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Policy Brief

Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources

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A prescription drug benefit has proven to be an elusive addition to the Medicare program. While policymakers are in nearly universal agreement on the need for drug coverage, Congress reached a stalemate during the summer of 2001 on what such a benefit should look like. The biggest area of controversy was, and continues to be, money: How much will the federal government contribute to such a benefit and what can beneficiaries be expected to pay?

Budget constraints will inevitably clash with goals for establishing a desirable benefit package. This policy brief considers how to structure a drug benefit and what trade-offs will need to be made in the context of financial limitations. It discusses three potential approaches, each of which employs a different cost/payment structure and each of which benefits one group while neglecting another. Nonetheless, it suggests that it is possible to craft a drug benefit that would preserve universal coverage by protecting low-income beneficiaries and placing a cap on high costs.

In 2001 and again this year, the opening salvo in the debate over a drug benefit focused on the level of federal contributions available over a 10-year period. In 2001, Congress initially set a goal of $300 billion over 10 years while the Bush administration proposed a lower amount. But even this amount was not enough to provide a benefit package that members of Congress were willing to endorse. For example, one proposal costing $318 billion required 50 percent coinsurance and a monthly premium of $50, which would be nearly as high as Medicare's Part B premiums for physician services and outpatient care. Focus groups of all ages soundly criticized a benefit that would ask beneficiaries to pay such a premium.[1]

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Numbers from the Congressional Budget Office suggest that keeping any benefit at the same level as last year will carry a substantially higher price tag. The discussion of a Medicare drug benefit began again in 2002 when the Bush administration proposed spending $190 billion over 10 years on all Medicare reforms, $77 billion of which would be for a low-income drug benefit. The drug bill passed by the House of Representatives in June is projected to cost about $320 billion over the next 10 years. Majority members of the Senate Budget Committee proposed setting aside $500 billion for all new health care spending over the next 10 years (including some money for the uninsured).

BACKGROUND

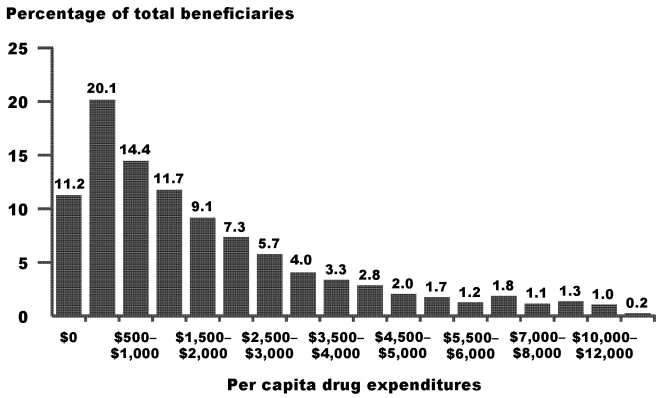
Prescription drugs are the primary acute care benefit excluded from Medicare coverage. Only in the hospital, nursing home, or hospice will Medicare cover oral prescription drugs. Many beneficiaries have turned to supplemental coverage, but with only limited success. Supplemental plans vary in quality, beneficiaries' access to them, and the degree to which the added coverage relieves financial burdens. Only employer-based retiree coverage and Medicaid offer *reliable* drug benefits, covering about 39 percent of Medicare beneficiaries.[2]

Like other health care spending, use of prescription drugs varies widely across the Medicare population (Figure 1). In 2002, an average beneficiary would spend about $1,912 on drugs.[3] About 45 percent of all Medicare beneficiaries are projected to have drug costs below $1,000 in 2002, and only 13.1 percent will spend more than $4,000. A sizable share of total spending on drugs is accounted for by a small proportion of beneficiaries. While just 1.2 percent of beneficiaries have annual expenditures of more than $10,000, for example, they account for 10.7 percent of all drug expenditures for the Medicare population (Figure 2). Futhermore, although average spending is low at the left-hand side of the figure, the large numbers of individuals represented there make it costly to provide "first-dollar" coverage, or full coverage for beneficiaries' initial costs.

