

A Medicare Prescription Drug Benefit

By Michael E. Gluck

Summary

Even though almost two-thirds of Medicare beneficiaries have some coverage for outpatient prescription drugs, pharmaceuticals are a major part of their out-of-pocket expenses and threaten the financial security of growing numbers of beneficiaries. Because pharmaceuticals are an integral part of modern health care, some have proposed adding a drug benefit to Medicare. Such proposals pose difficult questions of design, cost, and administration. A drug benefit could add between 7 and 13 percent to Medicare costs over the next decade. If such a benefit were added to Medicare, policymakers would have to decide who should bear these costs and whether subsidies should be provided to help lower income beneficiaries pay the portion of the costs borne by participants.

Pharmaceutical therapies have become increasingly important since Medicare was enacted in 1965. The pace of scientific advances in this area is accelerating. While the Food and Drug Administration approved 62 new drug entities during Medicare's first five years (1966-70), it approved 149 between 1994 and 1998, an increase of 140 percent.¹ In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, they facilitate expensive treatments (as in the use of immunosuppressant drugs for organ transplants). In other cases, they provide treatment where none existed before.

Overall, spending on prescription drugs has been rising faster than other components of the health care bill. Between 1992 and 1998, spending on pharmaceuticals in the United States almost doubled from \$49 billion to \$93 billion. In 1999 alone, drug costs are expected to rise between 14 and 18 percent, while all health spending is expected to increase 5.3 percent.²

Outpatient prescription drugs are not covered under Medicare's mandated benefits package. Even though most Medicare beneficiaries have some coverage of drugs from their supplemental insurance policies, pharmaceutical expenses are a substantial and growing out-of-pocket expense for many beneficiaries. Spending on outpatient pharmaceuticals in 1999 is estimated to average \$942 per beneficiary, roughly half paid by insurers and half paid out of pocket by beneficiaries.³

Like other health spending, total and out-of-pocket expenditures on drugs are skewed; a large fraction of beneficiaries spend relatively modest amounts on drugs and a minority spends a great deal (Table 1). The median out-of-pocket expenditure is about \$200. About 29 percent of beneficiaries have out-of-pocket drug expenses of more than \$500, 14 percent (about 4.5 million beneficiaries in 1999) have out-of-pocket expenses of more than \$1,000, and 4 percent (1.3 million beneficiaries) have expenses that exceed \$2,000.

Table 1**Distribution of Medicare Beneficiaries by Outpatient Prescription Drug Spending, 1999^a**

	Total Drug Spending (from all sources) ^b	Out-of-Pocket Drug Spending
No Expenditures	14%	17%
\$0.01-\$199	19	34
\$200-\$499	17	21
\$500-\$999	19	15
\$1,000-\$1,499	12	7
\$1,500-\$1,999	7	3
\$2,000 or more	13	4
Total Percent of Beneficiaries	100	100
Total Number of Beneficiaries	32,043,891	32,043,891

a Includes all non-institutionalized Medicare beneficiaries except those who enrolled in a Medicare+Choice plan at any point during the calendar year.

b Includes out-of-pocket spending by beneficiaries as well as payment by insurers.

Source: National Academy of Social Insurance, 1999; Estimates by Actuarial Research Corporation based on data from the 1995 Medicare Current Beneficiary Survey.

It is worth noting that the estimates in Table 1 exclude beneficiaries who were enrolled in a Medicare HMO (about 14% of beneficiaries in 1998). While 95 percent of Medicare HMO beneficiaries have prescription drug coverage,⁴ they are, on average, healthier than other beneficiaries⁵ suggesting they may have less need of pharmaceuticals.⁶

The growing importance of drug therapies in modern medicine, their increasing cost for Medicare beneficiaries, and concern that these costs keep growing numbers of Medicare beneficiaries from following the drug therapies prescribed by their physicians⁷ have led some experts and policymakers to advocate adding an outpatient prescription drug benefit to Medicare. The cost of such a benefit, combined with the fact that almost two-thirds beneficiaries have at least some coverage through other insurance policies, have led others to oppose such

an expansion, especially when changes are needed to assure adequate financing for the existing program. This *Brief* reviews issues that face policymakers as they consider whether to include a drug benefit in Medicare and, if they do, what form it should take.

Prescription Drug Coverage Among Medicare Beneficiaries

In 1995 about 65 percent of Medicare beneficiaries had some form of prescription drug coverage.⁸ Table 2 shows the sources of this coverage, which include employer-sponsored policies, Medicare HMOs (now part of the Medicare+Choice program), Medicaid, and individually-purchased Medigap policies. As shown in this table, 33 percent of Medicare beneficiaries in 1995 had supplemental coverage through employer sponsored plans, and 86 percent of these beneficiaries had drug coverage. Hence, 28 percent of all Medicare beneficiaries had employer sponsored supplemental coverage with drug benefits.

