Prescription Drugs as a Starting Point for Medicare Reform
Testimony before the Senate Budget Committee
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Chairman Domenici, Senator Conrad and Members of the Committee: Thank you for the opportunity to testify today on Medicare reform issues. In my testimony, I am going to concentrate on prescription drug issues because, as I will argue later, this is a reasonable place to start on improving Medicare for the future. I will also emphasize issues facing the traditional fee-for-service part of the program, which serves 34.4 million of the 40 million Medicare beneficiaries and is often left out when the discussion turns to major restructuring. Traditional Medicare needs to be improved, since for the foreseeable future it will serve the majority of beneficiaries and an even larger majority of older and sicker beneficiaries.

While there seems to be considerable consensus to provide some prescription drug coverage for the Medicare beneficiary population, the specifics remain highly controversial. Should this coverage be extended only in the context of other reforms? If so, how comprehensive do these reforms have to be to “qualify”? Should the benefit be restricted to those with low incomes? Should drug coverage be part of the regular Medicare benefit package or kept separate? Who should manage the program: private entities or government? How generous should the benefit be?

I address four major questions in my testimony: 1) what general approach makes sense for adding drug coverage, 2) what is the current situation facing beneficiaries, 3) what issues are most crucial for serving beneficiaries well, and 3) how does prescription drug coverage fit in with other reform issues?

**First Things First**

Three basic approaches to adding prescription drug coverage for Medicare beneficiaries have been suggested:

- Provide coverage only for those with low incomes—either as an initial step or as the full response;
- Provide universal coverage, but only in concert with other reforms such as relying on private insurance plans to serve Medicare beneficiaries; and
- Provide universal coverage with no conditions about other reforms.

The obvious advantage of offering coverage only for persons with low incomes is the lower costs of such a drug benefit. But this approach requires a separate administrative structure (likely run by the states) to determine eligibility and what drugs would be covered. This will take time to establish and may be problematic if it is time limited. But most important, a low income approach would solve only part of the problem.

The main reason to tie drug coverage to other reforms is to achieve a warmer reception for what may be very unpopular requirements on beneficiaries in other areas of the program. This strategy would likely delay adding drugs while controversies over the role of traditional Medicare and private plans are worked out. Meanwhile, the situation for beneficiaries will worsen each year. This approach also runs the risk of developing a drug benefit that works well in combination with private plan options, but treats coordination with the traditional Medicare program as an afterthought.

The approach I favor would deal with the prescription drug issue now, perhaps in conjunction with some other changes in Medicare, but not a full restructuring of the program. Getting it right on prescription drugs is a large task on its own. Regardless of whether the future of Medicare relies on incremental reforms or on a restructuring of the program to feature private insurers, a drug benefit is a necessary first step. Moreover, since both traditional Medicare and private plans are likely to be part of the future, any drug benefit needs to work in both situations.

**Prescription Drugs and Medicare Beneficiaries**

Prescription drugs are the primary acute care benefit excluded from Medicare coverage. Only in the hospital, a nursing home, or in a hospice program will Medicare cover drugs. But drugs are now, more than ever, a
critical part of a comprehensive health care delivery system. Lack of compliance with prescribed medications can lead to higher costs of health care over time. And for many who need multiple prescriptions, the costs can be beyond their reach.

An initial look at the existence of supplemental coverage might suggest that there is little need to expand benefits, except perhaps for those with very low incomes, since many beneficiaries have supplemental insurance plans. However, the needs are substantially greater. Medicare beneficiaries supplement their basic benefits from four sources. Employer-based retiree insurance and individual supplemental coverage are provided by private insurers, while Medicaid, a public benefit, subsidizes many low-income beneficiaries. Fourth, Medicare contracts with private plans, mostly health maintenance organizations (HMOs), to serve beneficiaries who choose to enroll. Such plans often cover services beyond Medicare’s basic coverage. These supplemental coverages vary in quality, beneficiaries’ ability to access them, and the degree to which they relieve financial burdens. Even those with supplemental coverage do not always have drug coverage. Only employer-based retiree coverage and Medicaid offer reliable drug benefits, and even then not to all their enrollees.

