Medicare Prescription Drug Coverage

By Laura Hermer

Medicare is the primary means by which most Americans age 65 and older, as well as certain disabled individuals, obtain primary coverage for health care. When Medicare was first enacted in 1965, pharmaceuticals were prescribed far less widely than they are today, and many health insurance plans accordingly did not include them within the scope of their coverage. In the ensuing 38 years, pharmaceutical costs have become a significant portion of most seniors’ medical bills. The Congressional Budget Office found that over half of all Medicare beneficiaries spend more than $1,000 per year on prescription drugs. Forty three percent of all Medicare beneficiaries spend between $1,000 and $4,000 yearly on pharmaceuticals. Eight percent spent between $4,001 and $6,000, and an additional 6 percent spent over $6,000 per year.

The traditional fee-for-service Medicare program does not cover most prescription drugs. Presently, 85 percent of all Medicare beneficiaries are enrolled in Medicare’s fee-for-service program. Because traditional Medicare covers only approximately 56 percent of all health care costs for beneficiaries, 87 percent of all Medicare enrollees obtain additional health insurance to supplement their coverage. Only three of the ten standard “Medigap” policies cover prescription drug costs, and they tend to be the most expensive options. Thus, even though a large majority of Medicare beneficiaries have Medigap policies, 38 percent of Medicare beneficiaries have no prescription drug benefits from any source.

In 1997, the “Medicare+Choice” program was established to offer beneficiaries several other choices for service delivery. Under Medicare +Choice, beneficiaries can elect to receive services through a managed care organization such as an HMO or PPO, through a private fee-for-service arrangement, or through catastrophic health insurance in conjunction with establishment of a medical savings account (MSA). The Medicare + Choice options operate, in effect, like a premium assistance system, where Medicare pays a flat rate to private insurers for each enrolled beneficiary. The beneficiary, in turn, must pay not only the standard premium for Part B coverage to Medicare, but may also need to pay an additional premium to the private insurer, along with any applicable deductibles and/or co-payments under the private insurer’s plan. At this time, Medicare + Choice is available to all categories of beneficiaries except those who qualify for Medicare due to end-stage renal disease.

It was originally thought that beneficiaries would be drawn to the Medicare+Choice program because items such as pharmaceuticals might be covered under the plan without the need for a Medigap policy. However, a large number of the HMO plans that originally chose to participate in the program have since dropped their Medicare beneficiaries. The combination of price and reimbursement caps imposed by the government in conjunction with the program’s benefit requirements became too costly for

5 See RANI E. SNYDER ET AL, PAYING FOR CHOICE: THE COST IMPLICATIONS OF HEALTH PLAN OPTIONS FOR PEOPLE ON MEDICARE I (Kaiser Family Foundation, January 2003).
7 See Kaiser Family Foundation, supra note 2.
many HMO plans to remain in the game. Thus, there are presently a dwindling number of HMOs from which beneficiaries may presently choose. Also, many remaining HMOs are cutting back on their services. Some have cut or even eliminated coverage for prescription drugs – one of the benefits most sought-after by beneficiaries electing the HMO option. Other insurers are putting caps on their prescription drug and other costly benefits, and are raising copayments for them.10

In this environment, Medicare beneficiaries are united in their call for prescription drug benefits. Yet providing such a benefit will be costly. Barring a massive influx of new money, any new prescription drug benefit will need to be structured so that it assists those with the greatest need with their most important drugs for the least amount of money. Towards this end, Congress has made several proposals. The two with the most widespread congressional support from the last session entailed adding a prescription drug benefit for all Medicare beneficiaries. Both would require a new premium of $25 or $33 per month. Each would cover differing amounts of costs, with the most popular Senate plan providing much more generous benefits (at a higher price tag) than the House bill. Although both contemplate the involvement of private insurers, neither would require Medicare beneficiaries to switch enrollment from a traditional plan to a Medicare+Choice plan, or vice versa. The Congressional Budget Office estimates the House plan would cost $309 million over the first 10 years of the program, and the Senate plan would cost $594 billion over the same period.11

The Bush plan, on the other hand, would require the enrollment of Medicare beneficiaries in a Medicare+Choice plan in order to access prescription drug benefits. As such, no new benefit would be offered; rather, prescription drug coverage would be incorporated into a whole health plan. Those who wished to remain in the traditional Medicare program could do so, but would have no prescription drug benefits through it. Instead, the administration’s latest proposal would merely provide them with a prescription drug discount card and cap their out-of-pocket expenses at $4,500 or $6,000 per year.