The nature and scope of the pharmaceutical coverage enjoyed by Medicare beneficiaries varies greatly and is changing:

Employer-sponsored coverage (for both retirees and Medicare beneficiaries who continue to work) has traditionally offered among the richest pharmaceutical benefits, with retirees often facing low deductibles and fixed dollar co-payments for each prescription dispensed. In recent years, the fraction of employers offering supplemental insurance for their retirees and the generosity of these benefits have declined.⁹ When offered, such policies increasingly require retirees to receive their health care through managed care plans, which, while limiting out-of-pocket expenditures, frequently use formularies that limit beneficiaries access to brand name drugs.

Medicaid covers virtually all prescription drug costs for Medicare beneficiaries with incomes low enough to be eligible for Medicaid.¹⁰ While many states have received federal waivers allowing them

Table 2

Outpatient Drug Coverage Among Noninstitutionalized Medicare Beneficiaries by Type of Supplemental Insurance, 1995

	Percent of Beneficiaries with Specified Type of Supplemental Insurance	Percent of Beneficiaries with Each Type of Supplemental Insurance who Have Drug Coverage	Percent of All Beneficiaries with Drug Coverage
Employer Sponsored ^a	33%	86%	28%
Medicaid ^b	12	90	11
Medicare Risk HMO	7	95	7
Individually Purchased (Medigap)	29	29	8
All Other ^c	3	89	3
Switched Coverage During the Year ^d	8	80	6
No Supplemental Insurance	8	0	0
Total	100	N/A	65 ^e

Key: N/A-not applicable. HMO-health maintenance organization.

Notes: Data are based on noninstitutionalized, community based population and include those who were enrolled in Medicare at some point during the year. Each person has been assigned to one supplementary insurance category, but they may or may not obtain their drug insurance coverage from that source.

a Includes those who only had employer-sponsored supplemental insurance and those who had both employer-sponsored and individually purchased supplemental insurance.

b Includes beneficiaries receiving full Medicaid benefits, as well as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs).

c Includes other public programs such as Veterans Affairs, Department of Defense, and State Pharmaceutical Assistance Programs for low-income elderly, as well as non-risk HMOs (cost and health care prepayment plans).

d Includes beneficiaries who did not spend 100 percent of their Medicare-eligible months in one insurance category.

e Column does not add up to total due to rounding error.

Source: National Academy of Social Insurance, 1999. Data from Davis, M., et al., "Prescription Drug Coverage, Utilization, And Spending Among Medicare Beneficiaries." *Health Affairs* 18(1): 231-243, January/February 1999 and the 1995 Medicare Current Beneficiary Survey.

to enroll Medicaid beneficiaries in managed care plans that may not cover all prescription drugs, dually eligible Medicare beneficiaries are exempted from these waivers. In addition, lower income elderly who do not qualify for Medicaid can receive assistance with prescription drug costs in 13 states through state-run programs.¹¹

Many **Medicare HMOs** (now **Medicare+Choice** plans) provide their beneficiaries with some drug coverage. Plans have been able to do this because the federal payments they receive for each Medicare enrollee have been relatively generous in areas in which fee-for service Medicare spending is high. Because federal rules limit the profit margins plans can make on their Medicare

business, some plans have chosen to attract beneficiaries by offering extra benefits to Medicare enrollees, including outpatient prescription drugs, for no additional premium. While these plans often require only a small co-payment from beneficiaries for each prescription, most limit their prescription drug payments to \$1,000 or less for each beneficiary each year.¹² The Balanced Budget Act of 1997 (P.L. 105-33) will reduce the growth rate in federal payments to Medicare+Choice plans, especially in areas where they have been relatively high. Plans may react by cutting back prescription drug coverage, increasing premiums, or both.

Medigap policies—individually purchased supplementary policies—offer limited or no coverage

Table 3

Average Annual Premiums of Selected Medigap Policies in Five Cities, 1999

	65 Year Old		75 Year Old	
	Policy C (does not include drug coverage) ^a	Policy I (includes outpatient drug coverage) ^b	Policy C ^a	Policy I ^b
Dallas, TX	\$1,046	\$2,294	\$1,295	\$2,974
Denver, CO	974	2,589	1,199	3,221
Los Angeles, CA	1,502	3,362	1,820	4,437
Miami, FL	1,510	3,428	1,890	4,158
Manchester, NH	917	1,945	1,247	2,581

a Benefits of Medigap policy "C" are: coverage of all Part A (hospital) coinsurance for stays longer than 60 days, the 20% Part A coinsurance, Parts A and B blood deductible, skilled nursing facility coinsurance, Part A deductible, Part B deductible, medical emergencies while outside the United States.

b Benefits of Medigap policy "I" are the same as those of policy "C" except that: (1) policy "I" includes coverage of 50% of outpatient prescription drug expenditures up to \$1,250 after meeting a \$250 deductible, 100% of any physician fees in excess of Medicare's "reasonable charges," and up to 40 at-home visits during recovery from an acute illness, and (2) policy "I" does not cover the Part B deductible.

