34.8
No supplemental coverage	0.0	0.0	100.0
Supplemental coverage			
Medicare HMO	95.0	**	4.1
Medicaid	87.8	2.0	10.2
Employer- Sponsored	83.9	2.4	13.7
Medigap	28.9	7.0	64.1
Other	78.5	**	20.1
Switched during year	77.0	3.3	19.7

Source: Davis, Margaret, et al. Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries. *Health Affairs*, January/February 1999.

Note: Numbers may not add due to rounding

****** Number unreliable due to small sample size.

Impact of Insurance Coverage on the Use of Prescription Drugs by Beneficiaries

The use of prescription drugs by Medicare beneficiaries varies by whether or not the beneficiary has supplemental drug coverage and the type of supplemental coverage. Overall, the HCFA study reports that 86% of the Medicare population used prescription drugs in 1995; the percentage was 89% for those with drug coverage and 81% for those without drug coverage. The percentage was considerably lower for certain population groups — 70% for persons with no supplementary health insurance coverage of any kind and 56% for the Medicaid population recorded with no drug coverage (i.e., the QMB-only and SLIMB-only groups). (See **Table 3**.) These persons are more likely to have lower incomes than the average Medicare beneficiary.

Table 3. Percentage of Medicare Beneficiaries Using Prescription Drugs, by Type of Supplementary Insurance Coverage and Presence of Drug Coverage, 1995

Type of coverage	All persons	With drug coverage	No drug coverage
All persons	86	89	81
No supplemental coverage	70	**	70
Supplemental coverage			
Medicare HMO	87	87	81
Medicaid	87	91	56
Employer-Sponsored	89	89	90
Medigap	87	87	86
Other	92	95	77
Switched during year	87	89	76

Source: Davis, Margaret, et al. Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries. *Health Affairs*, January/February 1999.

** Number unreliable due to small sample size.

Persons with no supplementary prescription drug coverage use considerably fewer prescriptions per year than do those with supplementary coverage. In 1995, persons with coverage used 20.3 prescriptions per year compared to 15.3 for those without supplementary coverage. The usage rate ranged from 5.1 prescriptions for the small number of HMO enrollees without drug coverage, to 12.7 prescriptions for those with no supplementary insurance coverage, to 27.0 for those with drug coverage under Medicaid. (See **Table 4**.)

Table 4. Average Number of Prescriptions Per Person, by Type of Supplementary Insurance Coverage and Presence of Drug Coverage, 1995

Type of coverage	All persons	With drug coverage	No drug coverage
All persons	18.5	20.3	15.3
No supplemental coverage	12.7	**	12.7
Supplemental coverage			
Medicare HMO	15.7	16.2	5.1
Medicaid	25.6	27.0	12.9
Employer-sponsored	18.4	18.6	16.9
Medigap	17.8	19.8	16.8
Other	19.4	20.9	13.4
Switched during year	18.8	20.6	11.6

Source: Davis, Margaret, et al. Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries. *Health Affairs*, January/February 1999.

**Number unreliable due to small sample size.

Spending for Prescription Drugs

Drug Expenditures Per Person

Total Per Capita Spending. The average total drug expenditure for Medicare enrollees living in the community was $600 in 1995.[17] The National Academy of Social Insurance has estimated that this number has increased to $942 per beneficiary in 1999.[18]

In 1995, total spending for persons with some drug coverage was $691 compared to $432 for those with no coverage. The average expenditure per person varied widely, depending on the type of insurance coverage. In every category, total spending was significantly higher for those who had supplemental drug coverage than for those who didn't. The lowest figure was $125 for persons in Medicare HMOs

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[17] Davis, Margaret, et al. Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries. *Health Affairs*, January/February 1999.

[18] Gluck, Michael. *A Medicare Prescription Drug Benefit*. Medicare Brief. National Academy of Social Insurance, no. 1, April 1999. (Hereafter cited as Gluck, *A Medicare Prescription Drug Benefit.*)

without drug coverage; this low spending level presumably reflects the fact that this population group was healthier than average. (See **Table 5**.)

The previous discussion reflects averages across the Medicare population. However, individual expenditures can vary dramatically. For example, in one Massachusetts HMO that provided unlimited drug coverage for Medicare beneficiaries, the average expenditure per beneficiary was $1,153 in 1998. For the 10% of enrollees with the highest level of drug use, the average was $3,953; these 10% of enrollees accounted for a third of drug spending for all Medicare enrollees in the plan.[19]

Out-of-Pocket Spending. Beneficiaries pay about half of their drug costs out-of-pocket; this compares with 34% of total prescription drug costs paid out-of-pocket by the population as a whole. In 1995, Medicare beneficiaries paid an average of $303. As was the case with total spending, out-of-pocket costs varied significantly by type of insurance coverage and whether or not that insurance included drug coverage. (See **Table 5**.)

