

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)
<p><i>Brief Description of Benefit Design:</i></p>	<ul style="list-style-type: none"> • \$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) 	<ul style="list-style-type: none"> • \$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 	<ul style="list-style-type: none"> • \$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
<p><i>1. Guarantee the benefit to beneficiaries at a guaranteed affordable premium</i></p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Coverage and premium will vary across the country • No guarantee of premium level • Coverage, premium depend on private insurance company and HMO participation 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Guaranteed benefit • Guaranteed premium

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2. <i>Reliable coverage</i>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Coverage is guaranteed, always available to all

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<p>3. Rein in growth of prescription drug expenditures through accelerated introduction of generic drugs and by assuring better value for prescription drug dollars spent</p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Speeds introduction of generics • Encourages use of cost-effective drugs • Federal government bargains for better prices
<p>4. Establish a standard benefit that beneficiaries will understand, avoiding confusing variations</p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Likely to result in varied benefits and confusion 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • No standard benefit • Benefits will vary • Premiums will vary 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Standard benefit
<p>5. Allow beneficiaries freedom of choice of doctor at an affordable cost</p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Transition to FEHBP model will mean less freedom-of-choice of doctor and increased out-of-pocket costs for the sickest 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Freedom of choice of doctor limited for those who enroll in PPOs and HMOs 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • By preserving traditional Medicare, assures the freedom of choice of doctor that beneficiaries value

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<p>6. <i>Generous benefit for low income consumers, with minimal cost-sharing, up to 175 percent of federal poverty level</i></p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">X/✓</p> <ul style="list-style-type: none"> • 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 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • No cost-sharing at income levels up to 175 percent of poverty
<p>7. <i>Meaningful financial relief for most beneficiaries who have moderate expenditures</i></p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Large gaps in coverage for those with moderate needs (doughnut hole) 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Large gaps in coverage for people with expenditures between \$4500 and \$5800 • High coinsurance for those getting basic benefit (50 percent) 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Meaningful benefit at all levels of prescription drug expenditures, without any gaps
<p>8. <i>True catastrophic protection for those with highest drug expenditures</i></p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Beneficiaries have to reach high prescription drug expenditure level of \$5,100 before receiving catastrophic protection 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Beneficiaries have to reach high prescription drug expenditure level of \$5,800 before receiving catastrophic protection 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Out-of-pocket costs are limited to a total of \$2,000

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<p>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 <i>Note: 28 percent of recipients will spend less than \$500 in 2003</i></p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • 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. 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Break-even point is \$800. Drug expenditures must exceed \$800 (total out-of-pocket costs equal \$1220) before benefits equal premium. 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Under HR1199, individuals would have to spend more than \$475 on prescription drugs to end up with a net benefit
<p>10. Consumer-friendly: stable and understandable without forcing complex decisions each year</p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Confusing variety of private insurance options. • Long-term: would require beneficiaries to make complicated decision about which health plan to use 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Confusing since insurance companies participating likely to change frequently, no assurance of availability through Medicare 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Traditional Medicare would continue to be the coverage of choice for most, without the need for complicated annual decisions
<p>11. Preserve the integrity of the traditional Medicare program, without privatizing Medicare</p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Would privatize Medicare and undermine traditional Medicare <p>Relies on participation of <i>reluctant</i> insurance industry</p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Enriches benefits for those in private coverage (preventive, catastrophic) • Undermines traditional Medicare 	<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Builds prescription drug benefit into Medicare (Part D) <p>Avoids adverse selection that will occur in privatized system (because risks vary)</p>

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<p>12. <i>Establish Medicare prescription drug spending as a national priority at the spending level needed to provide meaningful benefit, with a comprehensive benefit</i></p>	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Republican budget allocates \$400 billion for prescription drugs <i>and</i> Medicare “reform”, and will cover <i>at best</i> 22 percent of projected prescription drug expenditures 	<p style="text-align: center;">X</p> <ul style="list-style-type: none"> • Designs benefit to meet inadequate budget allocation of \$400 billion 	<p style="text-align: center;">✓</p> <p>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</p>

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.⁵ 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.⁶ 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.⁷ 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.⁸

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	767	641
H	Copay,catas.	0	0
I	Doughnut	0	0
J	Total OOP	1167	1041
K	Basic ben.	3067	2562
L	Catas. Ben.		
M	Total ben.	3067	2562

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 This amount was reduced to \$4,900 in the bill passed by the House.

⁴ 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.

⁵ *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, National Institute for Health Care Management, May 6, 2002, p. 6.

⁶ *Ibid*, p. 2.

⁷ Data Bulletin: Tracking Health Care Costs, Center for Studying Health System Change, June 2003.

⁸ Consumer Price Index, 1913-, Federal Reserve Bank of Minneapolis.

<http://minneapolisfed.org/research/data/us/calc/hist1913.cfm>