DESIGNING A DRUG BENEFIT

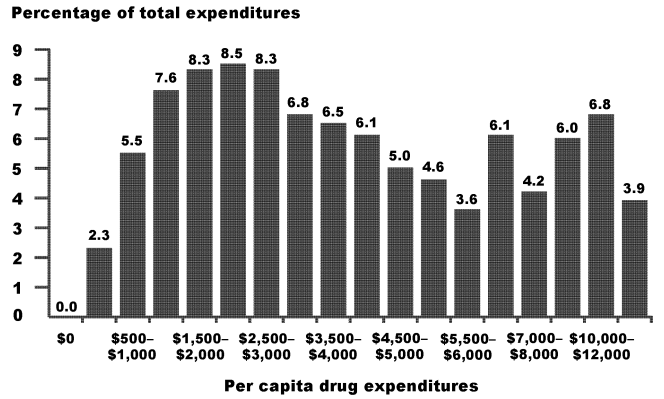
Drug benefits can be structured in many different ways. In this policy brief, we focus on the various elements that affect how drug expenditures are covered. Each drug benefit structure explored here demonstrates the difficulty of balancing the often competing goals of drug benefit plans. For this analysis, a 23 percent contribution is assumed—the share of drug spending by Medicare beneficiaries that $350 billion would cover over eight years, from 2005 to 2013, after a two-year start-up period.

Figure 1. Distribution of Beneficiaries by Level of Annual Prescription Drug Spending



Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

Figure 2. Share of Annual Total Drug Expenditures by Medicare Beneficiaries' Spending Levels



Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

Establishing Goals for a Drug Benefit

Policymakers and others often identify a number of goals that become "essential" parts of proposals for a prescription drug benefit, even when they may not be compatible. Consider five of the most important goals:

- *Stay within a federal budget constraint.* This goal tops all others and makes it difficult to meet other concerns. Because Medicare beneficiaries are spending nearly $2,000 per year on average for prescription drugs and 40 million beneficiaries would be covered by a universal benefit, the annual cost could easily reach tens of billions of dollars. Rapid growth in spending, furthermore, leads many policymakers to be wary of

higher costs over time. Thus, efforts to restrict the level of benefits offered will be part of any proposal.[4] The tools used to achieve this goal, however, may conflict with a number of other desirable benefit goals.

- *Make at least a partial benefit available to all.* Universal coverage is a hallmark of the Medicare program, and many policymakers would be reluctant to limit the availability of a drug benefit to just some beneficiaries—for example, those with low incomes. Moreover, the deterioration of prescription drug coverage in supplemental insurance plans over the years means that even individuals with high incomes may not have access to reliable coverage at any price. If offered with no subsidy, the premiums charged beneficiaries at higher incomes might be steep, but at least benefits would be available.

- *Protect those with very high expenditures.* This goal is most consistent with the traditional purpose of insurance. It is generally achieved through a "stop-loss" protection, above which no beneficiary would have to incur further expenses. Stop-loss amounts are usually defined in terms of what an individual pays out-of-pocket.[5] For example, for someone with $6,200 in expenses and no other insurance, a $6,000 stop-loss provides $200 in benefits. While only a small number of people directly benefit from stop-loss protection each year, such protections are expensive because of the extremely high costs that those beneficiaries incur. Further, if a benefit plan is voluntary, stop-loss-only insurance could be subject to substantial risk selection, undermining its value over time.

- *Encourage large-scale participation on a voluntary basis.* If the benefit to be offered does not require that individuals enroll, it is important to attract a broad cross-section of Medicare beneficiaries to avoid risk selection. To encourage participation, therefore, options often provide for first-dollar coverage, so that everyone who uses drugs gets at least some benefit.[6] If beneficiaries believe that they will not spend more than $500 on drugs, for example, they may be reluctant to adopt insurance coverage if they have to pay a premium. The goal of widespread participation thus conflicts with the purpose of a deductible and/or substantial coinsurance—to help hold down the costs of coverage.[7]

- *Protect beneficiaries with low incomes.* A universal benefit that is limited by budget constraints will likely have high cost-sharing and/or premiums, making the benefit less helpful to those with low incomes. As with the Medicare Savings Programs, which are intended to fill in the gaps in Medicare for low-income beneficiaries, many proposals seek to achieve protection for people with incomes below a target income level, such as 100 percent or 150 percent of the federal poverty level. A strong case can be made for setting an even higher income limit, given the costs of drugs relative to incomes of people at, say, 175 percent of the poverty level (which is less than $16,000 annual income for an individual). However, each incremental increase in beneficiaries covered will raise costs substantially.