Table 5. Average Drug Expenditures for Medicare Beneficiaries, by Type of Supplementary Coverage and Presence of Drug Coverage, 1995

		Out-of-pocket		
	Total	**All persons**	**With drug coverage**	**No drug coverage***
All persons	$600	303	232	432
No supplemental coverage	352	352	—	352
Supplemental coverage				
Medicare HMO	458	160	162	125
Medicaid	727	150	135	284
Employer-sponsored	698	260	224	484
Medigap	550	437	361	480
Other	618	277	249	385
Switched during year	547	303	297	331

Source: Davis, Margaret, et al. Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries. *Health Affairs*, January/February 1999.

*Out-of-pocket spending for persons with no drug coverage is the same as total spending for this population group.

The American Association of Retired Persons (AARP) estimates that Medicare beneficiaries who were not in HMOs (the fee-for-service population) averaged $350

[19] Soumerai, Stephen, and Dennis Ross-Degnan. Inadequate Prescription Drug Coverage for Medicare Enrollees — A Call to Action. Sounding Board. *New England Journal of Medicine*, v. 30, no. 9, March 4, 1999. (Hereafter cited as Soumerai and Ross-Degnan, Inadequate Prescription Drug Coverage for Medicare Enrollees.)

on out-of-pocket spending for prescription drugs in 1997. Persons who actually incurred drug costs in that year averaged $440. Of this group, 15% spent between $50 and $100 per month and 8% spent more than $100 per month. AARP further estimated that average out-of-pocket spending by fee-for-service beneficiaries represented 8% of income for persons with incomes below $10,000, 4% of income for those with incomes between $10,000 and $25,000 and 2% of income for those with incomes above $25,000.[20]

The National Academy of Social Insurance has estimated 1999 out-of-pocket drug expenditures for noninstitutionalized Medicare beneficiaries who are not in Medicare+Choice plans. It estimates that 17% of these persons will have no drug expenditures. For the remainder, 34% will have out-of-pocket expenditures under $200, 21% between $200 and $499, 15% between $500 and $999, 7% between $1,000 and $1,499, and 3% between $1,500 and $1,999. An estimated 4% will have out-of-pocket expenses of $2,000 or more.[21]

Drug Spending for the Medicare Population

There is limited information on total drug spending for the Medicare population. HCFA reports that the nation spent $78.9 billion on prescription drugs in 1997. Total expenditures in 1994 were $46.6 billion.[22] A different data source reports that in 1994 approximately $19.3 billion was spent on prescription drugs for the Medicare population. Out-of-pocket spending in that year represented 52.1% of the total ($10.0 billion), private insurance 27.5% ($5.3 billion), Medicaid 12.1% ($2.3 billion), Medicare 0.1% ($0.02 billion) and other sources 8.2% ($1.6 billion).[23]

Previous Efforts to Expand Medicare's Coverage of Prescription Drugs

The absence of an adequate prescription drug benefit has been of concern to policymakers since the enactment of Medicare in 1965. The projected cost of such a benefit has been the major deterrent to its implementation. Over the past decade, two major attempts were made to add drug coverage to Medicare. The first attempt came in 1988 with the passage of the Medicare Catastrophic Coverage Act of 1988. This legislation, which included a catastrophic prescription drug benefit for the Medicare population, was repealed the following year The second attempt was made as part of the health reform debate of 1994.

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[20] American Association of Retired Persons, Public Policy Institute. *FYI: Estimates of Financial Burden of Prescription Drugs on Beneficiaries in Medicare Fee-For-Service*, September 1998. (Based on analysis of 1995 Medicare Current Beneficiary Survey data.)

[21] Gluck, *A Medicare Prescription Drug Benefit.*

[22] HCFA web page, [http://www.hcfa.gov].

[23] Olin, Gary L., and Hongji Liu. *Health and Healthcare of the Medicare Population: Data from the 1994 Medicare Current Beneficiary Survey*. Rockville, Maryland, Westat, November 1998.

Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of 1988 (MCCA, P.L. 100-360) would have phased-in *catastrophic* prescription drug coverage as part of a larger package of benefit improvements. This legislation was repealed in 1989 (P.L.101-234). The repeal of MCCA was attributable to a number of factors. These included a significant increase in the program's cost estimates (particularly drug cost estimates) made shortly after enactment and the opposition by a number of seniors to the income tax surcharge which was to be imposed on higher income beneficiaries.

Under MCCA, catastrophic prescription drug coverage would have been available beginning in 1991 for all outpatient drugs, subject to a $600 deductible and 50% coinsurance.[24,25] The deductible was slated to go to $652 in 1992 and be indexed in future years so that 16.8% of beneficiaries would reach the deductible each year. The coinsurance was slated to be lowered to 40% in 1992 and 20% in 1993. The benefit was to be financed through a combination of an increase in the Part B premium and a portion of the new supplemental premium which was to be imposed on higher income enrollees.

When MCCA was enacted in 1988, limited data were available on which to base cost estimates for the new prescription drug program. At the time of enactment, CBO estimated FY1990-FY1993 costs at $5.7 billion. By July 1989, the estimates had more than doubled to $11.8 billion. The revised estimates reflected the availability of new data which suggested that both the average number of prescriptions used by enrollees and their average price had risen more than had been estimated previously.

