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## Issue Brief

# Continuing Policy Issues in Medicare Prescription Drug Coverage

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### Introduction

Passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 followed years of debate in Congress about adding a prescription drug benefit to Medicare. Medicare prescription drug bills that passed the House and Senate in June 2003<sup>1</sup> differed in the design of the benefit, the role of private insurers in providing the benefit, the amount of drug spending the government would subsidize, and the level and implementation of assistance for low-income beneficiaries.<sup>2</sup> Following four months of negotiations, a conference agreement on the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (H.R. 1) was issued on November 20, 2003.<sup>3</sup> The agreement passed the House by a vote of 220–215 on November 22 and the Senate by a vote of 54–44 on November 25. President Bush signed the bill into law on December 8, 2003.<sup>4</sup>

Although the drug benefit will assist millions of beneficiaries who currently have inadequate coverage or lack coverage entirely, questions remain about many aspects of implementing and administering the benefit. Issues to monitor once the new law is implemented include:

- adequacy of the benefit
- dealing with the long-term impact of cost on Medicare unfunded liabilities
- level of beneficiary access to new private drug plans within and across regions
- effectiveness of efforts to encourage private plan participation
- access and affordability of coverage for low-income beneficiaries
- how states respond to changes in prescription drug financing and coverage for dual eligibles (those enrolled in both Medicaid and Medicare)
- stability of existing employer-sponsored drug coverage for retirees
- whether cost containment efforts in the law will be effective, and if so, the effect of cost containment and drug pricing mechanisms on overall levels of

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- drug spending by beneficiaries, private purchasers and plans, and federal and state governments, and
- ability of the Centers for Medicare and Medicaid Services (CMS) to manage a complicated new benefit with limited funding.

### **An Overview of the Medicare Prescription Drug Benefit**

Beginning in 2006, Medicare beneficiaries will have access to a voluntary outpatient prescription drug benefit under a new Part D of the Medicare program. Coverage will be provided by private entities that will bear some of the financial risk for drug costs. After January 1, 2006, no Medigap policies providing drug coverage may be sold, issued, or renewed, except for beneficiaries who choose not to enroll in Part D. Prior to the availability of Part D drug coverage, beneficiaries will be able to enroll in a prescription drug discount card program, with a \$600 subsidy available to low-income beneficiaries. Enrollment is scheduled to begin in mid-2004. The Department of Health and Human Services (HHS) estimates savings of 10 to 15 percent per prescription through discount card use.<sup>5</sup> The provision of the new drug benefit through private plans will give seniors access to discounts negotiated between plans and drug manufacturers, which the HHS has estimated at 25 percent off of current retail prices.<sup>6</sup> Beneficiaries will pay for drug coverage through premiums, deductibles, and copayments, with subsidies available to those with low incomes. The law provides financial support to employers to encourage them to retain drug coverage for their retirees and assistance to states for drug coverage of the dual eligible population (those who qualify for both Medicare and Medicaid coverage). The law entitles dual eligibles to enroll in Part D drug coverage, rather than receive coverage through a state Medicaid program. The Congressional Budget Office (CBO) estimates that an average of 73 percent of beneficiaries enrolled in Medicare Part B will have drug coverage through the Part D benefit, 20 percent through employer plans, and 7 percent from other sources.<sup>7</sup>

### **Issues to Monitor in Implementing the Medicare Drug Benefit**

Although the law entitles Medicare beneficiaries to receive benefits and financial subsidies previously unavailable through Medicare, the implications of certain features of the drug benefit and how it will be implemented and administered are unclear.

#### *Benefit Structure*

The law adds voluntary drug coverage, starting in 2006, as Part D of Medicare to be delivered through private

entities offering stand-alone prescription drug plans (PDPs) or insurance plans that provide drug coverage along with other benefits (Medicare Advantage) or “integrated” plans. Under standard Part D coverage, beneficiaries will pay a \$250 deductible and 25 percent of total drug expenses from \$251 to \$2,250 a year. Coverage is then suspended until beneficiaries spend \$3,600 out of pocket, or \$5,100 in total drug expenses. After reaching this catastrophic spending threshold, beneficiaries will pay the greater of 5 percent of drug costs or copayments of \$2 and \$5 for generic and brand-name drugs, respectively. Estimated average premiums for the voluntary coverage are \$35 per month. Premiums and deductibles will increase at the rate of growth in per capita Part D drug spending. CBO estimates that in 2013, the monthly premium and annual deductible will increase to \$58 and \$445, respectively. In lieu of this cost sharing structure, plans can opt to offer actuarially equivalent formularies, which is the typical business model for current drug coverage in commercial plans.

