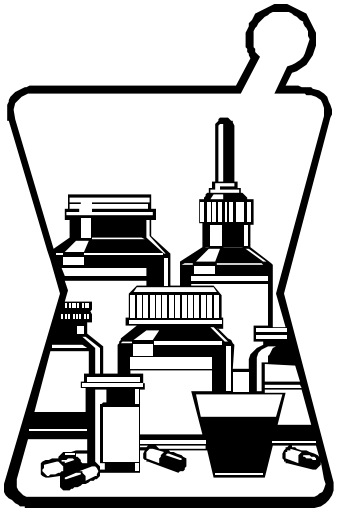
Skimpy Benefits and Unchecked Expenditures: Medicare Prescription Drug Bills Fail to Offer Adequate Protection for Seniors and People with Disabilities



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CONSUMERS UNION

June 17, 2003

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Executive Summary

Legislation that would add a prescription drug benefit to Medicare is rapidly moving through the House and the Senate. This report identifies 12 key elements of importance to consumers in assessing whether the various bills will meet their expectations. The results with regard to Medicare beneficiaries' out-of-pocket costs are most disturbing. The combination of skimpy benefits and historically high growth of prescription drug expenditures mean that most consumers without prescription drug coverage in 2003 would be worse off in 2007: they would face higher out-of-pocket costs in 2007 than they do in 2003 under both the House Ways and Means Committee bill and the bill reported out of the Senate Finance Committee on June 12, 2003.

House Ways and Means Committee Bill

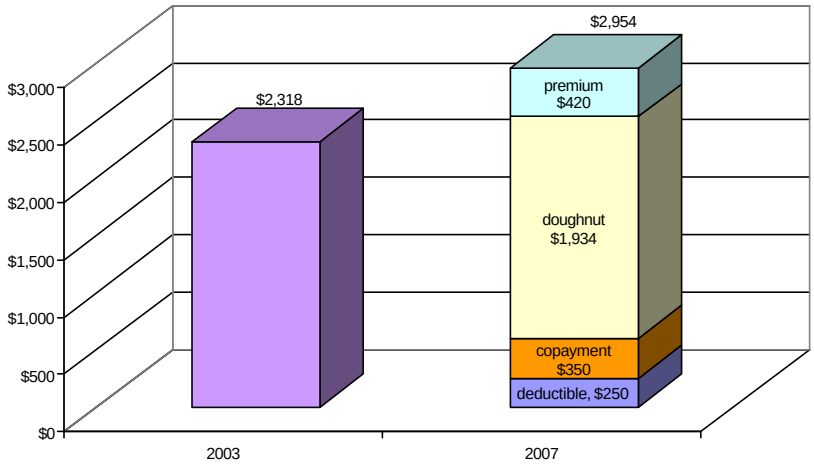
- The average Medicare beneficiary (without prescription drug coverage) spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including costs of premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,954 (real 2003 dollars).
- A person in the top third of prescription drug spending, with costs of $3,000 in 2003, would find his or her out-of-pocket costs reach $4,112 in 2007 (real 2003 dollars)
- If prescription drug growth moderates from its historical levels of 17 percent to 12 percent per year, then the average Medicare beneficiary without prescription drug coverage would face out-of-pocket costs in 2007 that are approximately the same as those in 2003, even after enactment of a Medicare prescription drug benefit ($2,318 in 2003; $2,323 in 2007, real 2003 dollars).

Senate Finance Committee Bill

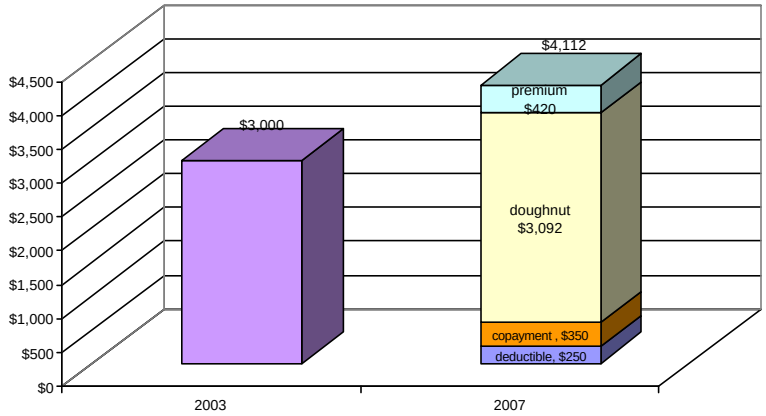
- The average Medicare beneficiary (without prescription drug coverage) spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including: premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,524 (real 2003 dollars).
- A person (without prescription drug coverage) in the top third of prescription drug spending, with costs of $3,000 in 2003, would find his or her out-of-pocket costs reach $3,399 in 2007 (real 2003 dollars).
- If prescription drug expenditures growth moderates below historical levels to 12 percent per year, the average Medicare beneficiary would face out-of-pocket cost in 2007 only marginally lower than those of 2003 ($2,318 in 2003; $2,209 in 2007, real 2003 dollars).

In order to provide Medicare beneficiaries with true relief from burdensome prescription drug costs, Congress needs to allocate additional funding, beyond the $400 billion in the Congressional budget resolution, so that it can design a comprehensive benefit package. In addition, it is essential that the federal government use all tools available to rein in growth of prescription drug expenditures. In order to curb the growth of expenditures, loopholes that delay introduction of generics should be closed; the federal government should use its purchasing power to negotiate low prices; and the government should construct a system that assures that consumers (and taxpayers) are getting the highest value for their prescription drug dollar through more cost-effective purchasing.

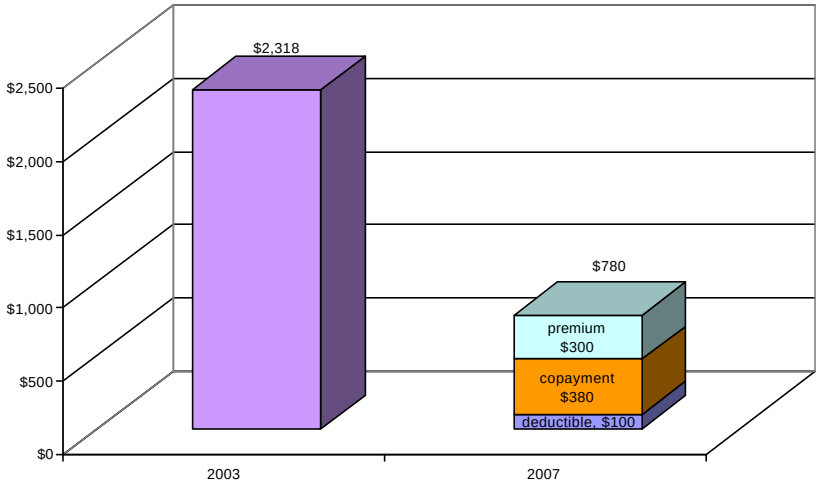
Out-of-Pocket Costs
Average-Spending Beneficiary (without prescription drug coverage)
House Ways and Means Bill



Out-of-Pocket Costs
Beneficiary (without prescription coverage in 2003) with High Spending
House Ways and Means Bill



HR 1199 Provides True Relief
For Average Spender
(without prescription drug coverage in 2003)



Introduction

Both the Senate and the House are expected to consider legislation during the next few days that would establish a prescription drug benefit for Medicare beneficiaries. Will the bills, if enacted and implemented, meet the expectations that Medicare beneficiaries expect and need from the burden of increasing prescription drug costs? The purpose of this report is to outline the key elements of importance to seniors and the disabled that will be key in their assessment of whether the legislation makes them better – or worse – off.

Key Elements of Concern to Consumers

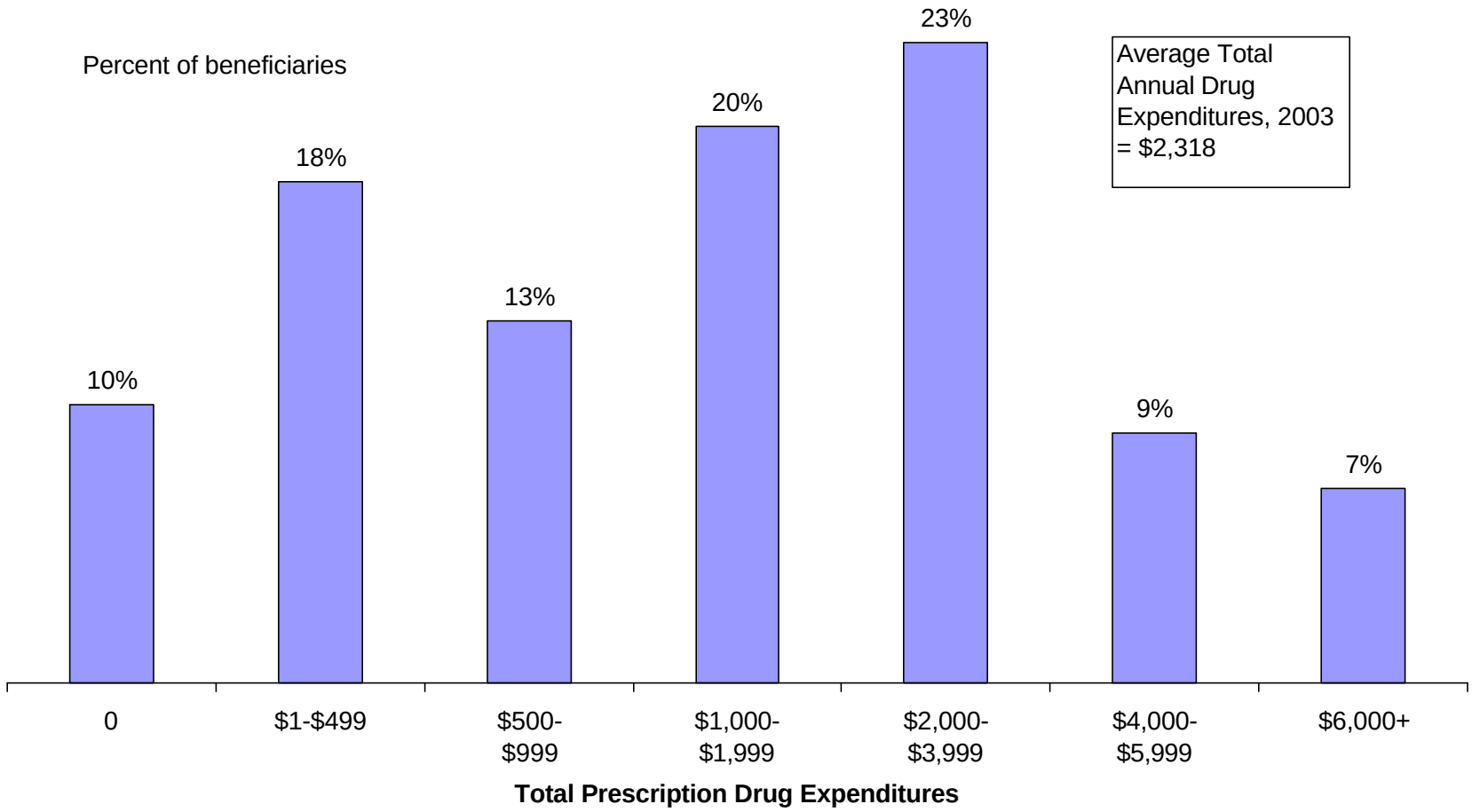
All Medicare beneficiaries need access to affordable, comprehensive coverage for prescription drugs. Before addressing the key elements of particular importance to consumers, it is important to understand that while the average beneficiary spends about $2,300 on prescription drugs each year, there is considerable variation. About 10 percent spend no money on drugs, while 7 percent spend more than $6,000. Below is a chart (by Kaiser Family Foundation, using Congressional Budget Office data) showing the variation in prescription drug expenditures among Medicare beneficiaries in 2003. The underlying variation in expenditures is a key reason why Consumers Union favors building a standard prescription drug benefit into the Medicare program.