Health Reform — 1994

The issue of prescription drug coverage was again considered as part of the health reform debate of 1994. The Health Security Act, proposed by the Administration, would have added a prescription drug benefit to Medicare Part B beginning in 1996. Medicare would pay 80% of the cost of each prescription once the beneficiary met a $250 annual deductible. Beneficiaries would be responsible for the remaining 20% with an annual limit on out-of-pocket expenses of $1,000. The Administration estimated that approximately 58% of beneficiaries would use the proposed drug benefit each year — a much larger percentage than the targeted 16.8% under MCCA.

As is the case for other Part B benefits, the Administration's plan would have been funded through general revenues (approximately 75%) and beneficiary premiums (approximately 25%). The beneficiary share for prescription drugs was estimated at

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[24] The coinsurance would have been 20% for drugs used in connection with the home intravenous drug therapy benefit.

[25] A limited benefit would have been available in 1990 with coverage for: (1) home intravenous drugs (furnished in connection with the new home intravenous drug therapy benefit) and (2) immunosuppressive drugs after the first year following a covered transplant (the drugs were already covered under Part B for the first year). The 1990 deductible would have been $550. Subsequent legislation extended the immunosuppressive benefit to 3 years.

$9 per month; this would have been added to the regular Part B premium. The Administration estimated net federal costs, after offsetting premiums, at $69.1 billion over the FY1996-FY2000 period. CBO estimated that the benefit would cost $19 billion in 2000, approximately $2 billion higher than the Administration's estimate for that year.

Proposed Expansion: Program Design Issues

Medicare coverage of prescription drugs is receiving renewed attention as part of the overall discussion of Medicare reform. Proponents of adding a drug benefit to Medicare argue that the current benefit package fails to adequately address beneficiaries health care needs. They also note that this would place Medicare coverage more in line with the health insurance coverage typically available to the under 65 population under plans offered by large employers.

Other observers caution that a new benefit is potentially very costly. They contend that it is inappropriate to add a major new benefit at the same time that the program is facing severe financial pressures. Some persons also object to a plan which would substitute federal dollars for current private spending under Medigap and employer-sponsored plans.

The issue of prescription drug coverage was one of the most difficult issues facing the National Bipartisan Commission on the Future of Medicare. The Commission was unable to recommend a formal Medicare plan. However, its deliberations focused renewed attention on the program's lack of a comprehensive drug benefit.

It is expected that interest in adding prescription drug coverage for the Medicare population will continue. The following sections outline some of the major issues that would need to be considered in the design of a benefit.

Persons Covered

Some observers have recommended extending prescription drug coverage to the entire Medicare population. Others have suggested targeting a new benefit toward those most in need, with need generally defined on the basis of low income.

Some observers have suggested that a new benefit should be limited to persons below 135% of poverty who are not eligible for full Medicaid benefits. This is the QMB/SLIMB population. This group generally does not have protection against prescription drug costs now; this group would also find it difficult to afford a Medigap policy with drug coverage.

Enrollment in the QMB and SLIMB programs has traditionally been low, though enrollment in the QMB program has recently increased. In early 1998, 78% (4.5 million) of the estimated 5.7 million potentially eligible for the QMB program were enrolled. SLIMB enrollment was considerably lower, with only 16% (270,000) of the

potential 1.6 million eligibles actually enrolled.[26] It is likely that these figures would go up if prescription drug benefits were added. This would have the effect of increasing federal and state Medicaid costs for the *basic* QMB/SLIMB benefits (i.e., cost-sharing and premium charges).

The new drug benefits could be financed the same way as other QMB/SLIMB benefits, namely through a combination of federal and state dollars. However, this approach is unlikely to be politically feasible given state opposition to unfunded mandates. The more likely approach would be to fund the benefit through Medicare. Decisions would need to be made regarding whether any beneficiary cost sharing would be required as well as how the benefit itself would be financed.[27]

One concern with the QMB/SLIMB approach is that some persons would have a fairly generous benefit while persons with incomes slightly above the income cutoff would have no protection against the costs of prescription drugs. It would be difficult to design a benefit to respond to this concern. One approach would be to allow persons to "spend down" to program eligibility by incurring expenses equal to the difference between their income and the program's cutoff. (This concept is currently used for some Medicaid eligibility categories.) This would be difficult to administer. It would also serve to increase per capita costs, since those who spent down would likely be those with higher drug costs.

Medigap Mandates

As noted earlier, only 3 of the 10 standardized Medigap plans offer prescription drug coverage. Further, drug coverage under all three plans is limited. Many persons have noted that only persons who expect to utilize a significant quantity of prescriptions actually purchase drug coverage. This adverse selection tends to drive up the premium costs of these policies.

Some persons have suggested that all Medigap policies be required to offer prescription drug coverage. Unless the benefit were identical across all plans, there would still be some adverse selection though probably not as great as there is now. However, requiring prescription drug coverage could potentially make any Medigap coverage unaffordable for some beneficiaries. Thus, this approach could result in less health care coverage for any person forced to drop their Medigap coverage. Countering this concern is the potential for at least some of these individuals to enroll in a managed care organization under the Medicare+Choice program; this organization could potentially offer prescription drug coverage.

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[26] Moon, Marilyn, Niall Brennan, and Misha Segal. *Improving Coverage for Low-Income Medicare Beneficiaries.* Policy Brief. The Commonwealth Fund, December 1998.