Employer-based plans normally offer comprehensive supplemental insurance, including drug benefits, and subsidize the premiums that their retirees pay. Thus, these plans both reduce out-of-pocket expenses and increase access to services. But such plans are limited to workers and dependents whose former employer offers generous retiree benefits. As a consequence, these benefits accrue mainly to higher income retirees. Medicaid, which also offers generous fill in benefits, is limited to persons with low incomes. As a joint federal/state program, states have latitude in establishing eligibility and coverage. Drugs are available to those with basic Medicaid coverage, which is usually limited to people with incomes well below the federal poverty level.

Medigap plans are not usually a good bargain for most beneficiaries. Medigap options that include drugs have become prohibitively expensive for many beneficiaries, particularly the very old who must pay substantially higher premiums than those aged 65 to 69, for example. And even with very high premiums, a number of insurers are declining to offer options with drug coverage. Medigap is likely to cease to be a source of drug coverage in the future except for a few who have been grandfathered into a reasonable plan.

Finally, beneficiaries can opt to go into a Medicare + Choice plan. These private plans generally offer additional benefits at a lower cost than Medigap, but require that enrollees meet certain conditions, such as agreeing to go only to doctors and other providers of care who are on a prescribed list. In recent years, the comprehensiveness of benefits offered by these plans have declined and/or premiums charged (over and above Medicare's Part B premium) have increased. Drug coverage has either been dropped altogether or stringent caps have been placed on the amount covered. Moreover, a number of plans have pulled out of the program, leaving beneficiaries to scramble for new arrangements.

Thus, while a substantial number of beneficiaries now have drug coverage, the share with reliable coverage (employer-based or Medicaid) is considerably smaller. Only 39 percent of Medicare beneficiaries have reliable coverage, and an even smaller percentage have it for a full year. The vulnerability of beneficiaries can be seen in Figure 1, which identifies those most in need of coverage across different levels of economic status (shown as income as a share of the poverty guidelines). The white areas in Figure 1 are beneficiaries with no coverage or who now rely on Medigap or Medicare+Choice plans. Further, states and former employers who now support good coverage may pull back in the future as prescription drugs become even more expensive, creating even greater demand for drug coverage in the future.

Another notable element of Figure 1 is that all groups have a majority of beneficiaries without reliable coverage. Cutting benefit eligibility at 135 percent or 175 percent of the poverty level would not do away with the problems that beneficiaries face of obtaining reliable prescription drug coverage. In fact, the group with incomes between 175 percent and 250 percent of poverty (about $15,000 to $20,000 for a single person) get little coverage from either employer-subsidized or Medicaid coverage. They are in many ways as vulnerable as many of the persons at lower income levels. If eligibility extends to 250 percent of poverty, that would include over 60 percent of the Medicare population. And even of those with incomes above 250 percent of poverty, only 41 percent have reliable coverage.

As Figure 2 indicates, spending on drugs on average is about the same across all income groups. The importance of this benefit does not decline with income, although ability to pay does improve. And even more important, the burdens on Medicare beneficiaries will continue to rise, even with no policy changes (Figure 3). Much of the growth in out-of-pocket burdens projected through 2025 is attributable to prescription drug cost growth.2

Issues Crucial to Beneficiaries

As shown above, prescription drug costs are a large and rising expense that many beneficiaries must face. The willingness of Medigap beneficiaries to pay high amounts to get drug coverage and of Medicare+Choice beneficiaries to enroll and switch plans to obtain coverage suggest that this would be a highly valued benefit. It is likely then, that beneficiaries would be willing to pay higher premiums to obtain this coverage. But, low income protections and a universal subsidy would be needed to make this an effective benefit.

If this is to be a voluntary option, a subsidy and probably some restrictions on enrollment would be even more important to assure that a reasonable mix of beneficiaries would take up the Medicare plan. Consider Part B of Medicare. It is a voluntary benefit, but a subsidy makes it sufficiently valuable to attract almost all beneficiaries. As a consequence there is very little problem with risk selection raising the costs of the
The structure of any prescription drug benefit will also matter. A standard drug benefit could be offered as an option through the Medicare program. The administration of the benefit could be contracted out to private companies just as Medicare now does for its payments to hospitals, physicians and other providers. This approach hews closely to the practice of the basic Medicare program. Alternatively, the private sector could be used to establish voluntary prescription drug options. Usually this is proposed as a way to allow coverage to vary from plan to plan and across the country.