Designing a Reasonable Drug Benefit

The structure of a drug benefit could vary depending on a number of key components. These include: stop-loss levels, coinsurance (or copayments),[8] deductibles, benefit caps, income-based eligibility requirements, and premiums. These pieces can be used in many combinations to achieve some of the goals outlined above.

Stop-loss protections provide protection in the event of catastrophic circumstances. Figure 3 indicates how many people would be helped by a stop-loss of various levels and the share of total spending that would be paid by the government (assuming no increase in use). A low stop-loss would help a larger share of people but at a very high cost. A stop-loss is usually provided in combination with protections that begin at lower levels of spending on drugs. If provided as a stand-alone benefit, a lower limit likely would need to be set so as to cover a substantial minority of the population.

Figure 3. Total Government Expenditure Under Different Stop-Losses, 2002

Stop-Loss of	Share of Total Drug Spending (Percent)	Share of Medicare Population Affected (Percent)
$8,000	6.0	2.5
$7,000	7.5	3.6
$6,000	9.9	5.4
$5,000	13.4	8.3
$4,000	18.8	13.1
$3,000	27.5	20.4
$2,500	33.5	26.2
$2,000	41.3	33.4
$1,500	51.2	42.5
$1,000	63.8	54.3

Note: Calculations exclude institutionalized and ESRD beneficiaries.
Source: 1998 Medicare Current Beneficiary Survey.

A second key component of any benefit package is the coinsurance that would be charged to individuals once the benefit begins. A 20 or 25 percent coinsurance, for example, would be in line with what younger families currently face, but this arrangement would become very costly to insurers. Many proposals carry a 50 percent coinsurance rate for at least part of the benefit in order to lower the costs of coverage, so that a substantial share of costs falls on the beneficiaries.

A third component is the deductible. Routine expenses below some given amount, for example $250, would not qualify for any protection. Once the deductible is met, the coinsurance rate would go into effect. This can help hold down costs, but may discourage participation by healthy beneficiaries. A fourth component is a cap on benefits. This is the opposite of stop-loss protection; that is, once an enrollee hits a certain level of expenditures, benefits end. Some proposals contain both a cap and stop-loss protection, effectively creating a range in which there is no coverage. This has been referred to as the "donut hole" and has been included in some proposals.

Most options also require that the beneficiary pay for at least part of the costs of insurance through a premium. If, for example, a 50 percent premium is assessed and the individual faces 50 percent coinsurance, the enrollee effectively receives a government subsidy of 25 percent. If the premium is high, however, participation will likely be lower and risk selection will occur, causing costs to rise rapidly over time. Even with an attractive benefit package, high premiums can result in low participation.

Finally, the issue of additional protections for those with low incomes is very important. If the overall benefit is comprehensive, the costs of low-income protection may be relatively minimal since fewer costs will need to be subsidized. In addition, the income cutoff level for eligibility could be lower if the overall benefit is generous. Low-income protections represent a vital part of any proposal; careful thought is needed about eligibility requirements, access levels, and limits on generosity. Coordination with Medicaid and other drug programs would also need to be addressed. Given the large number of Medicare beneficiaries with modest incomes, the cost of drug benefits just to this subgroup of low-income persons can be quite high. One study found that such an approach could cost up to $300 billion while aiding just 15 percent of the Medicare population.[9] Furthermore, the study assumed that only 54 percent of those eligible would likely participate, and a large number of other beneficiaries with modest incomes and no access to reliable coverage would be ineligible.