The exact level of financial assistance provided to a beneficiary will depend on how far into the coverage gap a beneficiary’s drug spending falls and whether total spending surpasses the catastrophic limit where coverage resumes. Medicare beneficiaries with chronic conditions and disabilities may be particularly vulnerable to this gap.<sup>8,9</sup> Although the monthly premium is estimated to average \$35, the actual amount will vary geographically and according to the design of the plan chosen by a beneficiary. The level of uncertainty associated with annual drug spending will make it difficult for beneficiaries to calculate in advance their total financial liability.

#### *Access to Drug Coverage Through Private Entities*

The law guarantees beneficiaries access to at least one PDP and one integrated plan, or two PDPs if no integrated plan is available. Plans will submit bids to the federal government to determine premiums, and will compete based on their premiums, which in turn will reflect negotiated drug prices. The government will contract for one-year terms with all eligible entities that meet the standards for plan sponsors. Subsidies to private entities and risk-sharing with the federal government are designed to encourage private plan participation, but the number of entities that will bid is uncertain. In regions where an insufficient number of private plans bid, the government will contract with private entities to provide a “fallback” plan. Whether the provision to allow regional fallback plans might discourage private insurers from bidding is unknown.<sup>10</sup>

Currently, no private entities offer drug-only policies. Risk-selection behavior by beneficiaries and insurers could help explain this.<sup>11</sup> Medicare beneficiaries

with high drug costs might be more likely than those with low costs to seek coverage, whereas insurers might design policies that discourage enrollment of relatively high-cost beneficiaries. The law includes provisions to reduce these incentives for risk-selection behavior. Beneficiaries who choose not to enroll in Part D within a specified initial eligibility period will face financial penalties of increases in the monthly premium amount if they enroll later (1% per month, or an actuarially sound equivalent). Insurers will not be allowed to deny coverage that they provide in a certain region to any eligible beneficiary who applies for coverage, and must include on their formulary drugs within each therapeutic category and class (as defined by the plan). Nevertheless, private insurers can cover different drugs on their formulary, make annual changes to their formulary, and establish varying cost-sharing amounts for different types of drugs (e.g., preferred and non-preferred; generics and brand-name drugs). These design features are likely to influence the enrollment choices of beneficiaries, and could steer certain types of beneficiaries toward or away from particular PDPs. In addition to insurers' flexibility in designing their drug policies, they are free to leave the market altogether.

Many beneficiaries will require assistance in making informed choices and understanding the rules associated with Part D cost-sharing amounts and coverage limits. The provision of coverage through competing private plans, offering different formularies and requiring different amounts of cost-sharing, will require beneficiaries to understand their choices in order to optimize their level of coverage. Plan changes in formulary design and covered drugs could impede access to drugs that are most effective for a beneficiary or lead to frequent switching between plans. Plan exits also could create instability in Part D drug coverage.

#### *Implications for Low-Income Beneficiaries and State Medicaid Programs*

The law eliminates the coverage gap and establishes different levels of cost-sharing and premium assistance for beneficiaries with incomes up to 150 percent of FPL.<sup>12</sup> Certain provisions will limit the reach of these protections, however. An asset test (for Medicaid or for the drug benefit), varying according to income level of individuals and couples, will be applied in determining eligibility for low-income subsidies, with the exception of beneficiaries who qualify for full benefits under Medicaid. The asset test is \$6,000 single/\$9,000 couple for enrollees with incomes below 135 percent of FPL, and \$10,000 single/\$20,000 couple for those with incomes below 150 percent of poverty. The asset test will exclude many beneficiaries who otherwise would be eli-

gible for low-income subsidies; data show that one-third of all seniors with incomes less than 135 percent of FPL have assets greater than \$12,000.<sup>13</sup> The law also requires dual eligible beneficiaries to pay nominal copayments for prescription drugs that could be higher than they currently pay under Medicaid.