Reliance on the private marketplace means that considerable resources will have to be spent assuring that those who have the highest expenditures are treated fairly, and are not subject to higher premiums. In addition, it means that the government must spend its resources to make sure that companies that cherry-pick the healthy are not reimbursed at the same level as companies who enroll people with a broad mix of prescription drug expenditures. Expanding competition from private companies threatens the financial future of the Medicare program, since private companies have a capability, a record and a strong financial incentive to enroll relatively healthy people while receiving reimbursements based on the average person.

The CBO data on spending include all Medicare beneficiaries – those with and without any prescription drug coverage. This analysis focuses on beneficiaries who lack any prescription drug coverage in 2003. This is the population most in need of relief. Premium data for 2003 for various types of coverage are not readily available, and the CBO data do not include out-of-pocket payments for premiums.

Chart 1

Distribution of Medicare Beneficiaries, by Total Prescription Drug Expenditures, 2003

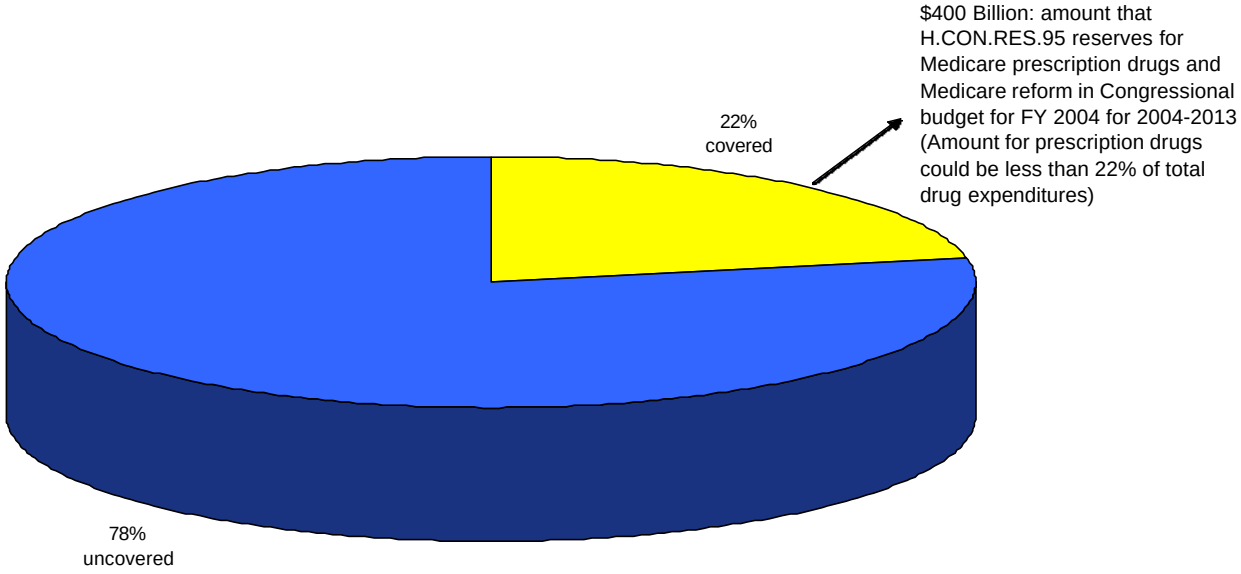


SOURCE: Medicare and Prescription Drug Fact Sheet, April 2003, Kaiser Family Foundation, citing CBO 2003, (www.kff.org)

It is also important to understand the mathematical impossibility of providing significant financial relief with the constraint of $400 billion in the Congressional budget resolution. The Congressional Budget Office estimates that Medicare beneficiaries will spend $1.8 trillion on prescription drugs between 2005 and 2014. The limited budget allocation will allow the new program to cover, at best, only 22 percent of prescription drug costs. (See chart below). The various bills that are rapidly moving through Congressional committees now rearrange the financial burden of prescription drug expenditures among various segments of the Medicare population – some favoring those with modest expenditures (e.g., up to $2,000), others favoring somewhat those with catastrophic expenditures (e.g., over $5,800). **Absent from these bills are policies that would dramatically reduce the burden on seniors and the disabled: provisions that would rein in the growth of prescription drug expenditures, promote cost-effectiveness, and increase the amount of money allocated to this national priority of providing true relief to seniors and the disabled from the high cost of prescription drugs.**

Chart 2

Republican Medicare Prescription Drug Plan:
Covering a Small Fraction of the Need



Total Prescription Drug Expenditures:
$1.8 Trillion

CBO projection of spending by Medicare enrollees on prescription drugs, 2004-2013: $1.839 trillion (Memorandum to Interested Parties, from Tom Bradley, Congressional Budget Office, Projected spending for prescription drugs by and on behalf of Medicare Enrollees, February 3, 2003)

Key Elements of Concern to Consumers

There are additional *significant* issues under consideration in the current debate; they are beyond the scope of this report which focuses on out-of-pocket costs, integrity of the Medicare program, and choice of doctor. These issues include:

- The harmful impact on Medicare beneficiaries who are eligible for Medicaid of requiring them to attain their prescription drug coverage through Medicaid, forcing them to deal with varying state eligibility rules and requirements, and preventing them from access to coverage through the traditionally universal Medicare program.

- The failure to relieve pressure on state budgets if dual eligible beneficiaries are covered through Medicaid, not Medicare.

- Incentives for employers to cut back retiree coverage if the benefits provided under such plans do not count toward the Medicare catastrophic benefit.

Will the Medicare prescription drug bill provide meaningful relief to consumers? The key elements in determining this are explained below.

1. Guaranteed benefit at affordable (and guaranteed) premium. A defined prescription drug benefit should be available to all beneficiaries at a premium level that is guaranteed to be no higher than a set amount in the range of $25 to $35. The premium should be the same for all Medicare beneficiaries, just as the Part B premium is the same no matter where a person lives. Varying benefits offered on a voluntary basis by the private insurance industry, with varying (and unpredictable) premiums and with uncertainty of the availability of the coverage in the future, would not meet this consumer need.

2. Reliable Coverage. Consumers want to be able to depend on the prescription drug coverage being stable, reliable, and not have to wonder whether the coverage will be available in the future. The best way to assure reliability of coverage is by building a prescription drug benefit into Medicare, just as hospital and doctor coverage is assured through Medicare. Medicare HMOs have been unreliable. Medicare HMOs come and go from the marketplace, they cut back prescription drug benefits, and they raise premiums for enrollees: all elements that render provision of a drug benefit through private insurance companies and HMOs unreliable.[1]

3. Rein in the growth of prescription drug costs. Unless prescription drug expenditures are held in check, out-of-pocket costs for Medicare beneficiaries are likely to continue to grow faster than other health care services. Some of the most effective policy options include: speeding introduction of generics, using the purchase power of the federal government to achieve substantial discounts on the purchase of drugs, and basing purchase decisions on the comparative effectiveness and cost-effectiveness of drugs, charging co-payments that are related to the comparative-effectiveness of drugs. Other countries have been able to rein in spiraling costs; a necessary feature of true Medicare reform will be curbing the growth of expenditures and better value for each prescription dollar spent.

4. Standard prescription drug benefit. As noted above, one underlying feature of prescription drug expenditures by Medicare beneficiaries is the uneven distribution of drug expenditures. While 1/3 of Medicare beneficiaries spend less than $500 a year on prescriptions, the average expenditure in 2003 is $2,318, and the median is roughly between $1,300 and $1,700, with about half spending more and half spending less. In light of this variation, the best guarantee to assuring that different health plans don't attract healthier or sicker people disproportionately is to provide a standard benefit in each of the options – whether it be traditional Medicare or a Medicare HMO. A recent Kaiser Family Foundation report demonstrated the importance of having a standard prescription drug benefit in the context of the use of pharmacy benefit managers in Medicare.[2] Another key reason to provide a standard prescription drug benefit is to reduce confusion on the part of Medicare beneficiaries. In addition, a standard benefit package improves the functioning of the market, allowing better comparisons among any choices to the benefit of beneficiaries and competition in the market.

5. Freedom of choice of doctor. When people get older, they often develop chronic health conditions, and the freedom to go to the doctor of their choice becomes increasingly important. Often discussion related to Medicare perpetuates the myth that beneficiaries need more choice of insurance plans. In reality, the ability to choose one's doctor is what people value the most. HMOs often severely limit the consumer's freedom to choose one's doctor. In addition, preferred provider organizations (PPOs) severely limit freedom of choice of doctor, and can expose consumers to unlimited out-of-pocket costs because they face higher copays for going to a doctor out-of-network.

6. Generous benefit for low-income beneficiaries through Medicare. In order to assure affordability of prescription drugs for low-income Medicare beneficiaries, cost-sharing should be nominal up to 175 percent of the federal poverty level. Dual eligibles (those eligible for both Medicaid and Medicare) should receive their drug benefit through Medicare, not Medicaid, both to provide

those who are dual eligibles the universal Medicare benefit and improve their care, and to provide budgetary relief to the states.

7. Meaningful financial relief for most beneficiaries who have moderate expenditures. While people with low income and people with catastrophic prescription drug expenditures face the largest financial burdens, people with moderate expenditures (e.g., $1,500 to $5,000) also struggle to pay their prescription drug costs. The benefit design should not have a "doughnut" that fails to cover drugs in the moderate expenditure range. (With a "doughnut," there is *no* benefit at all between the level at which some coverage ends, e.g., $2,000, and when catastrophic coverage begins, e.g., $5,800).

8. True catastrophic protection for those with the highest drug expenditures. Once drug expenditures are truly catastrophic, coverage should be complete without additional cost-sharing. Where to define "catastrophic" is debatable, but a level of approximately $2,000, is our target level for full protection. A design that includes cost-sharing for catastrophic expenditures undermines the goal of providing true stop-loss protection.

9. Reasonable "break-even point" at which your drug benefits exceed the premiums that you pay. The "break-even" point is the point at which your prescription drug expenditures are at exactly the level where the benefits that you receive are equal to the new premium you have paid in. For example, you would be at the "break-even point" if both the benefits you receive and the premium you pay in were $500. A break-even point of greater than $500 is very likely to lead to an unwillingness of many people to enroll, because 28 percent of beneficiaries currently spend less than $500 on their medicines. If large numbers of people choose not to enroll in drug coverage, those who do enroll are likely to be less healthy, adverse selection will occur, and private insurance companies and HMOs will come to Congress to ask for higher subsidies, while raising premiums for enrollees. The program will become unsustainable. The break-even point in the House Ways and Means Committee bill is about $775. The break-even point in the Senate Finance bill is $800. The break-even point in H.R. 1199 is $475. Note that these figures do not include premiums that would be paid in; actual out-of-pocket costs would be increased by the amount of the premium. (At the break-even point, out-of-pocket costs for the House Ways and Means bill would be $1,195; for the Senate Finance bill: $1,220; for H.R. 1199: $775.)

10. Preserve the integrity of the traditional Medicare program, without privatizing Medicare. The traditional Medicare program provides health care coverage to beneficiaries efficiently, with low administrative costs, and without diverting money for marketing and profits. When seniors and the disabled enroll in traditional Medicare, they are free to choose their own doctor, and they can be

confident that the benefits will be available year after year. Traditional Medicare is available regardless of a person's health status. Medicare HMOs, in contrast, have been unreliable partners and can leave a geographic area, could cut back benefits, and can raise premiums. Most beneficiaries, therefore, prefer traditional Medicare. If incentives (e.g., extra benefits) lure people into non-traditional forms of Medicare, and if funding is inadequate for traditional Medicare, in the future seniors and the disabled may have no choice but to enroll in a private plan, with less choice of doctor and greater out-of-pocket costs.