Source: "Medicare: New Choices, New Worries," *Consumer Reports* (September 1998): 27-39. Rice T., Graham, M.L., Fox, P.D., "The Impact of Policy Standardization on the Medigap Market," *Inquiry* 34 (Summer 1997): 106-116.

of prescription drugs. Federal law permits ten standard Medigap policies developed by the National Association of Insurance Commissioners.¹³ Only three of these plans (called plans H, I, and J) include prescription drug coverage. The prescription drug benefits in these plans are not particularly generous. Two plans (H and I) pay 50 percent of drug costs up to \$1,250 after the beneficiary meets a \$250 deductible. Plan J is the same except its maximum benefit is \$3,000.

The costs of these three Medigap plans are high relative to other Medigap plans. To illustrate, Table 3 compares premiums charged in several localities for Medigap plan C (which does not cover prescription drugs) and plan I (which is similar except that it adds limited drug coverage, some home health benefits not included in Medicare, and coverage of all physician charges not paid by Medicare). The added coverage more than doubles the beneficiary's annual premium; the bulk of this difference is attributable to the prescription drug benefit.¹⁴ The difference in premium suggests that the more extensive coverage may attract sicker patients who are heavy users of pharmaceuticals.¹⁵ In addition, those with

Medigap policies often pay high prices for their prescriptions. Like Medicare beneficiaries who lack prescription drug coverage, they do not receive the volume discounts that members of employer sponsored and managed care plans often enjoy.

Designing a Benefit

An outpatient prescription drug benefit can be designed to meet any of several objectives. It could be designed to protect Medicare beneficiaries from catastrophic drug costs, to help those with moderate expenses meet their bills, or to provide assistance to low-income individuals who lack access to prescription drug coverage at an affordable price. One important question for policymakers who opt for benefits designed to help those with catastrophic and moderate expenses is whether this coverage would create incentives for employers who currently offer retiree coverage to eliminate them, and whether it would be desirable for Medicare to absorb these costs currently borne by employers.

Coverage for all beneficiaries—Under this approach, Medicare would help pay for any benefi-

ciary's prescriptions once she paid an annual deductible. The lower that policymakers set the deductible, the more people would benefit. A key question for policymakers is whether such coverage would include a maximum benefit similar to those of Medigap policies H, I, and J in order to limit costs. Policymakers would also have to decide how much beneficiaries should pay for each covered prescription. Most employer-sponsored retiree health plans either pay 80 percent of drug costs after the beneficiary has met an overall medical spending deductible or require modest co-payments with each prescription (for example, \$5 co-payment for generic drugs,¹⁶ \$10-\$15 for brand name drugs) but no deductible.¹⁷ Another way to structure the benefit would be to provide beneficiaries with a voucher toward the purchase of private prescription drug insurance policies, which the federal government could choose to standardize as it has done for Medigap insurance.

Coverage for beneficiaries with extraordinary drug expenses only—Under this approach, Medicare would pay a share—for example, 50 percent—of drug costs above a fairly high deductible—for example, \$500. If out-of-pocket spending exceeded a threshold—for example, \$2,000—Medicare would pick up all additional costs.¹⁸ This type of benefit helps limit the financial liability of individuals with unusually high pharmaceutical bills, but beneficiaries would need to find other resources to pay for drug expenses up to the deductible as well as the coinsurance amounts.

Coverage for low income beneficiaries only—This approach would help only low income Medicare beneficiaries who lack other prescription drug insurance – in particular, the poor and near-poor who do not qualify for Medicaid.¹⁹ Such a targeted approach would limit the federal government's financial exposure for drugs.

There are at least two sharply different approaches to providing this type of benefit. One approach would be to provide pharmaceutical coverage to Qualified Medicare Beneficiaries (QMBs), Supplemental Limited Medicare Beneficiaries (SLMBs), and federally Qualified Individuals.

These three groups are low income Medicare beneficiaries who do not qualify for Medicaid, but who receive help in paying their Medicare premiums and cost sharing requirements. Under this approach, policymakers would have to decide how to split the costs of the program between the states and the federal government. Currently, large numbers of individuals who are eligible for QMB and SLMB subsidies do not apply for them.²⁰

An alternative approach would be to provide retrospective tax credits for prescription drug spending. While a tax credit would be relatively easy to administer through tax returns, it would require that beneficiaries pay for their prescriptions up front. In addition, some lower income beneficiaries may not file income tax returns.

Administering the Benefit

No matter what form a prescription drug benefit took, it would raise a number of administrative questions. Except for a tax credit, policymakers would have to decide who would manage the benefit for those enrolled in the traditional, fee-for-service part of the program. (Presumably, health plans would administer the benefit for those enrolled in Medicare+Choice, although the government would still have a role in setting and enforcing standards for drug coverage offered by the private health plans.)

If HCFA or its contractors were to process individual claims as they do for other Medicare services, the agency would need to oversee establishing relationships with providers (pharmacies) and **standardizing the claims filing and payment processes**. Overseeing claims processing of other covered services has been one of HCFA's core functions, and the agency has had some oversight role and understanding of how state agencies have administered Medicaid's drug benefit.