What Budget Limitations Mean

It is difficult to meet each of the aforementioned goals of fair and reasonable insurance when dollars are limited. To put the problem into perspective, we will consider what a prescription drug benefit from the government equal to 23 percent of all drug expenditures by Medicare beneficiaries could buy.[10] Figure 2 demonstrated the share of overall spending on drugs by individuals whose total spending fell into a particular range (such as $1,000 to $1,500). Figures 4, 5, and 6 indicate the government's share of overall drug spending as a proportion of these amounts under three distinct approaches:

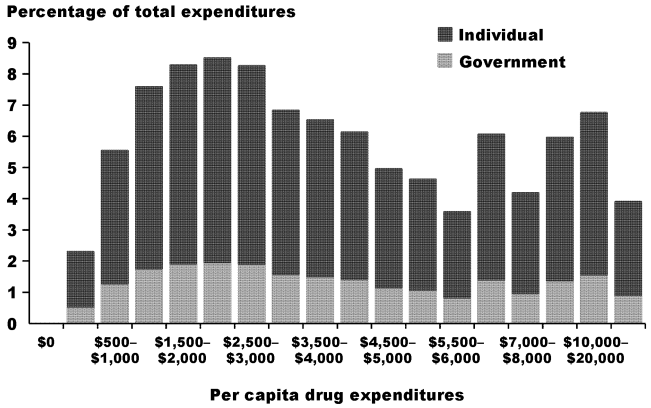
- a standardized benefit in which the government pays 23 percent of each dollar spent on prescription drugs by all beneficiaries;
- an "up-front" benefit in which the government pays for three-quarters of all drug spending up to the point at which government's share is 23 percent of all expenditures; and
- a "back-end" benefit in which the government pays all costs above a certain amount for those with the highest expenditures.

The approach depicted in Figure 4 provides benefits of equal proportions across all enrollees. This effectively results in a coinsurance rate of 77 percent. But this approach meets almost none of the coverage principles; in particular, protection for those with high costs and/or low incomes would be inadequate.

If the benefits instead are initially larger and begin with first-dollar coverage, beneficiaries might pay lower coinsurance—for example, 25 percent. The benefit, however, would be in place only for the first $812 worth of spending by each individual, for a maximum benefit of $609, only a small share of spending for those with high expenses (Figure 5). All beneficiaries with some costs would receive subsidies, but these benefits would not be focused on the neediest. Those with high costs would have only a small percentage of their drugs covered, and those with chronic conditions who are likely to spend $3,000 to $6,000 on drugs would also receive only limited help.

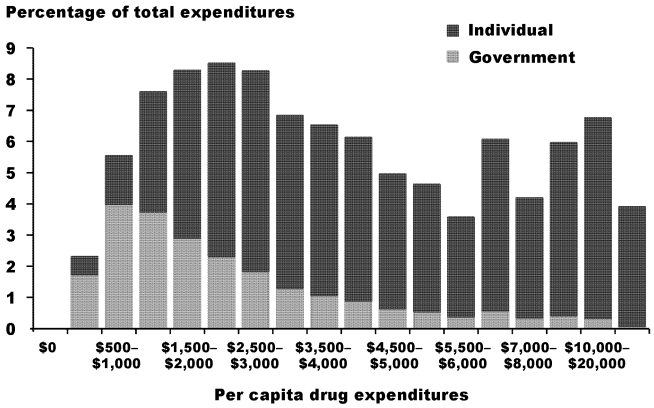
In a third approach, government benefits could be concentrated instead on those whose expenditures

Figure 4. Medicare and Beneficiary Share of Annual Drug Expenditures by Level of Beneficiary Spending, 77% Copay



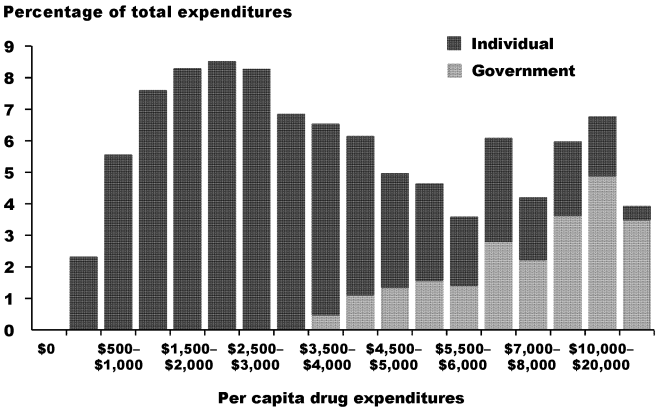
Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