11. Consumer friendly: stable and understandable, without forcing complex decisions each year. Medicare beneficiaries, unlike employees, do not have a human resources staff to assist them in selecting a health plan. They should not be forced to make a complicated decision between various health plans every year, with variations in benefits and variations in premiums.

12. Comprehensive benefit, which costs an amount in line with the national priority that it deserves. Because providing affordable prescription drugs to our nation's Medicare beneficiaries should be a key national priority, Consumers Union supports spending the necessary money to fund coverage equivalent to coverage that federal employees get. We understand that this could cost about twice as much as the amount reserved in this year's Congressional budget resolution. We support funding this national priority (in addition to covering the uninsured) by repealing earlier cuts in taxes for the wealthy.

House Ways and Means Committee Bill

The key parameters of the bill to be considered by the Ways and Means Committee, as of June 12, are:

- $250 deductible
- $35/month premium (estimated, not guaranteed)
- 80 percent benefit/20 percent cost-sharing on expenditures above deductible up to $2,000
- Gap in coverage (doughnut) for expenditures between $2,000 and $5,100.
- 100 percent coverage after out-of-pocket costs total $3,700 (and total drug expenditures equal $5,100)

The table below summarizes how consumers would fare under the provisions of the bill proposed by the House Ways and Means Committee. Some of the key concerns are:

- Because the total cost of the bill is designed to be $400 billion over 10 years, the bill will cover only 22 percent of projected drug expenditures, as projected by the Congressional Budget Office.
- Drug coverage will be unreliable, due to reliance of the private insurance industry and no guaranteed fallback benefit through the Medicare program.
- The bill lacks guaranteed coverage at an affordable premium.
- The benefit design allows for variation of the benefit and will result in confusion in the marketplace.
- The bill provides inadequate relief for low-income beneficiaries, especially because of inadequate relief for expenditures in the "doughnut" range (gap of coverage).
- Large gaps keep the bill from provided significant relief for those in the moderate spending range.
- The design of the benefit creates a high "break-even" point: beneficiaries would have to spend $775 on prescription drugs before they would receive benefits as high as the new premiums they pay in, even assuming the benefits are at the level currently estimated. Total out-of-pocket costs for a beneficiary at the break-even point, including premium, would be about $1,200. Approximately 1/3 of beneficiaries spend less than $775 in 2003.[3] $775 spending in 2007 would be the equivalent of about $450 to $550 spending in 2003, and about 28% of beneficiaries are not in this range of having spending below the "break-even" point in 2007.
- The bill would eventually substantially privatize Medicare through a transition to a FEHBP type of program in 2010.
- The bill introduces means-testing of benefits into Medicare for high-income beneficiaries, ending the universality of the Medicare program.
- The bill fails to take aggressive steps to rein in growth of prescription drug costs (e.g., close loopholes that delay generics; assure cost-effective drug purchasing; put the full negotiating power of the federal government to work to rein in prices).

Minimal Relief from High Out-of-Pocket Prescription Drug Costs

From a consumer point of view, perhaps the most important measure of effectiveness of the bill is the impact on out-of-pocket costs. Assuming that prescription drug costs continue to increase at the historical rate of increase, we estimated what various beneficiaries drug expenditures would be in 2007, and then compared their out-of-pocket expenditure in 2003 and 2007. For purposes of analysis**, we considered the situation for consumers who currently have no**

drug coverage. We found that in light of the combination of skimpy benefits and historically high growth of prescription drug expenditures, consumers in all spending range except catastrophically high expenditures would actually face higher out-of-pocket costs in 2007 (one year after the bill is implemented) than they do in 2003. All estimates of out-of-pockets costs in 2007 are adjusted for inflation and are expressed in real 2003 dollars. Specifically, we found:

- The average Medicare beneficiary (without prescription drug coverage) spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including: premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,954 (real 2003 dollars).
- A Medicare beneficiary with relatively low expenditures in 2003 of $500 (i.e., bottom third of spending) would find his or her out-of-pocket payments for prescription drugs are $790 in 2007 (real 2003 dollars).
- The beneficiary in the middle third of spending has prescription costs of about $1,500 in 2003, and this person would find that his or her out-of-pocket spending for prescription drugs is $$1,566 in 2007 (real 2003 dollars).
- A person in the top third of prescription drug spending, with costs of $3,000 in 2003, would find his or her out-of-pocket costs reach $4,112 in 2007 (real 2003 dollars).
- A person with prescription drug expenditure in the catastrophic range, $6,000 in 2003, would face *reduced* out-of-pocket spending of $4,120 in 2007 (real 2003 dollars).
- If prescription drug growth moderates from historical levels to 12 percent per year, then the average Medicare beneficiary will face out-of-pocket costs in 2007 of approximately the same level as those of 2003, even after enactment of a Medicare prescription drug benefit ($2,318 in 2003; $2,323 in 2007).

Chart 3

Out-of-Pocket Costs
Average-Spending Beneficiary (without prescription drug coverage)
House Ways and Means Bill

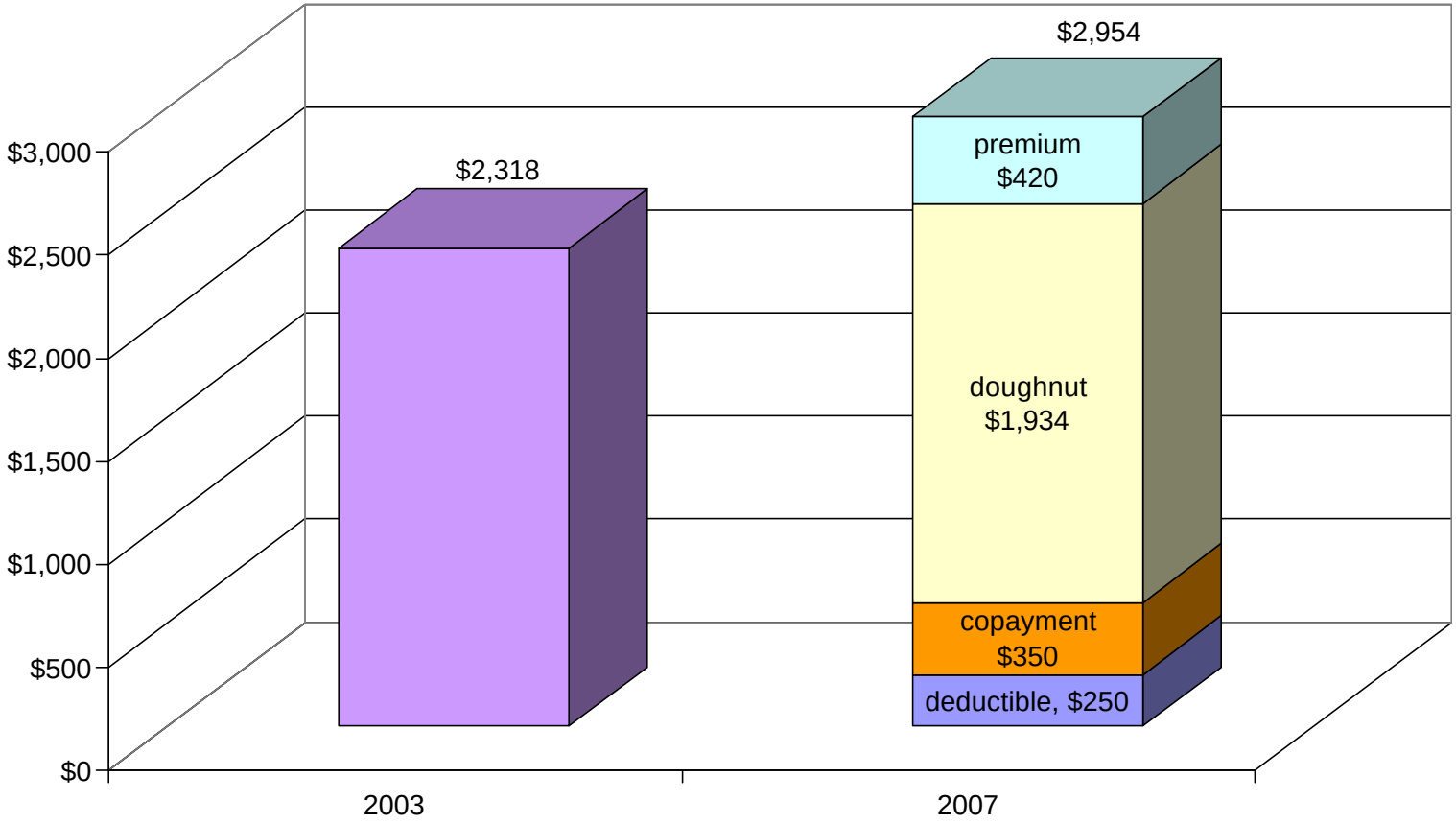


Chart 4

House Ways and Means Bill
Beneficiaries with Low Expenditures Face Increased Out-of-Pocket Costs in 2007