This private option fits better for enrollees who choose to be in private plans than for those in traditional Medicare because of the complexity that would result. Already most beneficiaries have two types of insurance, requiring coordination of benefits. Adding a third separate benefit, run by yet a different insurer, would undoubtedly add substantial complexity and confusion. This breaking up of coverage makes little sense from an insurance standpoint either, likely helping to explain why the insurance industry has not been interested in standalone drug plans.

Further, even for those in private plans, permitting variation in the benefit packages offered has a serious disadvantage. Allowing individuals to choose what is "best" for them is likely to separate the sick from the healthy and make it difficult to assure that coverage will remain affordable for those who need it most. Most Medicare beneficiaries who expect to use few drugs would choose a plan with no deductible, low coinsurance, and a low cap on benefits. Those who anticipate using more or higher priced drugs might want a plan that gave them greater overall protection even if they have to pay a deductible or high coinsurance for their initial purchases. A standardized benefit takes away one tool for achieving risk selection.

Finally, the generosity of the plan is a critical element. Even the most generous plans will not be as comprehensive as what most younger families have in coverage, although the needs are greater for Medicare beneficiaries. Protections ought to be generous enough to be valued by those who enroll, although the costs of a drug benefit are likely to be high and grow rapidly over time.

**Other Reform Issues**

What happens to prescription drug coverage is particularly important for other potential Medicare reforms. Drug coverage represents a logical first step in reform, helping to smooth the way for other reforms.

**Improving the Traditional Medicare Program.** One of the major criticisms leveled at fee-for-service Medicare is that when combined with supplemental insurance, many beneficiaries have nearly first dollar coverage. Such beneficiaries essentially do not face cost sharing requirements that might make them more conscious of the costs of care. The Congressional Budget Office has long signaled that this substantially raises the costs of Medicare. Nor is this dual coverage efficient for beneficiaries or society as a whole because of the excess administrative costs that result from beneficiaries having two (or more) different sources of coverage.

Adding prescription drug coverage would help to reduce the need for other supplemental insurance, but likely would not be sufficient to encourage beneficiaries to drop their Medigap plans. Other changes in cost sharing would be needed, such as reducing the very high Part A deductible and adding a limit on the total amount of cost sharing that any beneficiary would owe. A more rational Medicare cost sharing package would not have to be an expensive addition, especially if it increased cost sharing in areas such as the Part B deductible that are likely too low for a good plan to help pay for protections elsewhere. If the basic Medicare benefit could be made to look more like that of working families, with good protections but reasonable cost sharing, the traditional Medicare program could satisfy both beneficiaries and those worried about costs.

In addition, moving more basic health care services under the Medicare umbrella would result in substantially better protections for sicker and older beneficiaries. The very old get Medicare at community rates where everyone pays the same premium, but they tend to depend more on Medigap for their supplemental coverage even though these policies are age rated and hence are very costly. These beneficiaries are least able to afford Medigap premiums and could benefit if they were covered under Medicare instead. And in the case of younger disability beneficiaries, Medigap is often not available at all.

Another advantage for traditional Medicare of an expanded benefit package is that further reforms that might coordinate care through disease management or other programs can be effective only if the full range of care is available. The lack of prescription drug coverage or very high out-of-pocket costs increase the likelihood of non-compliance and loss of overall savings that such activities might achieve. That is, the extra expense of coordination of care would not be offset by better outcomes. For example, it makes no sense to have a program to control hypertension if beneficiaries cannot afford the drugs necessary to achieve that goal.