[27] It is likely that more persons would enroll in the QMB/SLIMB programs if drug coverage were added for this group. This could result in increased costs for the states even if the drug benefits were paid in full by Medicare.

Scope of Benefits

If a prescription drug benefit were added to Medicare, a number of decisions would need to be made regarding the scope of covered benefits. One series of questions relates to whether the benefit would either be catastrophic or, alternatively, more comprehensive in nature. A catastrophic benefit would only help a small portion of the population. For example, under the 1988 MCCA legislation, only 16.8% of beneficiaries would have used the benefit in a given year. A catastrophic benefit would likely have a high deductible and perhaps high coinsurance charges.

A more comprehensive benefit would have lower beneficiary cost-sharing charges. These could be comparable to those applicable under the current Part B program (i.e., $100 deductible; 20% coinsurance), though it is likely that a separate, and perhaps higher, deductible would apply.

Either approach could incorporate a cap on beneficiary spending. Once a beneficiary had spent a certain amount out-of-pocket, the program would pay in full, up to the program's recognized payment amount.

A related issue is whether beneficiaries would be liable for balance billing charges. Balance billing charges are charges imposed by a provider or practitioner which are in excess of the payment amounts recognized by the program. Under the current Medicare program, providers and practitioners are prohibited from imposing balance billing charges in certain cases but allowed to impose them in others. In some cases (such as when balance billing is permitted for physicians services) there are upper limits on the amounts that can be balance billed. In other instances (such as in the case of durable medical equipment), there are no limits on balance billing.

Payments for Drugs

Concerns have been raised that Medicare is paying more than it should for the limited number of outpatient prescription drugs covered under the program. Proposals to expand this coverage heighten concerns about how to establish the appropriate payment amount. Further, some observers have suggested that cost control strategies should be adopted. However, some drug industry representatives are concerned that if Medicare had a broad drug benefit, the cost controls would shrink industry profits to the point where it couldn't conduct necessary innovative research to develop new products.

Current Payment Policy. Medicare Part B spending for outpatient prescription drugs totaled an estimated $2.75 billion in FY1997.[28] Prior to the enactment of the Balanced Budget Act of 1997 (BBA 97) the program paid for drugs based on the lower of the estimated acquisition cost or the average wholesale price. BBA 97 required that beginning January 1, 1998, payments are to be made at 95% of the

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[28] U.S. Dept. of Health and Human Services. Office of Inspector General. *Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs*. #OEI-03-97-00293, November 1998. Washington, 1998. (Hereafter cited as DHHS, *Comparing Drug Reimbursement*.)

average wholesale price. Medicare pays 80% of this amount; the beneficiary is liable for the 20% coinsurance.[29]

The BBA 97 provision was enacted, in part, in response to concern that Medicare was paying more than it should for the limited number of prescriptions covered under the program. The Inspector General, in a report issued in December 1997, found that average wholesale prices being paid by Medicare frequently did not represent wholesale prices available to physicians and prescription drug suppliers. While it considered the recently enacted BBA 97 provision a step in the right direction, it recommended that further options to reduce spending should be considered.[30] The President's FY1999 Budget recommended paying the actual acquisition cost. The FY2000 Budget proposes setting the payment amount at 83% of the average wholesale price. A spokesmen from the Department of Health and Human Services (DHHS) indicated this level would roughly approximate actual acquisition costs.

Possible Cost Controls. Spending for prescription drugs has been increasing at a pace considerably faster than for health services as a whole. The Health Care Financing Administration (HCFA) reports that spending for prescription drugs rose 14.1% in 1997 compared to a 4.6% increase for health services as a whole. HCFA reports that prescription drugs spending has grown at double-digit rates during the last few years because of increases in the number of new, higher-priced drugs entering the marketplace, increased consumer demand induced by drug manufacturer advertising and an increase in the number of prescriptions filled.[31]

Many observers contend that a new Medicare prescription drug benefit would have to include some mechanisms to constrain overall program costs. There is no consensus on the extent of cost controls that should or would be included in a final package. The following outlines some approaches to cost controls that have been considered.

Formulary. Previous Medicare prescription drug proposals have generally covered all drugs and biologicals approved by the Food and Drug Administration, including off-label uses. Alternatively, coverage could be restricted to drugs in a formulary. Formularies are lists of drugs which are preferred for use by a health plan. A plan that has adopted an "open formulary" allows coverage for both formulary and non-formulary medications. A plan that uses a closed formulary limits coverage to the specified drugs. The formulary approaches have been used by several Medicaid programs. They are also used by some private insurers.

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[29] Payment is made either to the pharmacy or to the patient. In the case of "assigned" claims, payment is made directly to the pharmacy which agrees to accept Medicare's recognized payment amount as payment in full. In the case of nonassigned claims, payment is made to the beneficiary who in turn pays the pharmacy; the pharmacy may bill the patient over Medicare's recognized payment amount.

[30] U.S. Dept. of Health and Human Services. Office of Inspector General. *Excessive Medicare Payments for Prescription Drugs*. #OEI-03-97-00290, December 1997. Washington, 1997.