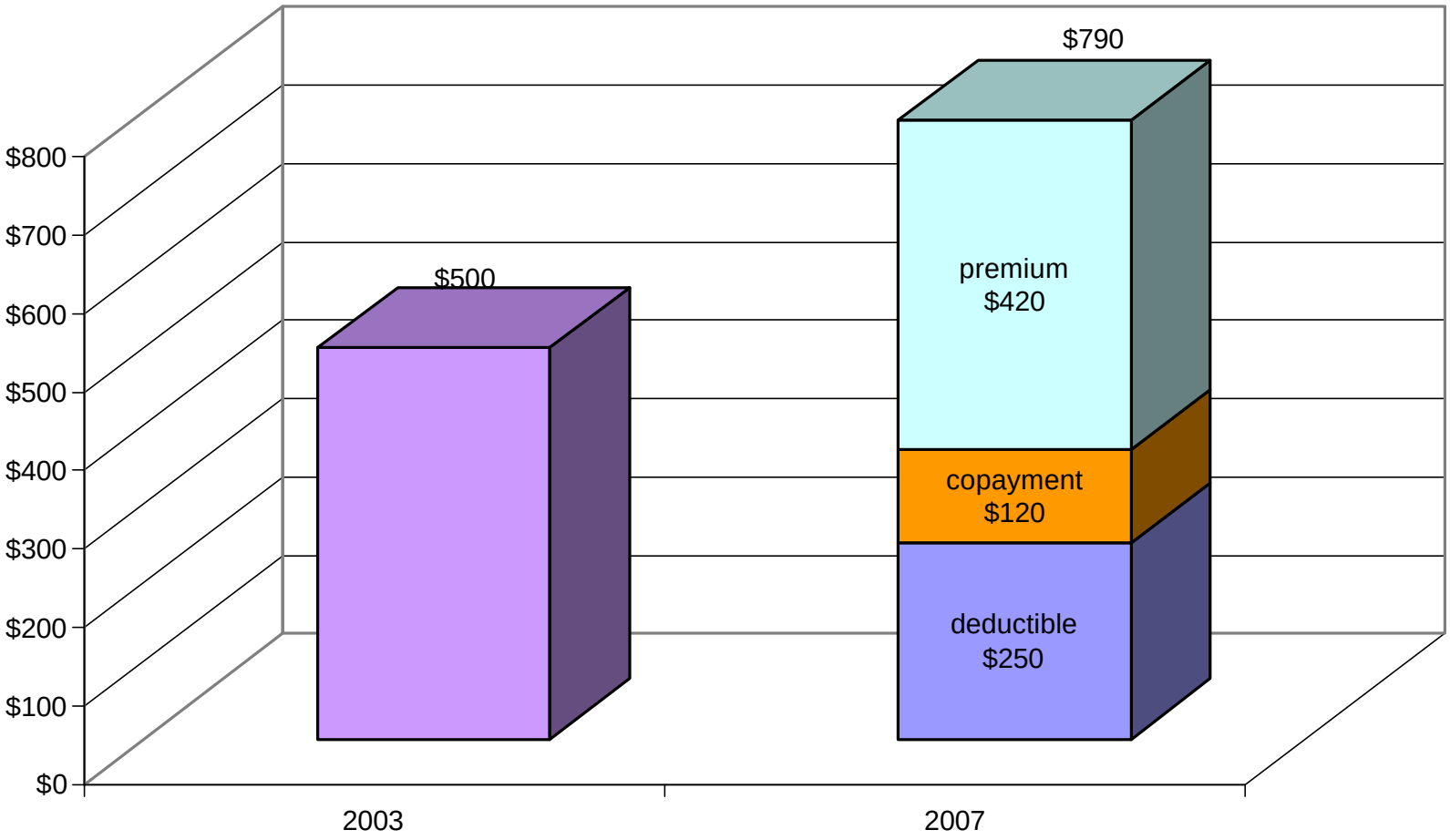


Chart 5

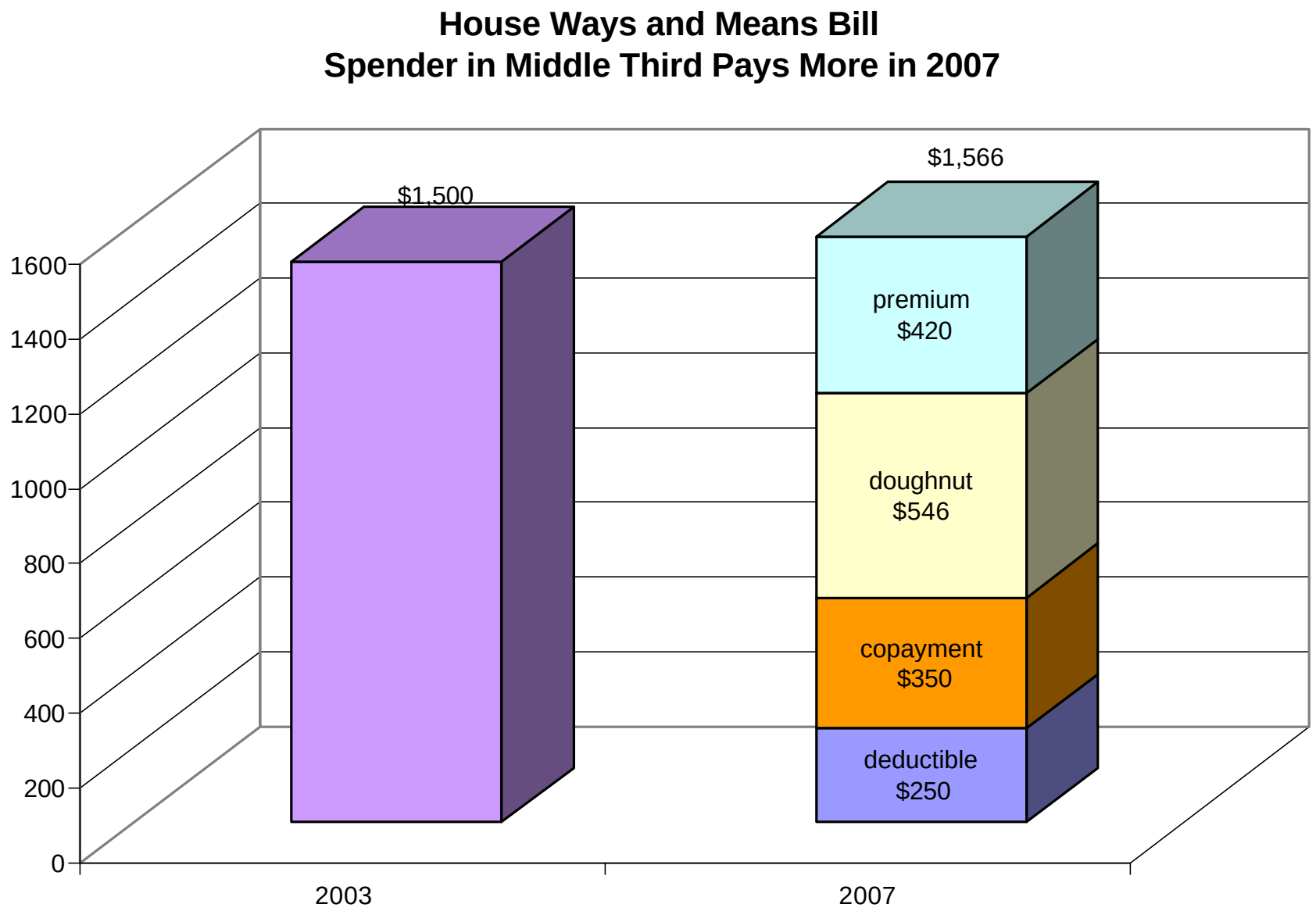

House Ways and Means Bill
Spender in Middle Third Pays More in 2007
$1,500
$1,566
premium
$420
doughnut
$546
copayment
$350
deductible
$250
1600
1400
1200
1000
800
600
400
200
0
2003
2007

Chart 6

Out-of-Pocket Costs
Beneficiary (without prescription coverage in 2003) with High Spending
House Ways and Means Bill

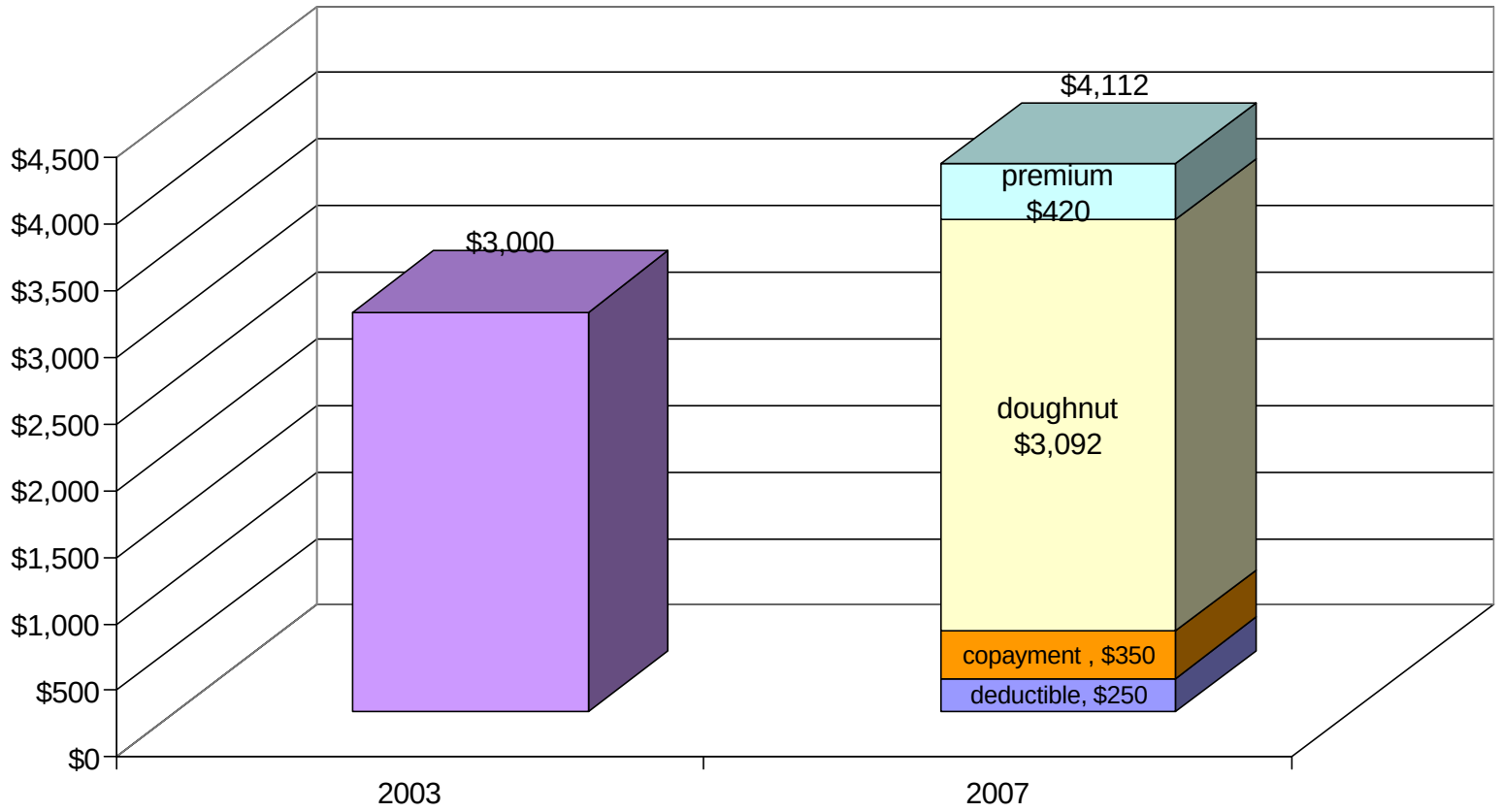
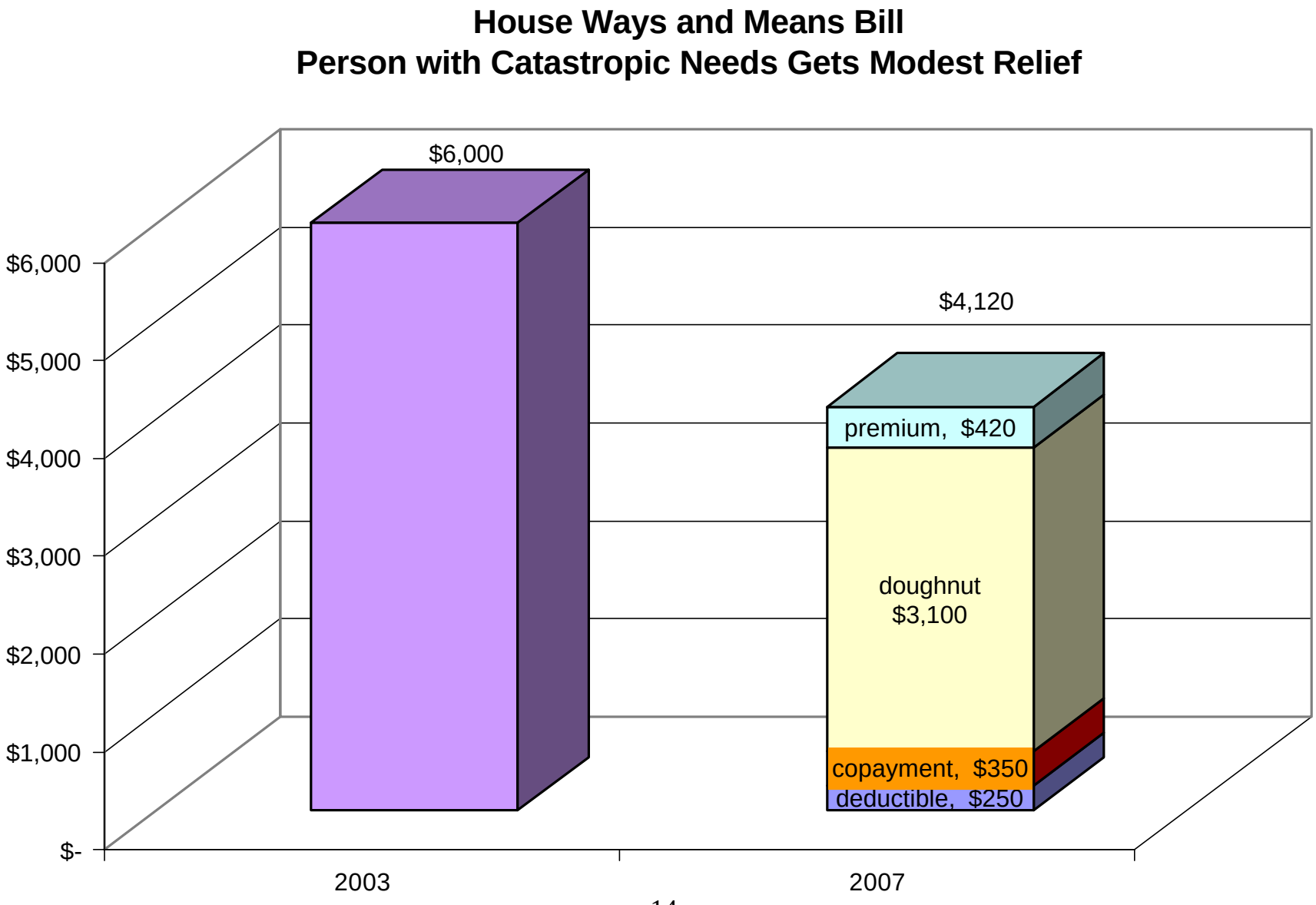