Figure 5. Medicare and Beneficiary Share of Annual Drug Expenditures by Level of Beneficiary Spending, 25% Copay up to $812



Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

Figure 6. Medicare and Beneficiary Share of Annual Drug Expenditures by Level of Beneficiary Spending, Stop-Loss of $3,462



Source: Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey.

are above a given level, offering only stop-loss protection. A stop-loss in which the government covered the top 23 percent of spending would begin at $3,462. People with even higher expenditures would pay $3,462, with the balance picked up by the government (Figure 6). While this would help those with the highest spending, the actual share of Medicare beneficiaries receiving *any* subsidy from the program would be about 20 percent.

None of these three approaches represents a palatable option, particularly when compared to employer-sponsored insurance plans, which cover about 75 to 80 percent of drug costs. Adding a premium that enrollees would be required to pay would make available resources go further, but it is hard to strike a balance between a reasonable premium and a desirable benefit. If the premium is relatively high, the benefit almost has to be offered as a *voluntary* option. For example, would beneficiaries be willing (or able) to pay nearly $40 dollars per month for a benefit that paid 50 percent of all drug expenses (with no stop-loss)? A $40 premium would be needed to keep the government's share at 23 percent. A study by the Henry J. Kaiser Family Foundation found considerable opposition among beneficiaries to a high premium even though the overall benefit would be subsidized by the federal government.[11] Moreover, if participation is low, the problem of risk selection will likely arise, resulting in rapid growth in premiums over time as only individuals with high drug expenditures enroll.

In all of these examples, resources are fully devoted to universal coverage, leaving nothing for protection of low-income beneficiaries. Yet, as noted above, a large share of available resources would be needed to offer a comprehensive benefit for those with low incomes.

Drawing on Existing Sources of Coverage

The federal government is already contributing to the costs of prescription drugs for Medicare beneficiaries through veterans' benefits and Medicaid. Together, these federal contributions amount to a little less than 10 percent of the costs of prescription drugs.[12] If these funds could be combined with the 23 percent increase in federal dollars proposed for spending, federal spending would grow to about one-third of the cost of drugs for Medicare beneficiaries. At 33 percent of spending, the packages would look considerably better. If states could be counted on to continue their contributions, the amount would rise to 44 percent.

It is important to note that Medicaid and most state drug benefits are targeted for people with low or modest incomes and would likely need to remain dedicated to them. To pay all of the drug costs for individuals below 100 percent of the poverty level and 80 percent of the costs for individuals living at up to 150 percent of the poverty level would require more than $300 billion. Even after accounting for state and federal Medicaid money—and perhaps some of the funds now spent by state supplemental programs—new federal contributions totaling at least $200 billion would likely be necessary.

That leaves only a small amount for the remaining two-thirds of beneficiaries with higher incomes. If the $350 billion figure is retained for the total, this would leave only about $150 billion for the remaining Medicare beneficiaries. This would represent about 15 percent of the projected expenditures for those persons with incomes above 150 percent of the poverty level. The only other likely source that could be tapped for higher-income groups would be veterans' benefits. But, since such benefits are more comprehensive than any likely across-the-board benefit, only part of those costs could be thought of as potential supplements to a Medicare benefit.

Employers who offer subsidized retiree coverage would likely redesign their benefit plans to conform to any new Medicare benefit. In cases where retiree benefits are comprehensive, some employers might reap savings, though retirees would likely gain few advantages from a new benefit. But retirees eligible for more limited benefits, or those whose former employers are raising cost-sharing, would likely gain from new Medicare drug benefits. Additional help from combinations of federal programs might compensate for some of the erosion in private protection. Similarly, beneficiaries enrolled in Medicare+Choice managed care plans might have their drug benefits improved considerably if the federal government makes specific payments for this purpose. Since these plans have been able to offer some additional benefits, they may be able to offer more comprehensive drug benefits than fee-for-service plans.