[31] HCFA web page, [http://www.hcfa.gov].

Formularies frequently suggest the use of a generic drug for a brand name drug. Many health plans, as well as pharmacy benefit managers (discussed below) encourage the use of generic substitution. The growth of generic substitution became possible in the late 1970s. By 1984, all states had changed their laws to allow pharmacists to dispense a generic drug even when a prescription specified a brand name, provided the physician had not indicated otherwise. By 1989, the dispensing of generic drugs on "brand written" prescriptions had become the chief source of generic drug sales through pharmacies. Substituting generic for brand name purchases results in overall savings.[32] However, it should be noted that in certain cases generic prices are experiencing significant increases.

Purchasing Discounts. Many observers have noted that individuals without prescription drug coverage are, in general, subject to higher drug prices than are paid by HMOs, insurance companies, Medicaid, federal programs and other bulk purchasers. A recent review suggests that seniors who buy their own medicines are paying double, on average, what is paid by these other entities.[33]

Many observers have suggested that the advantages of bulk purchasing should be made available to the Medicare population. (A few observers have suggested that these advantages should be made available regardless of whether or not Medicare's prescription drug benefit itself is expanded.)[34] In general, recommendations for bulk purchasing would apply both to the current Medicare benefit as well as to any expanded Medicare coverage.

One large purchaser which has been able to negotiate substantially lower prices than those paid by Medicare beneficiaries is the Department of Veterans Affairs (VA). The VA purchases drugs for its healthcare system directly from manufacturers or wholesalers. It uses a variety of purchasing arrangements including the Federal Supply Schedule, Blanket Purchase Agreements and VA national contracts. The Federal Supply Schedule allows agencies to purchase commonly-used products in various quantities while obtaining discounts associated with volume purchasing.

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[32] U.S. Congress. Congressional Budget Office. *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry*. CBO Study. July 1998. (Hereafter cited as CBO, *How Increased Competition from Generic Drugs Has Affected Prices*.)

[33] Serafini, Marilyn Werber. Bitter Pills. *National Journal*, October 31, 1998.

[34] See for example, H.R. 664 introduced by Representative Thomas Allen on February 10, 1999. This bill is intended to protect Medicare beneficiaries from discriminatory pricing by drug manufacturers and to make drugs available to beneficiaries at substantially reduced prices. This legislation would require each manufacturer of a covered outpatient drug to make available for purchase by each pharmacy such covered drug in an amount equal to the aggregate amount of the drug sold or distributed by the pharmacy to Medicare beneficiaries. (Covered drugs are those which would be covered under Medicaid). The manufacturers would be required to make the drug available at a price equal to: (1) the lowest price paid for the drug by any agency or department of the U.S.; or (2) the manufacturer's "best price" for the drug, as defined under Medicaid. For a discussion of this legislation see: CRS Issue Brief IB10025, *Prescription Drugs: Pricing Differences Between Insured and Uninsured Consumers*, by Christopher Sroka.

Using competitive procedures, contracts are awarded to companies to provide services and supplies over a given time period. The General Services Administration awards most of the Federal Supply Schedule contracts; however, the VA awards contracts for certain medical items. Agencies are not required to use the Federal Supply Schedule. They may be able to negotiate lower prices.[35]

The Inspector General recently compared Medicare allowances for prescription drugs with drug acquisition prices currently available to the VA. The study focused on 34 drug codes, each with over $10 million in allowed charges for 1996. The Inspector General noted that the Medicare allowance was greater than the VA acquisition cost for every drug reviewed. For the 34 drugs reviewed, the allowance ranged from 15% to 1600% more than the VA amount. The Inspector General concluded that Medicare could have saved $1.03 billion in 1998 if the allowed amounts were equal to the prices paid by the VA.

The Inspector General's report noted that HCFA and VA operated differently with VA purchasing drugs directly while Medicare pays doctors and suppliers for the drugs they administer. However, the Inspector General continued to recommend that HCFA further examine ways to reduce payments. Options suggested included: (1) greater discounting of published average wholesale prices; (2) basing payment on acquisition costs; (3) establishing manufacturers rebates similar to those used in the Medicaid program, and (4) using competitive bidding.[36]

Rebates. One potential method of controlling program expenditures is that of rebates.

In General. Rebates are a monetary return to a health insurer or payer from the manufacturer. The amount of the rebate is based on the utilization of drugs by program recipients or drug purchases by providers. The federal-state Medicaid program uses rebates. Manufacturers are required to enter into rebate agreements in order to have their drugs paid for under the program. Under Medicaid, the rebate for each single source and multiple source drug equals the total number of dosage units times the greater of: (1) the difference between the average manufacturer price (AMP) and the best price;[37] or (2) 15.1% of AMP. An additional rebate applies for any price increase higher than the increase in the consumer price index (CPI). Rebates for generic drugs are 11% of AMP.

The Administration's 1994 health reform plan would have established a drug rebate program under Medicare. If a manufacturer wished to have its drugs covered

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[35] DHHS, *Comparing Drug Reimbursement*, November 1998.

[36] Ibid.