Finally, the current Medicare+Choice plans are able to offer prescription drug benefits in part because they receive payments from the federal government in excess of what it costs to provide the current Medicare benefit package. The General Accounting Office has found, for example, that plans get payments more than 13 percent higher than what it would cost in fee-for-service to provide the basic benefits. Even the HMO industry now makes its case for higher payments over time as necessary to retain a "desirable" benefit package—not just the required Medicare benefits. The problem is that many of the 6 million beneficiaries in HMOs thus get subsidies for drug coverage, but those in traditional Medicare—who are sicker on average and more likely to need drugs—do not. Adding a prescription drug benefit to Medicare would help both Medicare+Choice enrollees and those in traditional Medicare. And since partial subsidies are already there for HMOs, accounting for this could lower the costs of providing universal coverage.

**Restructuring Options that Rel y on the Private Sector.** Proposals to rely more upon the private market...
to offer coverage to Medicare beneficiaries would also be helped if a reasonable prescription drug benefit were in place. Not only does managed care need a comprehensive benefit package to perform well, but such a benefit would help to reduce the incentive for risk selection that private plans now face. Plans would find it difficult to voluntarily add any benefits—such as drugs—without attracting sicker patients and thus incurring adverse selection. They would likely respond in the same way that current Medicare+Choice plans have responded by paring back drug coverage.

Thus, competition will work much better if the basic plan that all must offer is sufficiently comprehensive and standardized. This would still leave ample room for adding other benefits or competing on price. Until adjustments that could account for differences in health status are improved, it will be difficult to use competition in positive ways. The benefits to plans of seeking good risks are simply still too tempting. It is easier to make profits by attracting healthy patients than by coordinating care.

**Improving Beneficiary Education and Information.** Another factor that will be important to the success of any reform of Medicare is to empower beneficiaries to play a more active role in decisions about their own care. Simply giving them responsibility (for example, requiring them to choose a plan) will not be productive unless they have the tools to respond. Credible, independent sources of information will be essential.

A good place to start would be with the prescription drug benefit. A publicly funded but independent organization that would provide information on the quality of generic drugs and the extent of equivalence across name brands in the same drug categories, for example, could help beneficiaries to make more informed choices. Reassurance that a less expensive drug is just as effective will be more powerful coming from a credible source than from a plan that has a financial stake in that decision. Prescription drug coverage will be expensive; the government should invest in the resources necessary to make better decisions. This information would also be important in developing reasonable ways to hold down costs of drugs that could be adopted by either the private or public sector.

**Financing.** Expanding benefits is a separable issue from how the structure of the program evolves over time. It is not separable from the issue of the cost of new benefits, however. Adding drug coverage clearly raises financing issues. New revenues, likely from a combination of beneficiary and taxpayer dollars, will be required.

**Conclusion**

A familiar refrain for critics of Medicare is that it is a "Cadillac" program, but the model year is 1965. This criticism is often leveled at Medicare’s fee-for-service system. But in actual fact, Medicare has undergone a large number of changes and reforms of its delivery system. In the 1980s, it was a leader in pushing for payment reforms and its per capita growth rates were lower than that of private insurance. It now has a private option dominated by managed care plans, and increasingly reforms have sought to give the administration of the program some further flexibility in managing the costs of care. Where the criticism is more on target, however, is in the area of benefits. The basic structure of the Medicare benefit package has changed little since 1965.

The current patchwork approach to provide drug benefits through private insurance, such as we have at present, is seriously flawed. Prescription drug benefits generate risk selection problems; already the costs charged by many private supplemental plans for prescription drugs equal or outweigh their total possible benefits because such coverage attracts a sicker than average set of enrollees. A concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program. This commitment will require substantial new resources, but it is a logical place to begin reforms of Medicare.
Figure 1
Number of Beneficiaries by Eligibility Status, 2002 (in millions)

Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey

Figure 2
Total Drug Spending for All Medicare and Likely Eligible Beneficiaries (in 2002 dollars)

Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey
Notes

1. Senior Fellow, The Urban Institute. The views expressed herein are those of the author and do not necessarily reflect those of the Urban Institute, its trustees, or its sponsors.

2. Although these numbers are dramatic, they still may understate possible increases in out-of-pocket costs. For example, we do not assume changes in insurance coverage over time, and we assume relatively modest drug growth of 10 percent per year for 10 years and then the same growth rates as for other health care services.

Other Publications by the Authors

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