Chart 7


House Ways and Means Bill
Person with Catastropic Needs Gets Modest Relief
$6,000
$4,120
premium, $420
doughnut
$3,100
copayment, $350
deductible, $250
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$-
2003
2007

Senate Finance Bill

The key parameters of the bill that was reported out of the Senate Finance Committee on June 12, 2003 are:

- $275 deductible
- $35/month estimated (but not guaranteed) premium
- 50 percent coverage and 50 percent coinsurance up to expenditures of $4,500
- Gap in coverage (doughnut) for spending between $4,500 and $5,800
- 90 percent coverage and 10 percent coinsurance for spending above $500.

The table below summarizes how a consumer would fare under the Medicare prescription drug bill considered by the Senate Finance Committee on June 12. Some of the key concerns from a consumer perspective include:

- Because the total cost of the bill is designed to be $400 billion over 10 years, the bill would cover only 22 percent of projected drug expenditures.
- The bill provides extra benefits for those enrolling in and HMOs and PPOs, undermining the traditional Medicare program.
- Beneficiaries would often be forced to change health plans and change doctors, with private insurers coming in and out of the marketplace.
- The bill does not guarantee that premiums would be affordable.
- Benefits and premiums would vary from plan to plan.
- The bill has a large gap in coverage for those with moderate expenditures.
- The break-even point at which a person's expenditures are at a level at which benefits exceed the premium is $800.
- The bill fails to take steps to aggressively rein-in growth of prescription drug expenditures.

Minimal Relief from High Out-of-Pocket Prescription Drug Costs

The high cost-sharing, large doughnut and incomplete catastrophic protection, combined with increasing prescription drug prices, mean that most Medicare beneficiaries would experience very little relief from high out-of-pocket drug costs once the bill would be fully implemented in 2007. Again, this analysis considers hypothetical beneficiaries who have no prescription drug coverage in

2003. All 2007 dollar estimates of out-of-pocket costs are adjusted for inflation, to real 2003 dollars.

- The average Medicare beneficiary without prescription drug coverage spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including: premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,524 (real 2003 dollars).
- A Medicare beneficiary without prescription drug coverage with relatively low expenditures in 2003 of $500 (i.e., bottom third of spending) would find his or her out-of-pocket payments for prescription drugs are $982 in 2007 (real 2003 dollars).
- The beneficiary without prescription drug coverage with spending in the middle range, spending $1,500 in 2003, would find that his or her out-of-pocket spending for prescription drugs is $1,831 in 2007 (real 2003 dollars).
- A person in the top third of prescription drug spending, with costs of $3,000 in 2003, would find his or her out-of-pocket costs reach $3,399 in 2007 (real 2003 dollars).
- A person with prescription drug expenditure in the catastrophic range, $6,000 in 2003, would face *reduced* out-of-pocket spending of $4,545 in 2007 (real 2003 dollars).
- If prescription drug expenditures growth moderates below historical levels to 12 percent per year, the average Medicare beneficiary would face out-of-pocket costs in 2007 only marginally lower than those of 2003 ($2,318 in 2003, $2,209 in 2007).

The charts below depict these figures. These numbers are alarming indeed. They show that most seniors and disabled persons will experience very little real relief. They point to the need to focus intense attention on finding ways to rein in prescription drug spending.

Chart 8

Out-of-Pocket Costs, Average Spender Senate Finance Bill Skimpy Benefits + Unchecked Drug Prices: Average Medicare Beneficiary Faces Higher Out-of-Pocket Cost in 2007

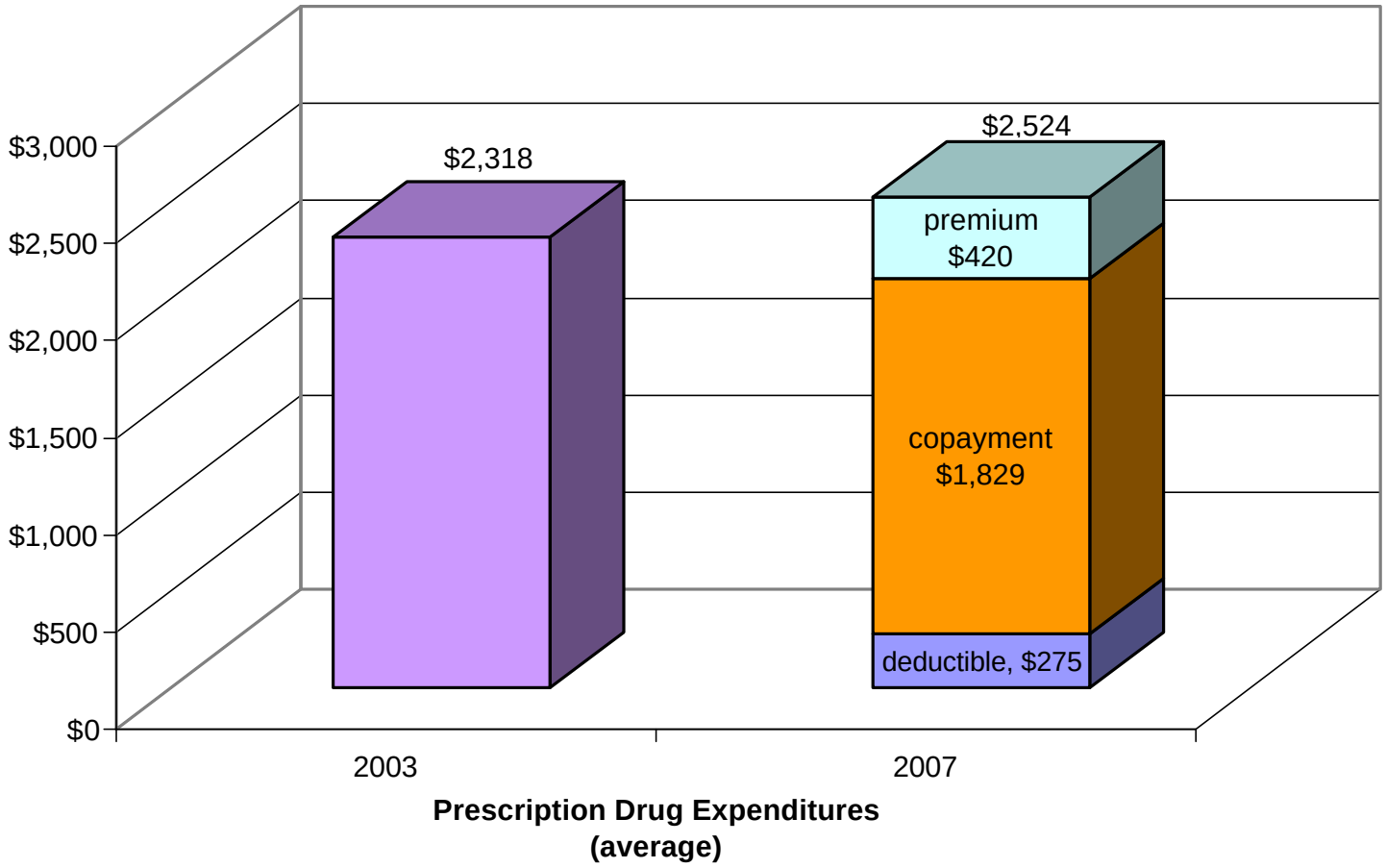


Chart 9

Senate Finance Bill
Beneficiaries with Low Expenditures Face Increased Out-of-Pocket Cost in 2007