[37] "Best price" for single source and innovator multiple source drug is defined as the lowest price available from a manufacturer to any wholesaler, retailer, provider, HMO, nonprofit entity or governmental entity excluding: (1) prices charged to the Department of Veterans Affairs, Department of Defense, Public Health Service; (2) prices charged under the Federal Supply Schedule; (3) prices used by state pharmaceutical assistance programs; and (4) depot prices and single award contract prices of any federal agency.

by Medicare, it would have been required to enter into a rebate agreement. No rebate would have been required for generic drugs.

It should be noted that if a rebate approach were adopted for Medicare, the program itself would end up recouping some of its costs. The savings would not be directly passed along to consumers. Consumers would still be paying coinsurance charges on the basis of the pre-rebate price. However, overall program costs would be lower. Assuming the program were financed in part through beneficiary premiums, lower program costs would translate into lower premium costs.[38]

Rebates for Breakthrough Drugs. One of the most contentious issues of the Administration's 1994 drug proposal was the treatment of breakthrough drugs. Breakthrough drugs, which represent a significant advance over existing therapies, have been introduced at prices ranging upwards from $10,000, $50,000, and even higher per patient per year. The Administration contended that the plan could not provide open ended funding of these costs. The legislation would have established an Advisory Council on Breakthrough Drugs which would advise the Secretary of DHHS on the reasonableness of the launch price of new drugs representing a significant advance over existing therapies. The Secretary could use the findings of the Advisory Council when negotiating rebate agreements with manufacturers for new drugs. The Secretary could exclude a drug for which an acceptable rebate agreement could not be negotiated. The Administration argued that this would be a rare occurrence. However, the industry viewed the provision with alarm. It argued that the Medicare population could be denied coverage for both life-saving drugs and other drugs which could significantly improve a patient's quality of life. It also argued that the implied price controls of the drug benefit would stifle investment in research and development.

The issue of controlling program payments for new drugs, whether through rebates or another mechanism, is likely to be considered as part of a Medicare drug benefit proposal.

Other Strategies. Health plans that cover prescription drugs use a variety of other strategies to control costs and assure quality. Some of these strategies could potentially be adopted by Medicare. These strategies include prior authorization for certain categories of drugs, implementation of quantity limits (for example, drugs limited to a 30 or 60 day supply and/or a limit on the number of refills in a specified period), and utilization review.

Some observers raise concerns regarding such strategies as quantity limits. For example, in 1981, there was a temporary change in New Hampshire's Medicaid benefit from unlimited prescription drug coverage to a limit of three per month. A large controlled study found that among the elderly and disabled with a high base-line use of medications, there were significant declines in the use of essential medications.

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[38] The rebate is structured so as not to adversely affect pharmacists. Presumably, the rebate could be structured so that both pharmacists and beneficiaries would be protected. For example, beneficiaries might pay less than the 20% coinsurance, to reflect the after rebate price.

A follow-up study found that the chronically ill elderly patients affected by the cap of three prescriptions per month were twice as likely as members of a control cohort to enter nursing homes, where they remained permanently in most cases. The reduced use of psychotropic drugs among patients with schizophrenia resulted in a doubled use of emergency and day hospital services. [39]

Pharmacy Benefit Managers (PBMs). A growing number of health insurers have contracted with companies called pharmacy benefit managers (PBMs). These companies, which manage pharmacy benefits on behalf of health plan sponsors, are charged with controlling rapidly rising pharmacy benefit payments. PBMs use a variety of cost control strategies. They may develop a retail pharmacy network arrangement; in this case, prices are negotiated with pharmacies which accept the discounts in return for attracting or retaining plan enrollees. PBMs may operate mail order pharmacies. They may use pharmacy and therapeutic committees to develop formularies; these formularies frequently include cost designations highlighting which are the less expensive and more expensive products. PBMs may also negotiate and obtain manufacturer rebates. Further, they may process claims and prepare periodic payment and drug utilization reports for plan customers.

A General Accounting Office (GAO) review of PBM services for the Federal Employees Health Benefits Program (FEHBP) showed that PBM services were credited with saving FEHBP plans significant costs by obtaining manufacturer and pharmacy discounts and managing drug utilization. However, the report noted that plans which encouraged the use of mail order pharmacies shifted business away from retail pharmacies. It also noted that PBM and plan officials, as well as other industry experts, acknowledged that additional efforts to control the FEHBP pharmacy benefit costs might require plans to adopt more restrictive cost containment procedures that could limit enrollees' access to drug and pharmacy services and lessen their satisfaction with their benefits.[40]

A subsequent report by the CBO also noted that PBMs help to hold down drug expenditures. It noted that much of the savings achieved by PBMs appear to come from lower prices paid to pharmacies rather than manufacturer rebates. It also noted that one way PBMs lowered drug costs was by promoting generic substitution both through formularies but also through pricing contracts with pharmacies.[41]

A number of observers have noted that many large PBMs have been acquired by pharmaceutical manufacturers. Concerns have been expressed that these PBMs could give their manufacturing partners an unfair advantage by including their products on

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[39] Soumerai and Ross-Degnan, Inadequate Prescription Drug Coverage for Medicare Enrollees.