The biggest remaining gaps would be for individuals with modest incomes. At $20,000 per year, beneficiaries would be ineligible for low-income protections, even though drug spending of $4,000 or more would be very burdensome. Some of these individuals are currently paying a great deal for drugs or for poor Medigap supplemental coverage, so they would not be measurably worse under the scenario of combined federal programs. On the other hand, they would certainly not achieve the level of protection they may have assumed was promised them by politicians in the 2000 election.

MAKING CHOICES

Given the level of federal dollars likely to be available, it is not surprising that the debate in 2001 bogged down over how to design a prescription drug benefit. In addition to limits on federal costs, designing a benefit requires setting priorities among the various goals of insurance described above.

One approach offered in 2001, for example, tried to help a broad cross-section of the population while also offering some stop-loss protections. In order to meet these two goals within the budget target, however, it was necessary to create a "donut hole" in the coverage between the level of spending where the government stops paying part of the costs of each prescription and the level where stop-loss protection begins. Consider an example with a 50 percent coinsurance up to $3,000 in spending (the cap), and a $5,000 stop-loss. Once an individual has reached $3,000 in expenses (and the government has paid $1,500 of that), he or she must pay 100 percent of further out-of-pocket expenses until he or she has paid $5,000 in drug costs. This stop-loss thus begins at $6,500 of total spending, where the government has paid $1,500 and the individual has paid $5,000. One reason why adding this donut hole keeps costs down is that nearly 35 percent of spending occurs in the range from $3,000 to $6,500. People with multiple or chronic medical conditions are likely to be particularly disadvantaged by this coverage gap, since they are likely to have total spending that falls in this range.

The approach of the Bush administration is to begin with low-income protections while promising universal coverage later as part of other Medicare reform. This also helps to hold down costs, but not by as much as it might at first appear, since future costs are likely to be much higher than the current level. For example, the Congressional Budget Office has estimated the 10-year costs of spending on prescription drugs by Medicare beneficiaries at $1.8 trillion, but that number falls to only $1.6 trillion if the first two years of the period are eliminated. This is because costs are expected to rise rapidly each year and hence the first two years of this period are relatively inexpensive.

The Bush administration has further proposed to devote $77 billion to a low-income benefit over 10

years—an amount substantially below the $269 billion that individuals with incomes below 150 percent of the poverty level and not receiving Medicaid are expected to spend over the next decade.[13] The Bush administration proposal would require higher contributions from some states before the more generous federal program would begin. This could mean more state dollars for drug spending, but it could also result in some states not participating in the program at all—an outcome that would hold down costs even further, but at the expense of low-income individuals in a substantial number of states.

What else could be done with the limited resources described here? One option worth considering would provide a low-income subsidy plus a stop-loss benefit for those with higher incomes offered at little or no cost to beneficiaries. All beneficiaries could be given a card, entitling them to the benefits of negotiated discounts while enabling tracking of their expenditures so that they could qualify for the stop-loss benefit. This would protect both low-income and high-cost beneficiaries, and would offer a universal benefit that could be added to later if more resources are made available. A supplementary benefit could also be offered either through Medicare or a private plan. Further, if protection for catastrophic events helps to reduce adverse selection, the cost of a supplementary benefit might be less than if it is offered as a stand-alone drug benefit.

If the new federal spending is $350 billion over eight years, $200 billion of which goes to low-income protections, the limit on protection for catastrophic events would have to be set at a relatively high level. The available $150 billion, which would represent just under 15 percent of drug spending by people above 150 percent of the poverty level, would allow protection to begin at about $5,000 in total spending.[14] One way to make the benefit available to a broader group would be to require individuals to pay for part of the costs of drugs above the cutoff—coinsurance of 10 or 20 percent, for example. In this case, the government could pick up 80 percent of the costs of all expenditures once an individual had spent $4,000 (here the $4,000 is effectively a deductible). Finally, an even lower deductible could be provided, say at $3,000, if beneficiaries were required to pay a slightly higher Medicare Part B premium. Coverage for catastrophic events would probably need to be mandatory to avoid adverse selection, thus limiting the level of any premium.