For those who wished to receive their health care through an HMO, the Bush administration proposes choosing the three lowest bidders from among private HMOs to provide Medicare services within 10 geographic regions. The standard plan would have a $275 deductible. Beneficiaries who choose to join an HMO would be responsible for half of all drug costs thereafter up to $3,050 per year. Thereafter, the beneficiary would be responsible for all further drug costs, unless she spends more than $5,500 per year on drugs, in which case the plan would pay for 90 percent of all further costs that year.12 The White House claims that the plan would “allow seniors to strengthen the private health insurance coverage that helps well over half of seniors today - seniors would not see their coverage replaced by a one-size-fits-all government plan.” It also claims that “all seniors would have choices of drug coverage . . . no senior would be forced to accept just one or two “options” in which the government controls which drugs are covered.”13 Its cost is preliminarily estimated to be $400 billion over ten years.14

One can argue that some prescription drug coverage is better than none, and therefore that it is better for at least one of the proposals to pass in some form than for none to pass at all. There are, however, a number of serious questions about the proposals which warrant their reconsideration. One must first question why the federal government – as contemplated in all three proposals - would want private health insurers to act as intermediaries between the federal government, which will be the primary payor, and those Medicare beneficiaries who choose to participate in the program. Will there really be substantial cost savings by putting for-profit companies in charge of offering and administering benefits?

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10 Milt Freudenheim, Many H.M.O.s for the Elderly Make Deep Cuts in Drug Aid, NEW YORK TIMES (January 25, 2002).
11 See, e.g., HEALTH POLICY ALTERNATIVES, INC., PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: A SIDE-BY-SIDE COMPARISON OF SELECTED PROPOSALS 60 (Kaiser Family Foundation, July 2002).
14 See Robert Pear, supra note 12.
Will beneficiaries really be better served? It is not as if the prescription drug plans contemplated by the House and Senate bills currently exist. They do not. Therefore, a federal incursion into the terrain would be no more novel than private efforts in that regard. Moreover, the federal government can be relied upon to create an appropriate prescription drug program, provided it is given the mandate to do so. Moreover, with respect to the enrollment of Medicare beneficiaries in a Medicare+Choice HMO, most beneficiaries prefer the traditional Medicare program, despite significant governmental efforts to persuade them to switch to Medicare+Choice.\textsuperscript{15} Also notably, in many areas of the country, not a single Medicare+Choice plan exists.

Second, while reliance upon the private sector for development of prescription drug plans keeps the federal government out of the game of directly administering and rationing benefits, it does so at significant potential expense. This scheme leaves plan standards largely to the discretion of private insurance companies, who are beholden to their shareholders above all others, rather than to potential plan subscribers. While both the House and Senate bills provide general frameworks within which participating private insurance plans would have to work, they both provide considerable latitude for the plans to develop and alter their own formularies (the House plan certainly more so than the Senate). And while shareholders may theoretically be well-served by making the company’s customers happy, a dearth of choices can lock beneficiaries into a program, as many people may rationalize that a poor plan is better than none.

Both the House and Senate plans implicitly acknowledge that participating prescription drug plans will utilize some system of rationing. This is undoubtedly true. As such, they are more honest than the Bush administration, whose literature implies that the private sector will provide far more benefits than the government would.\textsuperscript{16} Rationing will have to occur to at least some degree in order to keep costs and utilization in line. Given that rationing is necessary, it would be preferable for the federal government to publicly develop a rationing system itself. After all, the government is accountable to beneficiaries and is supposed to represent their interests. This way, the process is open and relatively transparent, and the individuals making the decisions are accountable in a way that HMO employees who develop drug formularies will never be.

The proposals do get at least one thing right. All Medicare recipients, not necessarily just those with low incomes, may need assistance with prescription drug costs. Making the prescription drug benefit available to all recipients and putting a cap on out-of-pocket expenses are excellent steps. Relative wealth or financial security may not necessarily protect one from extraordinary pharmaceutical expenses, if one is unfortunate enough to incur catastrophic drug costs. At the same time, however, arbitrarily capping out-of-pocket expenses at $3,700 or $4,000 puts a greater burden on lower- and middle-income Medicare recipients than wealthier ones. It may be more reasonable, therefore, to cap out-of-pocket drug expenses as a percentage of the beneficiary’s income. Thus, for example, the legislature could choose to mandate that no Medicare beneficiary need spend more than five or ten percent of his income on prescription drug costs. This option is more equitable.

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\textsuperscript{15} An AARP study adds an interesting wrinkle. It found that only about ten percent of Medicare beneficiaries had sufficient knowledge about HMOs to make an educated choice between Medicare fee-for-service and Medicare+Choice. Those with better knowledge tended to choose traditional Medicare in higher numbers. On the other hand, those who chose the Medicare+Choice program tended to have a poorer comprehension of the differences between the Medicare fee-for-service and HMOs than the remainder of their cohort. See Judith Hibbard & Jacquelyn Jewett, \textit{An Assessment of Medicare Beneficiaries' Understanding of the Differences Between the Traditional Medicare Program and HMOs} (AARP, June 1998).