Among states, the implications of provisions related to dual eligibles and other low-income groups are uncertain. The new law gives states the responsibility for eligibility determinations, yet the asset test could make the eligibility and enrollment process difficult. Under current Medicaid program rules, states can use federal Medicaid matching funds to fill in gaps in Medicare benefits for dually eligible beneficiaries. Under the new drug benefit, however, states are prohibited from using federal matching funds on Part D copayments or on drugs excluded from a PDP's formulary. States that want to continue this "wrap-around" coverage will have to pay the cost entirely out of their own budgets. The law gives the federal government a greater role in financing drug coverage for dual eligibles under Part D than it currently has, thus saving the states money, but the total amount of savings to states will be reduced by a "take back" provision in the law. According to this provision, states will be required to pay the federal government a portion of the amount they would have spent on Medicaid drug coverage for dual eligibles in the absence of the new Medicare drug benefit. Of the 100 percent of state funds that would otherwise have been spent on drug costs for dual eligibles, states will be spending only 75 percent by 2013. CBO estimates that the net reduction in state Medicaid outlays will be \$17.2 billion from 2004 to 2013.<sup>14</sup>

#### *The Impact on Employer-Sponsored Retiree Drug Coverage*

Rising prescription drug costs have led a number of employers to make changes to their retiree drug coverage in recent years, including imposing higher cost-sharing and more aggressive utilization management.<sup>15</sup> How the new Part D drug benefit will affect beneficiary access to retiree drug coverage is unclear. Employers who offer more generous retiree drug coverage could scale back or cease to provide this coverage. Beneficiaries who lose employer-sponsored drug coverage as a result might pay more and receive less coverage under Part D than they currently have.<sup>16</sup>

The law provides \$71 billion in direct subsidies over 10 years to encourage employers to retain drug coverage for retirees. Employers that offer "qualified" drug coverage—that which is actuarially equivalent to standard Part D coverage—will be entitled to receive funds that cover 28 percent of retirees' drug costs between \$250 and \$5,000. These payments will not be

taxable as income to employers and will be fully deductible. This tax exclusion increases the value of the subsidy by approximately \$15 billion. These employer payments, however, will not count toward the out-of-pocket payment threshold. Despite this financial assistance, CBO estimates that 2.7 million retirees, or 23 percent of the 11.7 million nonfederal retirees, could lose access to existing employer-provided drug coverage as a result of the new Medicare drug benefit.<sup>17</sup>

#### *Cost Containment and Drug-Pricing Mechanisms*

The law allows only private plans to negotiate prices with drug manufacturers, with the intent of promoting price competition among private entities responsible for delivering the benefit.<sup>18</sup> Private entities will face incentives to negotiate low prices to the extent that low prices enable them to set low premiums, making them a more attractive choice for beneficiaries and to the extent they share risk.<sup>19</sup> Whether drug price discounts negotiated between private entities and drug companies on behalf of a plan's enrollees will be greater or less than those the federal government might receive if it were negotiating on behalf of all Medicare beneficiaries is unknown.

CBO estimates that the new law will result in a \$394.3 billion net increase in direct federal spending between 2004 and 2013.<sup>20</sup> Many fear that the growing costs, availability, and use of prescription drugs could make the Medicare drug benefit more expensive than estimated by CBO and allocated for in the President's FY 2004 budget.<sup>21</sup> The actual amount of federal spending will depend on such factors as the number of low-income beneficiaries who receive subsidized coverage, the number of employers who receive payments for retiree coverage, the structure and administration of the PDPs and integrated drug plans, the effectiveness of cost-containment efforts by private entities offering the drug benefit, and trends in medical treatment and the pharmaceutical market that affect the price, availability, and use of prescription drugs.

#### **Conclusion**

Enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 will not end policymakers' attempts to revise the Medicare program. Policymakers on both sides of the aisle have been critical of many provisions in the law related to the drug benefit. Some legislators are concerned about adding a prescription drug entitlement to Medicare without establishing more stringent provisions for cost containment. Others view the level of drug coverage as inadequate, leaving many beneficiaries vulnerable to high out-of-pocket spending. With Part D drug coverage

not scheduled to begin until 2006, legislation to amend it and other provisions of the law has already been introduced.

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