[40] U.S. General Accounting Office. *Pharmacy Benefit Managers: FEHBP Plans Satisfied with Savings and Services, but Retail Pharmacies Have Concerns*. Report, GAO/HEHS-97-47. February 1997.

[41] CBO, *How Increased Competition from Generic Drugs Has Affected Prices*, July 1998

lists of preferred drugs and excluding those of competing firms.[42] Potentially, this could also neutralize the benefits of a PBM.

Cost Estimates

It is difficult to predict the cost of a Medicare drug benefit. In part, the costs are dependent on the benefit parameters such as the level of deductible and coinsurance. The Congressional Budget Office (CBO) recently estimated that a new benefit with a $250 deductible, 20% coinsurance, and an annual cap on out-of-pocket costs of $1,000 would have a net cost of $22.5 billion in 2000.[43] Net costs are after payment of beneficiary premiums (presumed to be the same 25% of total costs as apply to Part B benefits). Thus the total benefit, before premiums would be $30 billion. These estimates are considered illustrative. The actual cost would depend on the specifics of the implementing legislation.

The National Academy of Social Insurance (NASI) has estimated that a drug benefit could add between 7% and 13% to Medicare's cost over the next decade. This estimate is based on an analysis of the cost of five illustrative drug benefits. (See **Table 6**.) The analysis assumes that the deductibles, coinsurance rates, maximum benefits, and stop loss levels rise at the same rate as the consumer price index. It is assumed that per capita drug costs will rise faster than other Medicare costs over the 30 year projection period; thus the percentage increase in Medicare costs in 2030 would range from 12% to 34% depending on the option chosen.[44]

Table 6. National Academy of Social Insurance: Estimated Cost of Five Illustrative Medicare Drug Benefits, 1999

Benefit	Cost per beneficiary	Percent increase in Medicare costs
$200 deductible, 20% coinsurance, $2,000 maximum benefit	$609	10.0%
$200 deductible, 50% coinsurance, $2,000 stop loss	463	7.6
$200 deductible, 50% coinsurance, $3,000 stop loss	443	7.2
$200 deductible, 20% coinsurance, $2,000 stop loss	530	8.7
$200 deductible, 50% coinsurance, $1,000 stop loss	552	9.0

[42] Ibid; U.S. General Accounting Office. *Pharmacy Benefit Managers: Early Results on Ventures With Drug Manufacturers*. Report, GAO/HEHS-96-45, November 1995.

[43] U.S. Congressional Budget Office. *Health Care and Medicare Spending*, by Dan Crippen. Handouts presented to the Subcommittee on Health, House Committee on Ways and Means. March 8, 1999. Washington, 1999.

[44] Gluck, *A Medicare Prescription Drug Benefit.*

The ability to make cost estimates is complicated by a number of factors. The first is what beneficiaries can be expected to do in response to the addition of a drug benefit. Some beneficiaries would have coverage for some expenses previously paid out-of-pocket. The level of utilization is expected to rise in response; this is known as *induced demand*. It is particularly difficult to gauge the precise extent of induced demand that will occur.

Other factors could be expected to play a major role in the costs of a drug benefit. These include demographic considerations and major technological developments. Medicare will begin to face the impact of the baby boom population in 2011. This will result in a rapid increase in the sheer number of aged Medicare beneficiaries over the ensuing 20 years. The baby boom population is expected to live longer than previous generations. For at least the younger cohorts of aged (for example ages 65-69 or 65-75), this may mean a reduced incidence of disability compared to previous generations. It will also mean an increase in the number of older (and potentially sicker) Medicare beneficiaries.

The number and health status of the aged population will also be affected by future advances in medical technology. Of particular interest are the advances which are expected in pharmaceuticals. It is expected that many drugs currently in the development stage will have a major impact on health status. Many of these same drugs are likely to be more expensive than the drug therapies they are replacing.

It is difficult to predict the net impact of demographic trends and technological innovations on per capita spending. The addition of a Medicare drug benefit could further complicate the analysis. While the use of prescription drugs could rise for the target population, the utilization of some other perhaps more costly services (such as inpatient hospital services) could decline.

Financing

There is no consensus on how a drug benefit would be financed. Currently, Medicare's limited drug benefit is funded under the Part B program. As is the case for other Part B spending, beneficiary premiums cover 25% of program costs, while federal general revenues finance the remaining 75%. Absent other changes, the addition of a comprehensive drug benefit would mean a significant increase in overall Medicare expenditures paid by general revenues. Some have suggested that specific federal revenues could be targeted. For example, tobacco taxes could be increased or federal estate tax revenues could be earmarked for the new benefit.

As noted previously, decisions would need to be made regarding what portion of the costs would be assumed by the beneficiaries themselves. For example, would beneficiaries pay a premium equal to 25% of program costs as they currently do for Part B benefits (including covered drugs)? Some proposals (including the 1988 MCCA bill) would have had higher income beneficiaries pay a larger portion of the costs while the lower-income paid a smaller portion. This approach, which also has been suggested for other Medicare expenditures, is controversial.

It is expected that one of the most difficult issues to resolve during the coming debate on drug coverage will be how the benefit should be financed.