If HCFA were to administer the benefit, policymakers would have to **specify a method for determining reimbursable prices** for pharmaceuticals. Medicare could adopt the pricing formula already used by Medicaid under which the federal govern-

ment has mandated that it receive a rebate from pharmaceutical manufacturers.²¹ An alternative would be for the federal government to negotiate prices directly with manufacturers, perhaps with the use of formularies, as described in the next paragraph. No matter what option policymakers choose, the pricing of drugs reimbursed by Medicare would be controversial given the dominant role the program would play in the market for pharmaceuticals.

Policymakers would have to make a decision about **whether to cover all drugs** under all prescribed circumstances. When there is more than one drug on the market that treats a given condition in a particular way, the decision of an insurer to reimburse for only a limited number of them can foster price competition among manufacturers that produces cost savings. Lists of reimbursable drugs are referred to as formularies and have been increasingly used by private health insurers. The more restrictive the formulary, the greater the bargaining power and cost savings for the insurer.²² Although restricting access to FDA-approved therapies might be a controversial undertaking for Medicare,²³ the desire to balance the needs of beneficiaries, manufacturers, and the public fisc may make this an option that policymakers will consider. In addition, at least one national group who advocates on behalf of Medicare beneficiaries, the American Association of Retired Persons, does not oppose the use of formularies by health plans and other providers as long as they maintain certain protections for patients.²⁴

An alternative to HCFA administering a prescription drug benefit itself would be to adopt a “**carve out**” model like those used by private health insurers. Firms that administer pharmaceutical insurance programs under contract to health plans are referred to as pharmaceutical benefit management companies or PBMs. HCFA could contract with PBMs on a capitated basis (i.e., for a set amount per Medicare enrollee) or through partial capitation in which the PBMs receive supplemental payments for patients with extraordinarily high pharmaceutical utilization.²⁵

Because PBMs save money by negotiating discounts and rebates from drug manufacturers, wholesalers, and pharmacies in exchange for being able to steer patients to particular products, largely through formularies,²⁶ saving money under this option would depend on PBMs ability to adopt formularies for Medicare beneficiaries as mentioned above. More generally, to what extent would the government regulate the PBMs and the benefits they provide? In considering options for a privately administered benefit, policymakers would have to weigh the simplicity of limited government involvement against the need to provide sufficient oversight to protect beneficiaries and taxpayers.

Cost Implications

Cost is a major concern in expanding Medicare’s benefit package to include prescription drugs. Cost estimates for a prescription drug benefit are difficult to make given limited available data and the uncertainty and importance of how a benefit would be structured and administered. However, given the centrality of cost, the National Academy of Social Insurance Study Panel on Medicare Financing²⁷ commissioned Actuarial Research Corporation to estimate the costs of five illustrative Medicare drug benefits to provide some insight into the general level of costs associated with this coverage.

One of the illustrative benefits has a maximum benefit of \$2,000 per year, while the other four have a stop loss (maximum out-of-pocket liability for beneficiaries) that ranges from \$1,000 to \$3,000 (Table 4). Members of the Study Panel were particularly interested in benefits with a stop loss feature to help beneficiaries with high drug costs, but hypothesized that such a design would cost more than one with a maximum benefit. The Panel chose to estimate several stop loss benefits to determine whether varying deductibles and coinsurance rates might lessen the fiscal impact of a stop loss.

The estimates assume that the federal government will realize a 10 percent discount from amounts

Table 4

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	\$610	10.0%
\$200 deductible, 50% coinsurance, \$2,000 stop loss	463	7.6
\$200 deductible, 50% coinsurance, \$3,000 stop loss	443	7.2
\$500 deductible, 20% coinsurance, \$2,000 stop loss	530	8.7
\$200 deductible, 50% coinsurance, \$1,000 stop loss	552	9.0

Source: National Academy of Social Insurance, 1999; Estimates by Actuarial Research Corporation, based on data from 1995 Medicare Current Beneficiary Survey.