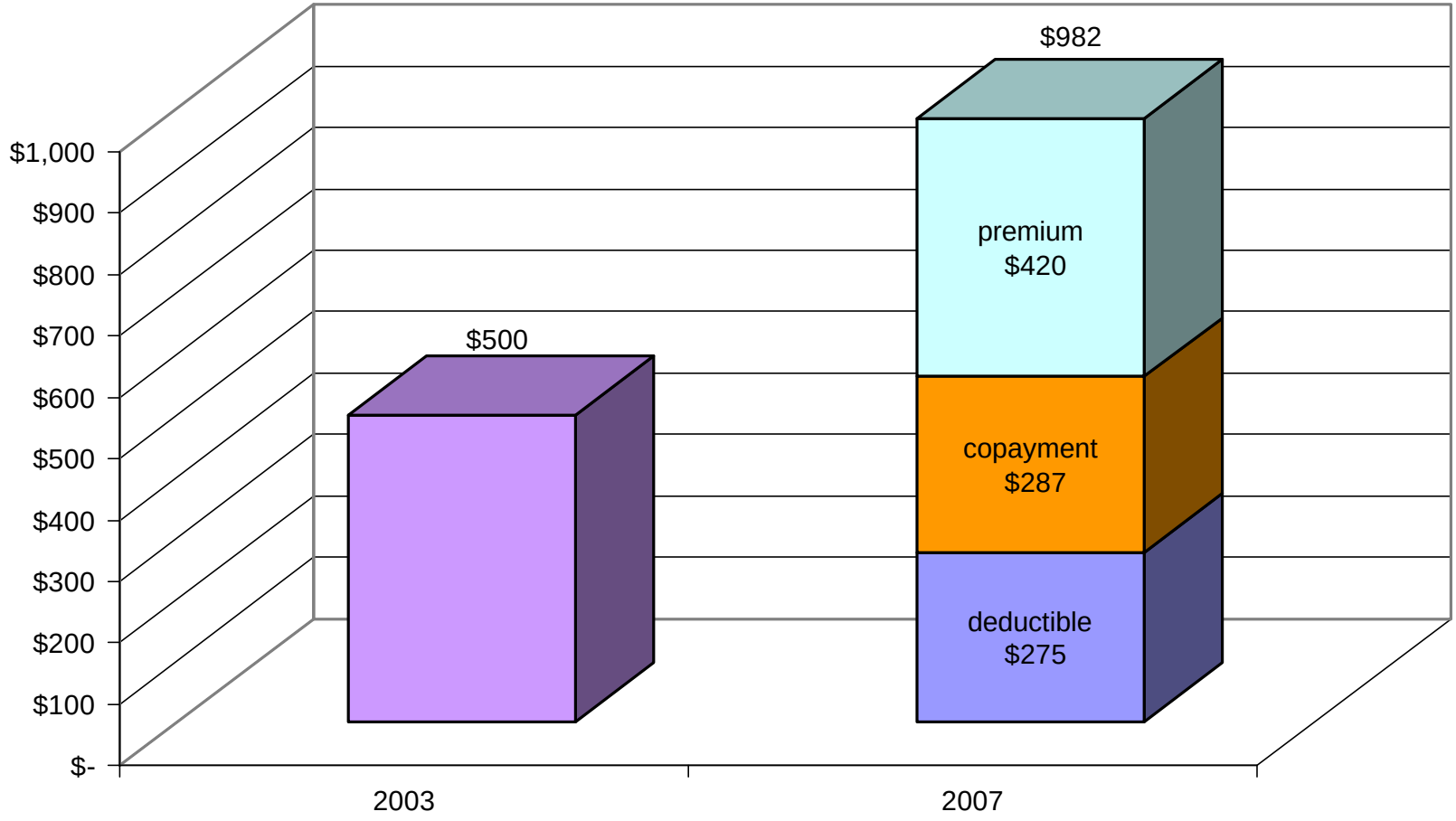


Chart 10

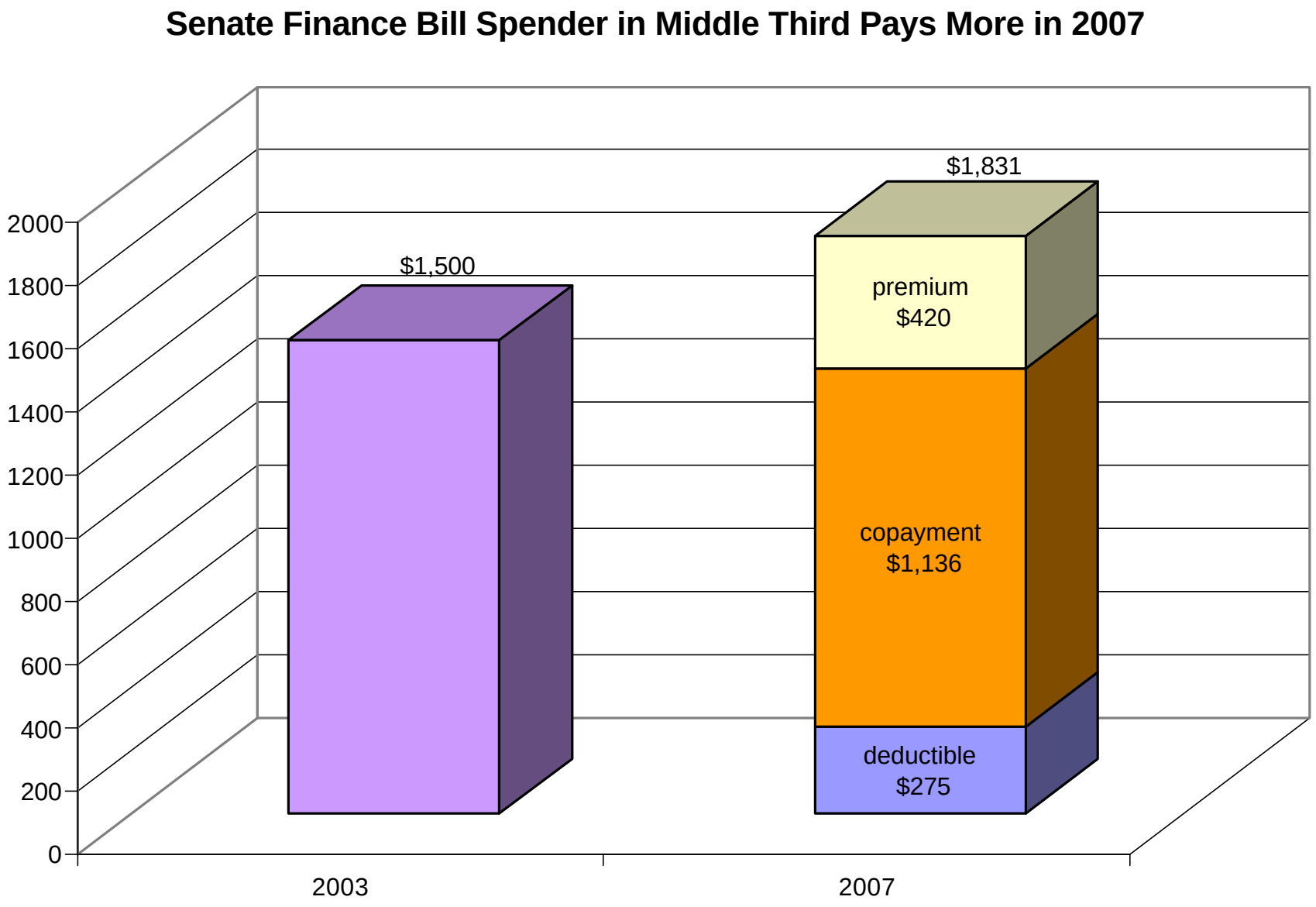

Senate Finance Bill Spender in Middle Third Pays More in 2007
2000
1800
1600
1400
1200
1000
800
600
400
200
0
$1,500
$1,831
premium
$420
copayment
$1,136
deductible
$275
2003
2007

Chart 11

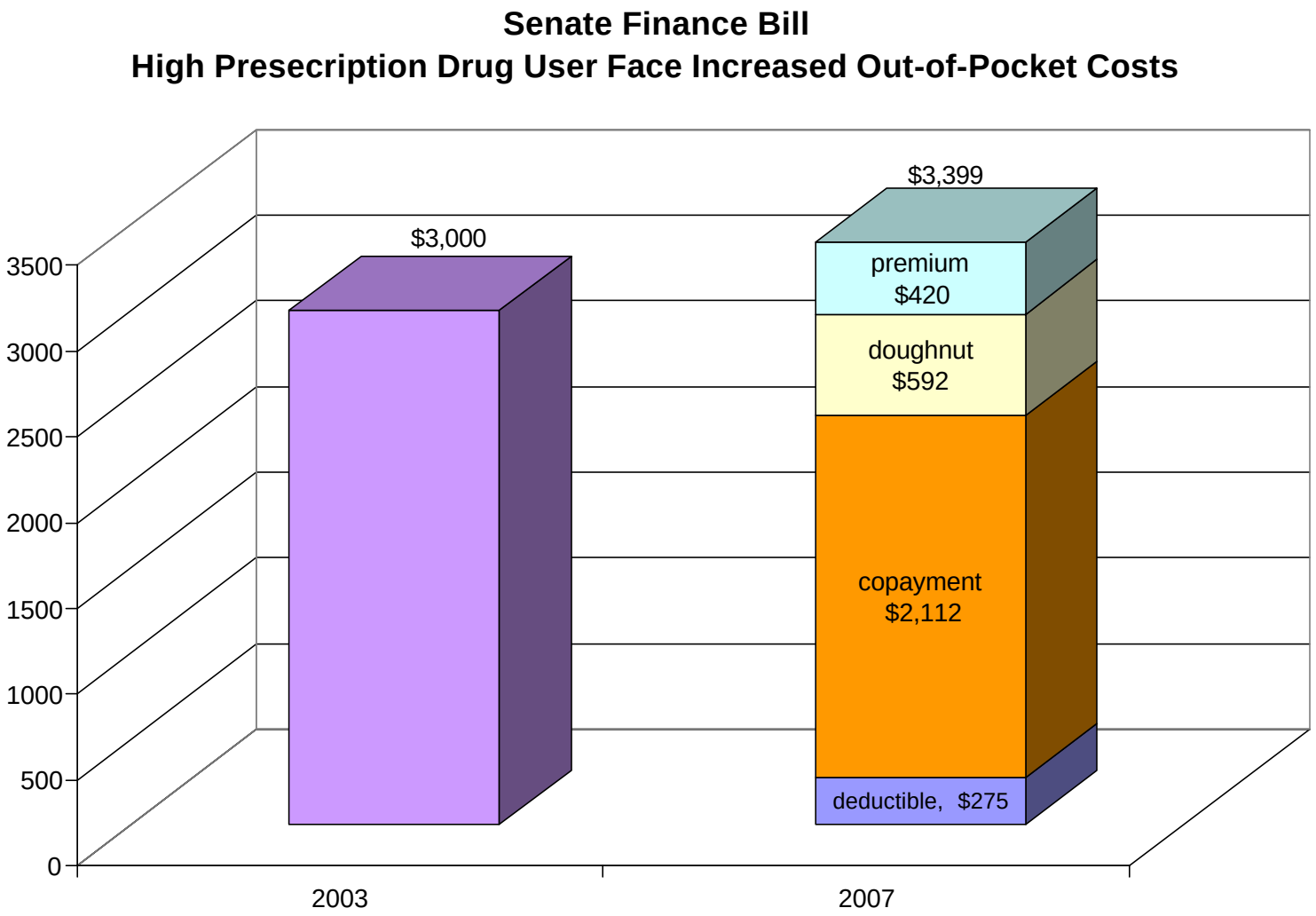
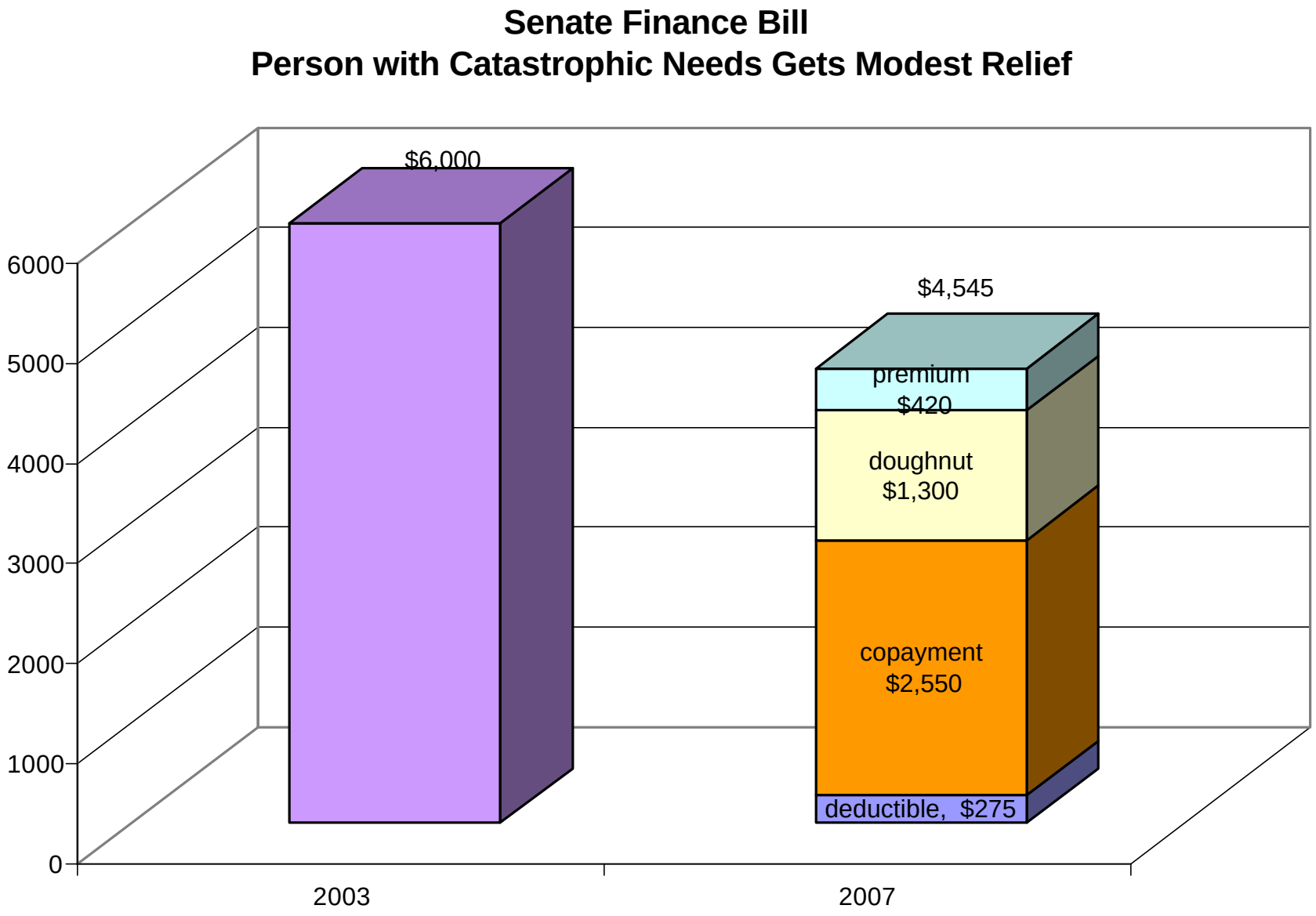