If a higher federal subsidy amount were made available, it would be possible to design more attractive benefit packages. If protection against drug costs could be offered at a lower stop-loss level—thus including a larger share of the Medicare population—then a catastrophic benefit would likely be a more popular option. For example, if the new subsidy were to rise to about $450 billion, the same low-income protections described above could be offered and a straightforward, $3,000 stop-loss benefit provided to those with higher incomes. Alternatively, the benefit could consist of a deductible of $2,500 with coinsurance of 20 percent above that. Many people with chronic conditions who take several medications daily would receive considerable financial relief if the benefit began at $2,500. Overall, about one-quarter of the Medicare population with incomes above 150 percent of poverty would receive benefits in this instance.

Unless federal spending is raised above $350 billion, even the limited approach described here would not be very attractive to higher-income beneficiaries. Yet, with only a modest amount of additional funding, a benefit for catastrophic events for those with higher incomes could represent a reasonable starting point in an era of scarce resources. In the more generous option described above, even the limited benefit could reach about a quarter of the higher-income population, including many of those with chronic conditions, and provide more generous assistance to beneficiaries below 150 percent of the poverty level.

Notes

[1] Public Opinion Strategies and Peter D. Hart Research Associates, *Medicare and Prescription Drug Focus Groups, Summary Report,* Henry J. Kaiser Family Foundation, July 2001.

[2] For more background information on drug coverage and costs, see Marilyn Moon, "Putting the Costs of Prescription Drugs in Context," *Caring, The Pride Institute Journal,* forthcoming.

[3] This number omits the institutionalized Medicare population, whose expenditures are not reported on the Medicare Current Beneficiary Survey and for whom we can only simulate averages. If they were included, the average would be $1,969 for 2002. Since much of our analysis relies on the distribution of spending, we based it on the community-dwelling Medicare population only. Our numbers are lower than those of the Congressional Budget Office (CBO) because we make different assumptions about under-reporting of drug use. At the aggregate spending level, we use percentages of spending so as to be able to calibrate our estimates to those used by CBO.

[4] Cost-containment efforts are not examined here directly but are also likely to be part of any proposal.

[5] This is because the stop-loss is usually paired with partial coverage of costs below the stop-loss amount. It makes sense then to "give credit" to the other portion of the benefit and base protection on what individuals actually have to pay.

[6] And even though other requirements such as a one-time sign-up can be used, many analysts believe that beneficiaries must feel they are getting something from their plan—particularly if the premium is high.

[7] The principle of good insurance normally suggests that routine costs for individuals are not covered. This usually implies the adoption of a deductible in which the benefit does not begin until after, say, $250 or $500 has been paid by the beneficiary.

[8] Coinsurance is usually expressed as a percentage of the costs of the drug, while a copayment is a fixed dollar amount. Private drug plans use both approaches, sometimes in combination. Coinsurance makes consumers aware of the costs of each prescription and is thus favored by those who worry that people will demand more expensive drugs.

[9] Marilyn Moon and Matthew Storeygard, *Targeting Medicare Drug Benefits: Costs and Issues,* Henry J. Kaiser Family Foundation, May 2001.

[10] For simplicity, we ignore issues such as increased use of services when some are covered by the government and discounts that might be achieved under various forms of cost control. These effects move in countervailing directions, but many analysts believe there would be a net increase in spending, suggesting that $350 billion could amount to a share of less than 23 percent. The amounts shown here are only intended to be illustrative of how benefits might be structured. Increased use of services may also be an issue depending on the structure of the benefit.

[11] Public Opinion Strategies and Peter D. Hart Research Associates, July 2001.

[12] Congressional Budget Office, testimony by Dan Crippen, "Projections of Medicare and Prescription Drug Spending," before the Committee on Finance, United States Senate, March 7, 2002.

[13] This estimate was derived from our calculations of the share of total spending for this group under the Medicare Current Beneficiary Survey and applied to Congressional Budget Office numbers found in Statement of Dan Crippen, Congressional Budget Office testimony, "Projections of Medicare and Prescription Drug Spending," before the Committee on Finance, United States Senate, March 7, 2002.

[14] These numbers are approximate and reflect 2002 spending levels. They are meant to offer an illustrative benefit rather than to represent any formal cost estimate.

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