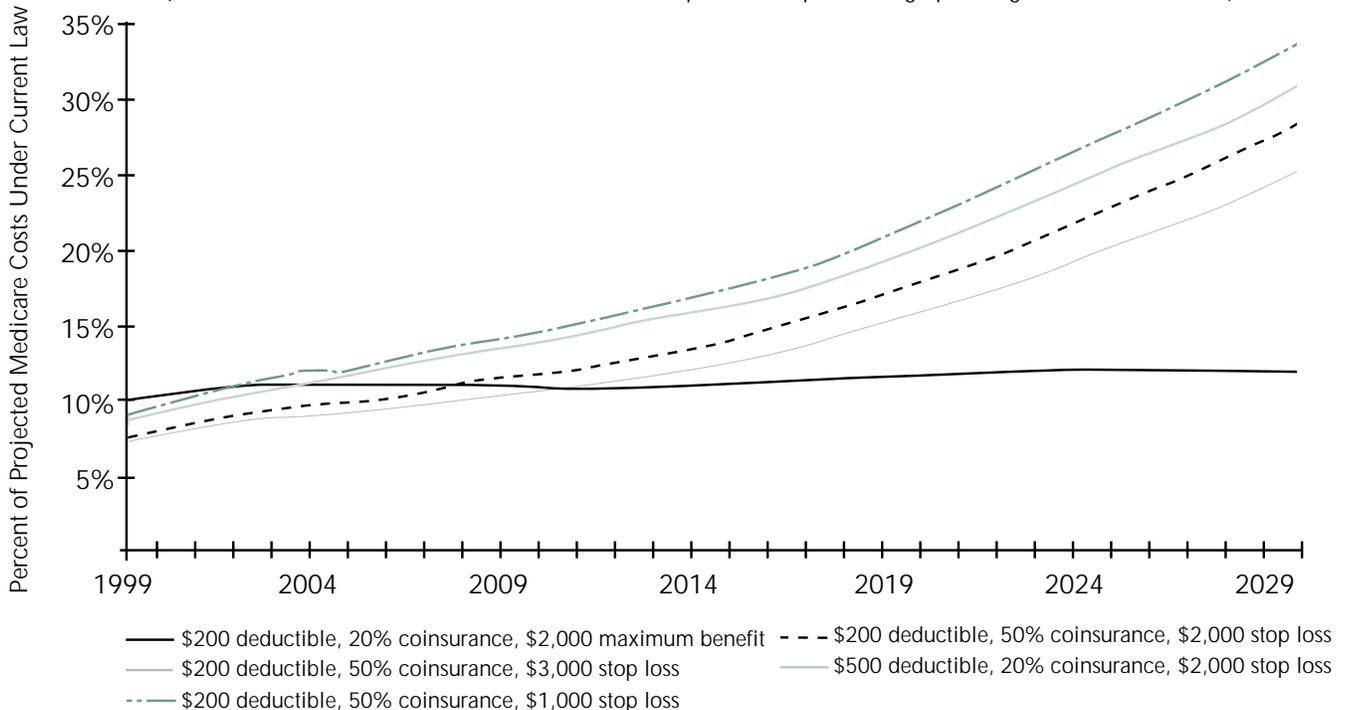
currently paid by beneficiaries for their drugs. They also assume that expanded coverage will lead to increased utilization. The deductibles, coinsurance rates, maximum benefits, and stop loss levels are assumed to rise at the same rate as the consumer price index (CPI).²⁸ Assumptions about how much Medicare beneficiaries' drug spending will increase over the 30 year period of the estimates are discussed in greater detail below.

In 1999, the estimated costs for the illustrative benefits would range from \$443 per beneficiary to \$609 per beneficiary (Table 4). As a percentage of projected baseline Medicare costs, the costs of a drug benefit with a stop loss guarantee would rise significantly over time (Figure 1).²⁹ This occurs because the model assumes that per capita drug costs will rise faster than other Medicare costs over the 30 year period of the projections³⁰ (and *despite*

Figure 1

Estimated Cost of Five Illustrative Medicare Drug Benefits as a Percentage of Projected Medicare Costs Under Current Law, 1999-2030

(Assumes Nominal Annual Growth Rate in Per Capita Prescription Drug Spending of 8.3% After 2008)



Source: National Academy of Social Insurance, 1999; Estimates by Actuarial Research Corporation, based on data from 1995 Medicare Current Beneficiary Survey.

the fact that the model assumes that deductibles, stop losses, and maximum benefits increase each year at the rate of the consumer price index). In 2030, the percentage increase in Medicare costs range from about 12 percent for the illustrative benefit with a \$2,000 maximum to about 34 percent for the illustrative benefit with a \$1,000 stop loss.

These results are extremely sensitive to assumptions about how fast per capita prescription drug spending will grow over time. If nominal per capita prescription drug spending after 2008 were to grow at 6.1 percent per year rather than the 8.3 percent rate that was assumed, projected cost increases in 2030 drop to a range from 10 percent for the benefit with a \$2,000 maximum to 19 percent for the benefit with a \$1,000 stop loss (Figure 2).³¹

No one knows how fast drug costs will increase over the next three decades. Sustained rapid growth in drug expenditures may increase pressure

for public policies to slow such growth as happened when other medical costs exploded during the 1980s and policymakers responded by introducing the prospective payment systems for Medicare hospital and physician services.