Senate Finance Bill
High Presecription Drug User Face Increased Out-of-Pocket Costs
$3,000
$3,399
premium
$420
doughnut
$592
copayment
$2,112
deductible, $275
3500
3000
2500
2000
1500
1000
500
0
2003
2007

Chart 12

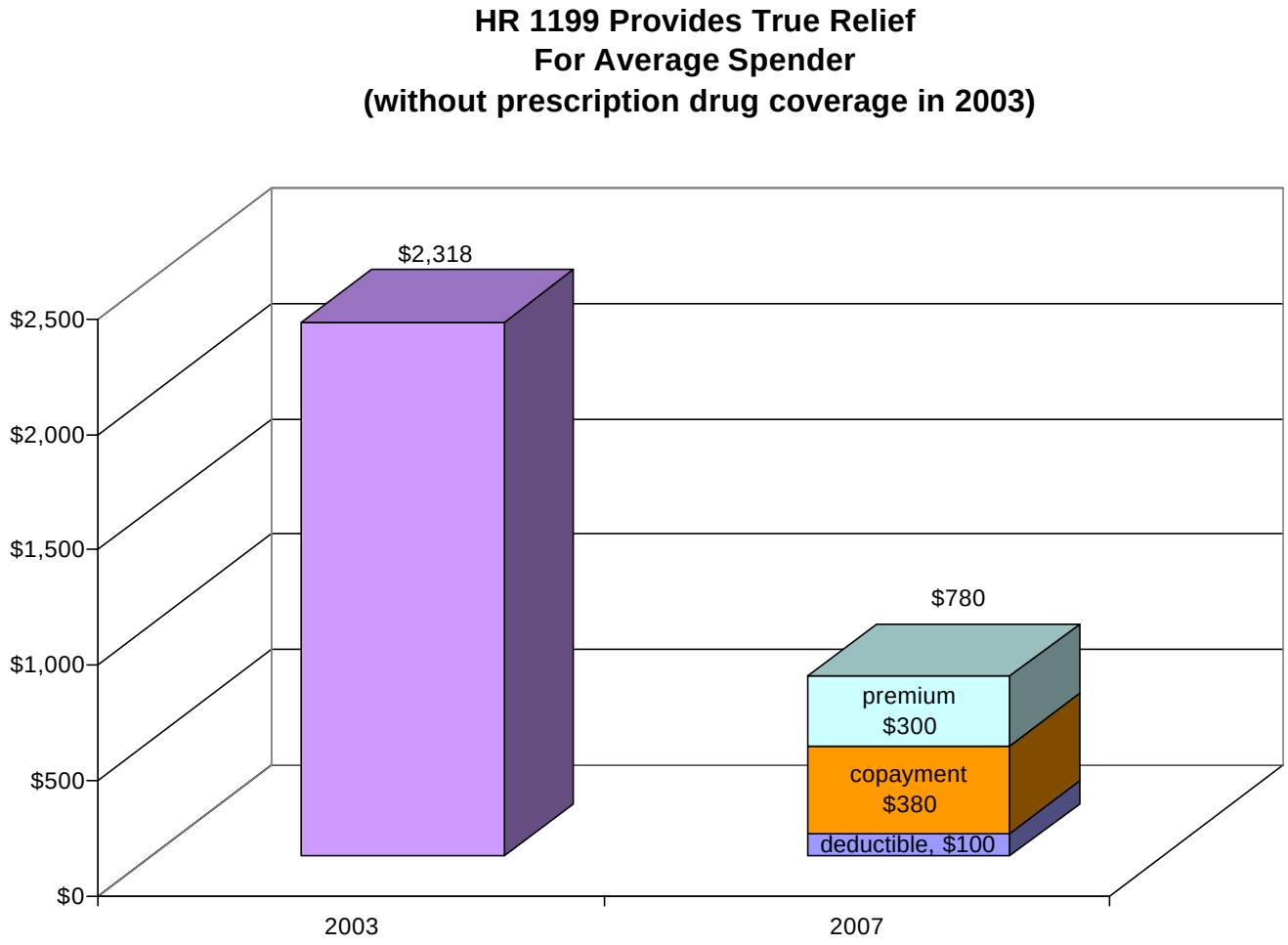

Senate Finance Bill
Person with Catastrophic Needs Gets Modest Relief
$6,000
$4,545
premium
$420
doughnut
$1,300
copayment
$2,550
deductible, $275
6000
5000
4000
3000
2000
1000
0
2003
2007

H.R. 1199 Provides True Relief

The analysis above suggests that true relief from burdensome out-of-pocket costs depends on a more generous benefit design and aggressive steps to rein in growth of prescription drug expenditures. H.R. 1199 has both. Under H.R. 1199:

- A person (without prescription drug coverage) with average spending in 2003 would have out-of-pocket costs of $780 in 2007 (real 2003 dollars) if prescription drug costs continue to increase at rates similar to the recent levels.
- A person without prescription drug coverage with average spending in 2003 would have out-of-pocket costs of $780 in 2007 (real 2003 dollars), if expenditures increase at a more moderate rate of 12 percent. (The federal government's benefit payments would be substantially lower than it would have been under the higher growth rate).

Chart 13



What do Consumers Want in a Medicare Prescription Drug Bill?

What do Consumers Need?	What would House Ways & Means bill do?	What would Senate Finance bill do?	What would Democratic bill HR1199 do? (Rangel/Dingell)
Brief Description of Benefit Design:	• $250 deductible • $35/month estimated premium • 80 percent coverage;20 percent coinsurance • Doughnut: $2,000 to $5,100 • 100 percent coverage after $3,700 out-of-pocket ($5,100 expenditures)	• $275 deductible • Estimated average monthly premium of $35/month • 50 percent coinsurance to $4,500 • Doughnut to $5,800 • 90 percent coverage above $5,800	• $100 deductible • $25/month premium • 20 percent coinsurance; 80 percent coverage • Stop-loss of $2,000 per year (maximum out-of-pocket, not including premium) • Coinsurance depends on preferred/non-preferred status
*1. **Guarantee** the benefit to beneficiaries at a **guaranteed** affordable premium*	X • No guarantees of private coverage availability • No guarantee of premium • Depends on participation of private industry • Likely to result in different benefit availability in different regions	X • Coverage and premium will vary across the country • No guarantee of premium level • Coverage, premium depend on private insurance company and HMO participation	✓ • Guaranteed benefit • Guaranteed premium
2. Reliable coverage	X • No option of guaranteed coverage, guaranteed premium through traditional Medicare program • Medicare HMOs have been UNRELIABLE: they leave regions; reduce prescription drug coverage; raise premiums	X • Private companies likely to come and go from market, like Medicare HMOs • If two plans exist in region with steep premiums, fallback not available • No guarantee of option of coverage through Medicare	✓ • Coverage is guaranteed, always available to all

What do Consumers Need?	What would House Ways & Means bill do?	What would Senate Finance bill do?	What would Democratic bill HR1199 do? (Rangel/Dingell)
3. Rein in growth of prescription drug expenditures through accelerated introduction of generic drugs and by assuring better value for prescription drug dollars spent	X • Does not close loopholes that delay generics or take other aggressive steps to contain expenditures • Through participation of multiple private companies, fails to tap potential savings that federal government as purchaser could achieve	X • Does not close loopholes that delay generics or take other aggressive steps to contain expenditures • Through participation of multiple private companies, fails to tap potential savings that federal government as purchaser could achieve	✓ • Speeds introduction of generics • Encourages use of cost-effective drugs • Federal government bargains for better prices
*4. Establish a **standard** benefit that beneficiaries will understand, avoiding confusing variations*	X • Likely to result in varied benefits and confusion	X • No standard benefit • Benefits will vary • Premiums will vary	✓ • Standard benefit
5. Allow beneficiaries freedom of choice of doctor at an affordable cost	X • Transition to FEHBP model will mean less freedom-of-choice of doctor and increased out-of-pocket costs for the sickest	X • Freedom of choice of doctor limited for those who enroll in PPOs and HMOs	✓ • By preserving traditional Medicare, assures the freedom of choice of doctor that beneficiaries value
6. Generous benefit for low income consumers, with minimal cost-sharing, up to 175 percent of federal poverty level	X • Full premium and cost-sharing subsidy up to 135 percent of poverty • Premium subsidy phases out between 135 and 150 percent of poverty • BUT assets test • But: no coverage for doughnut	X/✓ • Generous subsidy: Low-income subsidies for those below 160 percent of poverty • But: Requires dual eligibles to get their prescription drug coverage through Medicaid, not Medicare	✓ • No cost-sharing at income levels up to 175 percent of poverty

What do Consumers Need?	What would House Ways & Means bill do?	What would Senate Finance bill do?	What would Democratic bill HR1199 do? (Rangel/Dingell)
7. Meaningful financial relief for most beneficiaries who have moderate expenditures	X • Large gaps in coverage for those with moderate needs (doughnut hole)	X • Large gaps in coverage for people with expenditures between $4500 and $5800 • High coinsurance for those getting basic benefit (50 percent)	✓ • Meaningful benefit at all levels of prescription drug expenditures, without any gaps
8. True catastrophic protection for those with highest drug expenditures	X • Beneficiaries have to reach high prescription drug expenditure level of $5,100 before receiving catastrophic protection	X • Beneficiaries have to reach high prescription drug expenditure level of $5,800 before receiving catastrophic protection	✓ • Out-of-pocket costs are limited above drug expenditures of $2,000
9. Reasonable "break-even point": amount that you must spend on prescription drugs so that the benefits you get exceed the premiums that you pay *Note: 28 percent of recipients will spend less than $500 in 2003*	X • Break-even point is $775. Total out-of-pocket costs at break-even point, including premium, are $1200. About one third of beneficiaries have lower expenditures in 2003.	X • Break-even point is $800. Drug expenditures must exceed $800 (total out-of-pocket costs equal $1220) before benefits equal premium.	✓ • Under HR1199, individuals would have to spend more than $475 on prescription drugs to end up with a net benefit
10. Consumer-friendly: stable and understandable without forcing complex decisions each year	X • Confusing variety of private insurance options. • Long-term: would require beneficiaries to make complicated decision about which health plan to use	X • Confusing since insurance companies participating likely to change frequently, no assurance of availability through Medicare	✓ • Traditional Medicare would continue to be the coverage of choice for most, without the need for complicated annual decisions

What do Consumers Need?	What would House Ways & Means bill do?	What would Senate Finance bill do?	What would Democratic bill HR1199 do? (Rangel/Dingell)
11. Preserve the integrity of the traditional Medicare program, without privatizing Medicare	X • Would privatize Medicare and undermine traditional Medicare Relies on participation of *reluctant* insurance industry	X • Enriches benefits for those in private coverage (preventive, catastrophic) • Undermines traditional Medicare	✓ • Builds prescription drug benefit into Medicare (Part D) Avoids adverse selection that will occur in privatized system (because risks vary)
12. *Establish Medicare prescription drug spending as a national priority at the spending level needed to provide meaningful benefit, with a comprehensive benefit*	X • Republican budget allocates $400 billion for prescription drugs *and* Medicare "reform", and will cover *at best* 22 percent of projected prescription drug expenditures	X • Designs benefit to meet inadequate budget allocation of $400 billion	✓ After taking into account expanded use of generics and expanded purchasing power of federal government, likely to cover considerably more than half of projected expenditures

APPENDIX

Methodology

First, we assumed that the distribution of prescription drug expenditures in 2003 is correct as reported in the Kaiser Family Foundation's Medicare and Prescription Drug Fact Sheet, April 2003, using CBO figures. (See Chart 1 above). Next, we estimated how fast prescription drug costs will increase between 2003 and 2007. We assumed that, since the bills moving through committee lack adequate provisions to rein in costs, costs will continue to increase at the rate that they have grown since 1997.