Breaux-Thomas Plan [45]

Coverage of prescription drugs was one of the most difficult issues facing the National Bipartisan Commission on the Future of Medicare. The Commission, established by BBA 97, was charged with making recommendations concerning a number of specific program issues. The Commission was required to report its recommendations to Congress by March 1, 1999. However, by statute, any recommendations had to have the approval of 11 of the 17 Commission members.

Senator Breaux (Statutory Chairman) and Congressman Thomas (Administrative Chairman) offered a Medicare reform proposal to the Commission members. On March 16, 1999, the Commission voted 10-7 for the Breaux-Thomas plan. Since the proposal failed to get the necessary 11 votes, no formal report will be made to the Congress or the President. However, both Senator Breaux and Congressman Thomas have stated that they intend to introduce legislation patterned on their recommendations.

The final Breaux-Thomas proposal dated March 16, 1999 offered a premium support plan under which beneficiaries could choose from competing health plans to obtain their health services; they could also remain in the traditional fee-for-service program. The proposal contained several provisions relating to prescription drug coverage. The Breaux-Thomas plan would have provided federal coverage for prescription drug costs for persons below 135% of poverty (i.e., the QMB/SLIMB population). It would also have required all Medigap plans to offer prescription drug coverage and one plan would be limited to prescription drug coverage only.

When beneficiaries chose between competing private health plans, they would have the option of selecting a basic plan (which covered current Medicare benefits) or a high option plan with prescription drug benefits. Beneficiaries remaining in fee-for-service could purchase a high option drug package to supplement their fee-for-service coverage.

Low-Income Coverage

Under the Breaux-Thomas proposal, Medicare prescription drug coverage would be immediately extended to the population below 135% of poverty. Full federal funding would be provided for the drug benefit. In addition, *full* federal funding would be provided for any additional costs for the *basic* QMB/SLIMB programs (i.e., cost sharing and premium charges) which occurred as a result of increased enrollment.

The summary indicates that this portion of the proposal would benefit 6 million people. The drug provisions would cost $31 billion over 10 years (FY2000-FY2009) and the expanded basic QMB/SLIMB coverage would cost an additional $30 billion over the period.

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[45] Summary of final Breaux-Thomas plan taken from handouts at Commission Meeting, Tuesday March 16, 1999.

Medigap

The Breaux-Thomas plan would require all Medigap plans to offer basic coverage for prescription drugs. One plan would be a prescription drug only plan. The March 16, 1999, summary states that the coinsurance could vary by plan. Medigap prescription drug coverage would vary significantly among plans if a wide range of coinsurance was allowed (for example from 20% to 50%).

Premium Support

The Breaux-Thomas proposal would combine the current Medicare Part A and Part B programs. As noted, the proposal contained a premium support plan under which Medicare beneficiaries could choose from competing health plans to obtain their health services. They could also remain in the fee-for-service program.

All plans would offer a standard benefits package which covered services under the existing Medicare Part A and Part B programs. In addition, all private plans would be required to offer a high option that included at least the standard benefits package plus coverage for prescription drugs. The government-run fee-for-service plan would also offer a high option plan covering prescription drugs.

On average, beneficiaries would be expected to pay 12% of the total cost of standard option plans.[46] There would be no beneficiary premium for plans costing 85% or less of the national weighted average premium. On the other hand, beneficiaries would pay all premium costs above the national weighted average premiums for plans costing above this level. Only the costs of the standard benefit package would count toward the computation. High option plans would be required to separately identify the incremental costs of benefits above the standard package. The government contribution would be calculated without regard to the costs of the additional benefits. (Thus in most cases, beneficiaries would pay the full cost of the additional benefits.)

A special provision would apply in areas where only the government-run fee for service plan operated. Beneficiary premiums would be limited to the lower of 12% of the fee-for-service premium or 12% of the national weighted average premium, whichever was lower.

Prescription drug coverage for low-income persons could be provided through high option plans when the premium support system was implemented. Special provisions would apply for the government contribution for persons below 135% of poverty. The government would pay 100% of the premiums of high option plans which were at or below 85% of the national weighted average premium of all high option plans. In areas where all high option plans exceeded this threshold, the percentage would be determined locally to ensure that all low income beneficiaries had access to high option plans. The Breaux-Thomas summary indicated that the financial support would neither limit the low-income beneficiaries' choice of plans nor

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[46] Under current law, beneficiary Part B premiums are expected to be 12% of total Medicare expenditures when BBA 97 is fully implemented.

restrict plans' design with regard to cost-sharing or other flexibility authorized by the newly established Medicare Board. Presumably, this would mean that low-income beneficiaries could be liable for the same cost-sharing charges as other beneficiaries under the same high option plan.

Current Prospects

It is anticipated that the 106th Congress will consider adding prescription drug coverage to Medicare. It is expected that any such discussion will take place as part of the larger discussion on potential reforms to Medicare. Some observers contend that any reform package that gets congressional approval will have to include a drug benefit.

It is difficult to gauge whether the 106th Congress will be able to pass a Medicare reform bill. Many observers contend that the pressure for immediate reform has been removed. They cite both the failure of the Commission to gain sufficient votes for a reform proposal and a significant delay in the projected insolvency date of the Part A trust fund.