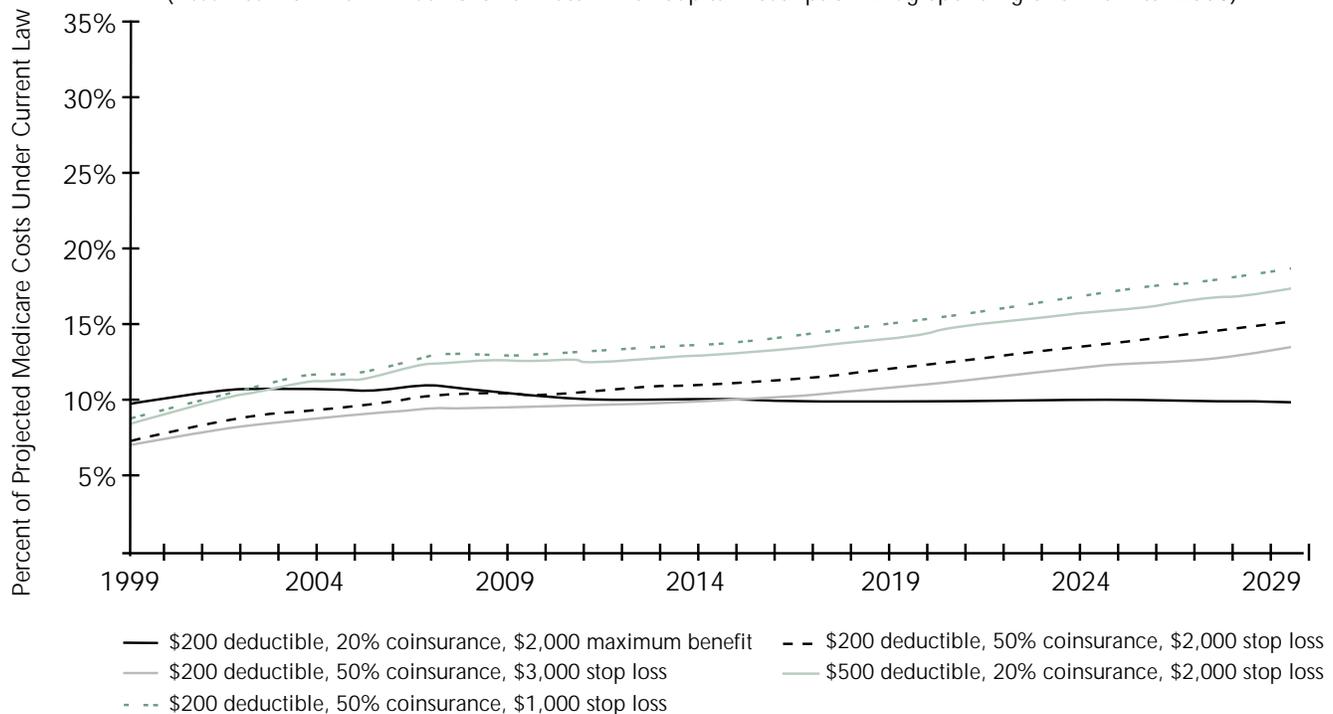
Other caveats to these estimates:

- Because respondents to the MCBS survey self-report their use of prescription drugs, there may be under reporting.³² Such underreporting would understate prescription drug spending and make the cost estimates above too low.
- The estimates do not include any new administrative costs of setting up a pharmaceutical benefit (which could be significant in the early years) or of maintaining it.
- The estimates may not accurately reflect the role that pharmaceuticals will play in the future. The estimates implicitly assume new

Figure 2

Estimated Cost of Five Illustrative Medicare Drug Benefits as a Percentage of Projected Medicare Costs Under Current Law, 1999-2030

(Assumes Nominal Annual Growth Rate in Per Capita Prescription Drug Spending of 6.1% After 2008)



Source: National Academy of Social Insurance, 1999; Estimates by Actuarial Research Corporation, based on data from 1995 Medicare Current Beneficiary Survey.

medical technologies will continue to add to health care costs. It is possible, however, that new pharmaceuticals may substitute for spending for other Medicare services such as hospitalization, surgery, or outpatient treatments.

- The estimates assume that the federal government would realize the 10 percent discount off of prices currently paid by Medicare beneficiaries and their insurers, but do not specify how it would be achieved.

Other Issues

Another issue is how any new costs to Medicare should be shared. A new pharmaceutical benefit would shift to Medicare some costs now borne out-of-pocket by beneficiaries for the drugs they purchase directly or for Medigap policies H, I, or J. It would shift to Medicare costs currently borne by employers for retiree coverage of prescription drugs. And it would shift to Medicare, prescription drug costs for low income beneficiaries eligible for Medicaid, which are jointly financed by federal and state funds. To what extent should these costs be borne by taxpayers versus beneficiaries and their former employers through premiums, deductibles, co-payments, and drugs or expenses not covered? Should states who will experience reduced Medicaid expenditures, be asked to chip in? Should the costs borne by low income beneficiaries be the same as those with high incomes? Or should there be subsidies? All these questions will have to be addressed in designing a Medicare drug benefit. In short, even if Congress and the public are convinced that Medicare should cover prescription drugs, creating an acceptable program will not be easy.