The key reasons that expenditures are increasing are price increases, an increase in the number of prescriptions, and a shift to higher cost drugs.[4] The National Institute of Health Care Management estimate of increase in retail spending on prescription drug ranged from 17.1 percent to 18.9 percent per year between 1997 and 2001, with the average annual increase 18.3 percent.[5] The Center for Studying Health System Change calculates the annual increase in prescription drug spending to range between 13.2 and 18.4 between 1998 and 2002. The average annual rate of increase of the average of these two studies is 17 percent. We also made estimates for average prescription drug users at an average annual rate of increase of 12 percent, far lower than the recent historical increase. A 12 percent increase is the average rate of increase in expenditures projected by the Congressional Budget Office over the next 10 years. We used the higher rate for the primary analysis because we believe that the recent experience is likely to be the best predictor of the future. The absence of tough measures to rein in growth of expenditures are likely to result in continued high increases in prescription drug prices, which in 2002 increased at five times the rate of growth of the gross domestic product.[6] In addition, the endorsement of both the House and Senate bills by the pharmaceutical industry is a good indicator that the bills are unlikely to rein in growth of prescription drug spending.

We estimated the impact of the bill for a range of prescription drug expenditures: We first estimated the impact of the key bills under consideration in the House and the Senate for a person with average prescription drug spending in 2003, $2,318 (Congressional Budget Office). We then estimated how the bill would affect people who have no prescription drug coverage in 2003 and who are ineligible for low-income subsidies at various points in the distribution of prescription drug spending: A person in the lowest third of spending, a person at the middle level of spending, a person in the top third of spending, and a person whose spending is catastrophic.

For each spending level, the 2003 spending level was used to estimate spending in 2007, using the 17 percent average annual increase. The next step was to adjust the nominal dollars in 2007 to the equivalent spending in 2003 dollars, to adjust for overall inflation. The average rate of increase in the consumer price index (CPI) between 1999 and 2003 (projection) was 2.5 percent. We deflated the 2007 numbers with the assumption that the average CPI increase will be 2.5 percent annually over the next 4 years.[7]

We carried out the same analysis at each spending level for the Senate Finance Committee mark of June 12, 2003.

We estimated the out-of-pocket costs for a beneficiary with average spending in 2003, under HR1199, the Rangel bill.

Changing the Assumptions

We tested the results by changing the assumption about the rate of growth of prescription drug expenditures. For the average beneficiary, we estimated out-of-pocket costs in 2007 if the average annual increase in expenditures were 12 percent, the average number projected by the Congressional Budget Office.

Table A-1

House Ways and Means Bill (June 10)
Out-of-Pocket Costs and Benefits
At Various Consumer Expenditure Levels
(Historical growth of prescription drug expenditures)

A		average	bottom third	middle third	top third	catastrophic
B	2003	2318	500	1500	3000	6000
C	2007	4344	937	2811	5622	11243
D	2007 inf.adj.	3934	849	2546	5092	10184
E	Premium	420	420	420	420	420
F	Deductible	250	250	250	250	250
G	Copay,basic	350	120	350	350	350
H	Copay,catas.	0	0	0	0	0
I	Doughnut	1934	0	546	3092	3100
J	Total OOP	2954	790	1566	4112	4120
K	Basic ben.	1400	479	1400	1400	1400
L	Catas. Ben.	0	0	0	0	5084
M	Total ben.	1400	479	1400	1400	6484

About the data in the rows:

A. Data points selected for analysis
B. Individuals at average, bottom third, middle third, top third and catastrophic expenditures were selected for 2003 based on CBO distribution of consumer expenditures as summarized in Medicare and Prescription Drug Fact Sheet, April 2003, Kaiser Family Foundation, citing CBO 2003
C. Nominal 2007 expenditures. 2003 expenditures are increased at rate of 17 percent per year, between 2003 and 2007. (See report for how the 17 percent increase figure was calculated).
D. 2007 nominal expenditures are adjusted for an assumed annual increase of the CPI of 2.5 percent, the average rate for the past five years. (Divide figure in C by 1.104)
E. Estimate of average premium. Note that this level is not guaranteed.
F. Deductible
G. Basic co-payment
H. Co-payment on catastrophic
I. Doughnut
J. Total out-of-pocket costs
K. Basic benefit
L. Catastrophic benefit
M. Total benefit

Table A-2

Senate Finance Bill:
Out-of-Pocket Costs and Benefits
At Various Consumer Expenditure Levels
(Historical growth of prescription drug expenditures)

A		average	bottom third	middle third	top third	catastrophic
B	2003	2318	500	1500	3000	6000
C	2007	4344	937	2811	5622	11243
D	2007,adj.	3934	849	2546	5092	10184
E	Premium	420	420	420	420	420
F	Deductible	275	275	275	275	275
G	Copay,basic	1829	287	1136	2112	2112
H	Copay,catas.	0	0	0	0	438
I	Doughnut	0	0	0	592	1300
J	Total OOP	2524	982	1831	3399	4545
K	Basic ben.	1829	287	1136	2112	2112
L	Catas. Ben.	0	0	0	0	3946
M	Total ben.	1829	287	1136	2112	6058

About the data in the rows:

A. Data points selected for analysis

B. Individuals at average, bottom third, middle third, top third and catastrophic expenditures were selected for 2003 based on CBO distribution of consumer expenditures as summarized in Medicare and Prescription Drug Fact Sheet, April 2003, Kaiser Family Foundation, citing CBO 2003, (www.kff.org)

C. Nominal 2007 expenditures. 2003 expenditures are increased at rate of 17 percent per year, between 2003 and 2007. (See report for how the 17 percent increase figure was calculated).

D. 2007 nominal expenditures are adjusted for an assumed annual increase of the CPI of 2.5 percent, the average rate for the past five years. (Divide figure in C by 1.104)

E. Estimate of average premium. Note that this level is not guaranteed.

F. Deductible

G. Basic co-payment

H. Co-payment on catastrophic

I. Doughnut

J. Total out-of-pocket costs

K. Basic benefit

L. Catastrophic benefit

M. Total benefit

Table A-3

Out-of-Pocket Expenditures and Benefits
Of House Ways & Means bill and Senate Finance Bill
At Lower-than-Historical Growth of Prescription Drug Expenditures

A		House W&M	Senate Finance
B	2003	2318	2318
C	2007	3647	3647
D	2007,adj.	3303	3303
E	Premium	420	420
F	Deductible	250	275
G	Copay,basic	350	1514
H	Copay,catas.	0	0
I	Doughnut	1303	0
J	Total OOP	2323	2209
K	Basic ben.	1400	1514
L	Catas. Ben.	0	0
M	Total ben.	1400	1514

About the data in the rows:

A. Data points selected for analysis
B. Individuals at average, bottom third, middle third, top third and catastrophic expenditures were selected for 2003 based on CBO distribution of consumer expenditures as summarized in Medicare and Prescription Drug Fact Sheet, April 2003, Kaiser Family Foundation, citing CBO 2003, (www.kff.org)
C. Nominal 2007 expenditures. 2003 expenditures are increased at rate of 12 percent, (considerably lower than the recent historical increase levels) per year, between 2003 and 2007.
D. 2007 nominal expenditures are adjusted for an assumed annual increase of the CPI of 2.5 percent, the average rate for the past five years. (Divide figure in C by 1.104)
E. Estimate of average premium. Note that this level is not guaranteed
F. Deductible
G. Basic co-payment
H. Co-payment on catastrophic
I. Doughnut
J. Total out-of-pocket costs
K. Basic benefit
L. Catastrophic benefit
M. Total benefit

Table A-4: H.R. 1199

Out-of-Pocket Expenditures and Benefits
(At historical and lower-than-historical rate
Of increase of prescription drug expenditures)

A		Historical increase	Lower than historical (12 percent)
B	2003	2318	2318
C	2007	4344	3647
D	2007,adj.	3934	3303
E	Premium	300	300
F	Deductible	100	100
G	Copay,basic	380	380
H	Copay,catas.	0	0
I	Doughnut	0	0
J	Total OOP	780	780
K	Basic ben.	1520	1520
L	Catas. Ben.	1934	1303
M	Total ben.	3454	2823

About the data in the rows:

A. Data points selected for analysis
B. Individuals at average, bottom third, middle third, top third and catastrophic expenditures were selected for 2003 based on CBO distribution of consumer expenditures as summarized in Medicare and Prescription Drug Fact Sheet, April 2003, Kaiser Family Foundation, citing CBO 2003, (www.kff.org)
C. Nominal 2007 expenditures. 2003 expenditures are increased at rate of 17 percent per year, between 2003 and 2007, in the first column. (See report for how the 17 percent increase figure was calculated). An annual rate of 12 percent is used in the second column.
D. 2007 nominal expenditures are adjusted for an assumed annual increase of the CPI of 2.5 percent, the average rate for the past five years. (Divide figure in C by 1.104)
E. Estimate of average premium. Note that this level is not guaranteed
F. Deductible
G. Basic co-payment
H. Co-payment on catastrophic
I. Doughnut
J. Total out-of-pocket costs
K. Basic benefit
L. Catastrophic benefit
M. Total benefit

[1] Marsha Gold and Lori Achman, *Average Out-of-Pocket Health Care Costs for Medicare + choice Enrollees Increase Substantially in* 2002, Commonwealth Fund, November 2002. Available at www.cmwf.org.
[2] Debra A. Draper, Anna E. Cook, Marsha R. Gold, *How Do Medicare+Choice Plans Manage Pharmacy Benefits? Implications for Medicare* Reform, Kaiser Family Foundation, March 2003. Available at www.kff.org.
[3] Based on CBO distribution figures reported by Kaiser Family Foundation, 13% of beneficiaries spend between $500 and $999 in 2003. With 28% spending less than $500, it is estimated an additional 5-7% spend less than $775.
[4] *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, National Institute for Health Care Management, May 6, 2002, p. 6.
[5] *Ibid*, p. 2.
[6] Data Bulletin: Tracking Health Care Costs, Center for Studying Health System Change, June 2003.
[7] Consumer Price Index, 1913-, Federal Reserve Bank of Minneapolis.
http://minneapolisfed.org/research/data/us/calc/hist1913.cfm