Endnotes

1. Hewitt, P., Research Librarian, Tufts Center for the Study of Drug Development, Tufts University, Boston, MA, personal communication, February 12, 1999.
2. Dichter, E., "Drug Trends" presentation to the Council on the Economic Impact of Health System Change conference on Technological Change and the Cost of Health Care, Washington, DC, February 10, 1999. U.S. Congress, Congressional Budget Office, *The Economic and Budget Outlook, 1999-2008* (Washington, DC: U.S. Government Printing Office, January 1999).
3. Unless otherwise noted, the cost and expenditure estimates in this *Brief* were done for the Academy by Actuarial Research Corporation using data from the 1995 Medicare Current Beneficiary Survey (MCBS) projected forward to 1999.
4. Davis, M., et al., "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries" *Health Affairs* 18(1): 231-243, January/February 1999.
5. U.S. Physician Payment Review Commission, "Risk Selection Remains a Problem in Medicare," *PPRC Update No. 21* (Washington, DC: July 1997).
6. In addition, as discussed in greater detail later in this *Brief*, the MCBS data set may underreport drug utilization, suggesting larger portions of beneficiaries may have drug expenditures that exceed each of these amounts.
7. Soumerai, S.B., et al., "Inadequate Prescription-Drug Coverage for Medicare Enrollees – A Call to Action" *New England Journal of Medicine* 340(9): 722-728, March 4, 1999. <http://www.nejm.org/content/1999/0340/0009/0722.asp>
8. Davis, M., et al., 1999, *op. cit.* These results are higher than previous estimates reflecting methodological improvements in working with the Medicare Current Beneficiary Survey (MCBS) data that brought to light supplemental prescription drug coverage not previously included. See for example, Chulis, G., Eppig, F., and Poisal, J., "Ownership and Average Premiums for Supplementary Insurance Policies," *Health Care Financing Review* 17(1): 255-274, Fall 1995.
9. In large measure the decline has been caused by accounting standards adopted in 1993, which require firms to record future retiree health benefits as a liability on their balance sheets. McArdle, F., "Presentation on Employer-Provided Retiree Health Benefits," to the Reform Task Force, National Bipartisan Commission on the Future of Medicare, Washington, DC, July 14, 1998. U.S. Congress,

General Accounting Office, *Private Health Insurance: Declining Employer Coverage May Affect Access for 55 to 64 Year-Olds*, GAO/HEHS-89-8133 (Washington, DC: U.S. Government Printing Office, June 1998).

10. This does not include Qualified Medicare Beneficiaries (QMBs) or Specified Limited Medicare Beneficiaries (SLMBs), who receive Medicaid funds to help them pay their Medicare cost-sharing obligations.
11. States with low income pharmaceutical assistance programs for the elderly in 1999 are: Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, Vermont according to Kim Moran, Project Coordinator, Communications Department, National Pharmaceutical Council, Incorporated, Reston, Virginia, personal communications, February 23, 1999.
12. Soumerai, S.B., et al., 1999, *op. cit.* For the details of benefits offered by Medicare+Choice plans throughout the country, see the "Medicare Compare" database at U.S. Health Care Financing Administration website <http://www.medicare.gov>.
13. Premiums for any given policy vary as well to reflect the risk of the individual except under certain circumstances established by the federal government.
14. Rice T., Professor of Health Services, University of California at Los Angeles, personal communications, March 22, 1999. In background analysis conducted for Rice T, M. L. Graham, and P. D. Fox, "The Impact of Policy Standardization on the Medigap Market," *Inquiry* 34 (Summer 1997) 106-116, prescription drug coverage represented 21 percent of the total actuarial value of Plan I or 71 percent of the difference in actuarial values of Plans C and I plus the actuarial value of coverage of the Part B deductible. (Plan I has prescription drugs and two other benefits not found in Plan C, but Plan C offers one benefit not found in Plan I – coverage of the Part B deductible.)
15. Rice, T., "Problems with the Supplemental Insurance System: Implications for Medicare Reform," commissioned paper for the National Academy of Social Insurance Study Panel on Medicare Financing, November 1998; "Medicare: New Choice, New Worries," *Consumer Reports* (September 1998): 27-38.
16. Brand name drugs refer to those chemical entities covered by patents and typically manufactured by only one firm. Generic drugs refer to those chemical entities whose patent has expired and are sold by multiple manufacturers, usually at lower prices than brand name drugs.
17. McArdle, F., *op. cit.*
18. The Medicare Catastrophic Coverage Act of 1988 (repealed in 1989) offered this type of coverage for pharmaceuticals. Once a beneficiary met a deductible, Medicare would have paid 80 percent of the drug's allowed price. The federal government would have set the deductible each year so that 16.8 percent of beneficiaries would have had prescription drug spending that exceeded the deductible. In the first year of the program (1990), the deductible would have been \$550.
19. In 1997, only 42 percent of poor beneficiaries qualified for Medicaid at any point during the year. Of those with incomes between 100-125 percent of poverty, 20 percent had no supplemental coverage at all; and for those between 126-200 percent of poverty, 16 percent had no supplemental coverage of any type; Gross, D. J., *op. cit.*
20. Families USA Foundation, *Shortchanged: Billions Withheld from Medicare Beneficiaries* (Washington, DC: July 1998).
21. For "non-innovator, multiple source drugs," (i.e. those not covered by patents that prevent generic manufacturing), the rebate is equal to 11 percent of the average manufacturer price (AMP) per unit of drug sold. For innovator drugs (i.e. those covered by patents that prevent generic manufacturing), the rebate is equal to (1) 15.1 percent of AMP or (2) the difference between AMP and the best price plus an additional rebate based on increases in the drug's cost that exceed overall inflation in the economy (based on the CPI-U) since the drug entered the market. AWP is the drug's list price before discounts. AMP is the price of the drug net of all discounts provided to private purchasers. Best price is the lowest price charged to any purchaser in the United States including wholesalers, retailers, non-profit organizations, and governmental agencies. These definitions are provided in the rebate agreement between the Secretary of Health and Human Services and pharmaceutical manufacturers which may be found through the worldwide web at <http://www.hcfa.gov/medicaid.drug8.htm>. For a more detailed description of the Medicaid rebate program and its possible unintended impact of reducing discounts given to private purchasers of drugs, see U.S. Congress, Congressional Budget Office, *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry* (Washington, DC: U.S. Government Printing Office, January 1996) and U.S. Congress, General Accounting Office, *Medicaid: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain*, GAO/HEHS-94-194FS (Washington, DC: U.S. Government Printing Office, 1997).

22. U.S. Congress, Congressional Budget Office, *op. cit.*; U.S. Congress, Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry* (Washington, DC: U.S. Government Printing Office, July 1998).
23. Some state Medicaid programs used formularies until the Omnibus Budget Reconciliation Act (OBRA) of 1990, the same law that established the rebate program described in note #21, prohibited them.
24. In particular, AARP states that health plans who use formularies should: “ensure participation of plan physicians in the development of the formulary; disclose the nature of formulary restrictions and utilization management policies; inform the plans members about whether the drug benefit is being managed by a PBM as well as the PBM’s parent company; and make allowance for formulary exceptions when medical necessity dictates that a non-formulary alternative is needed, and ensure that plan members are aware of how such alternatives can be obtained.” Gross, D., Senior Policy Advisory, AARP Public Policy Institute, Washington, DC, personal communications, March 18, 1999.
25. Reimbursing PBMs on a purely fee-for-service basis (i.e. a reimbursement for each pharmaceutical used) would be equivalent to the PBMs acting as a claims processor without necessarily having incentives to be prudent purchasers or otherwise cost conscious. The federal government would retain all of the responsibilities for deciding about pricing and formularies outlined above.
26. U.S. Congress, Congressional Budget Office, July 1998, *op. cit.*
27. This Study Panel is one of five groups convened by the Academy as part of its *Restructuring Medicare for the Long Term* project. Each panel is charged with analyzing a different aspect of Medicare’s long-term challenges and includes experts drawn from diverse philosophical, institutional, and disciplinary backgrounds. The Academy’s web site contains greater detail about the project, Study Panel members, reports, and other products: <http://www.nasi.org>.
28. The data for the estimates come from the 1995 MCBS trended forward to 1999.
29. Projections of Medicare spending under current law are based on Trustees of the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds, *1998 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* and the *1998 Annual Report of the Board of the Federal Supplementary Medical Insurance Trust Fund* (Washington, DC: April 28, 1998).
30. These assumptions are based on HCFA projections for real per capita growth in prescription drug expenditures, real per capita growth in expenditures for other Medicare services, and projected increases in the gross national product price deflator. The estimates presented in Figure 1 assume a 5.6 percent real annual per capita increase in drug expenditures through 2008 plus a 3.1 percent gross domestic product (GDP) annual price deflator to capture general inflation in the economy (compounded to a nominal annual per capita increase in drug expenditures of 8.9 percent). After 2008, the estimates in Figure 1 assume a 5.0 percent real annual per capita increase in drug expenditures plus a 3.1 percent GDP price deflator (8.3 percent compounded). Estimates in Figure 1 also assume a 2.4 percent annual increase in real per capita expenditures in other Medicare costs plus a 3.1 percent implicit GDP price deflator (compounded to 5.6 percent) over the whole 31 year period.
31. The estimates in Figure 2 assume a 2.4 percent real annual per capita increase in drug expenditures plus a 3.1 percent GDP price deflator (6.1 percent compounded) after 2008. All other assumptions for estimates shown in Figure 2 are the same as those shown in Figure 1.
32. Davis M, et al, 1999, *op cit.* Although the MCBS survey administrators attempt to verify drug expenditures by checking other databases and asking respondents to save pill bottles and records, some beneficiaries may not remember to record all of their spending. Previous household surveys found 15-20 percent underreporting in prescription drug costs and use. See Berk, M., Schur, C., and Mohr, P., “Using Survey Data to Estimate Prescription Drug Costs,” *Health Affairs* 9(3):146-156, Fall 1990.

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NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

1776 Massachusetts Avenue, NW
Suite 615
Washington, DC 20036-1904
202/452-8097
202/452-8111 Fax
nasi@nasi.org
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