Finding a Formula for Medicare Drug Benefits
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The political debate over how to add a prescription drug benefit to Medicare has dragged on now for more than four years. Prescription drugs have become an integral part of health care delivery, but unlike insurance for most working families, the Medicare program for older and disabled people provides almost no drug coverage. Politicians from both parties know they have to do something, but the hurdles are big: money and control.

The debate in the Senate is still ongoing. But large differences along party lines remain, and the Republican House plan that was passed on a party line vote in June makes hopes for compromise remote given the desires of consumers for broad coverage and of drug companies for minimal government controls.

The sums needed are enormous; over the next 10 years, Medicare beneficiaries are expected to spend $1.8 trillion for drugs. Thus, while the Senate Republicans' top offer of $370 billion over eight years is a lot of money, it represents only a bit more than one-fifth of drug spending over that period. The Republican plans contain big gaps in coverage and allow restrictions on what drugs will be covered. Democrats offer more coverage, but at a cost of $500 billion or more.

Since all proposed plans would be voluntary, those who spend relatively little on prescriptions need to be wooed into participating with the promise of receiving some benefits. Otherwise, only high users will enroll and any program will become very expensive over time.

All the competing plans offer generous coverage above a certain level of spending for those with catastrophic expenses. The differences arise in how to treat people who spend below the catastrophic level but still spend several thousand dollars annually on drugs. The Senate Democratic proposal requires beneficiaries to pay a portion of the costs, up to $4,000 a year. Beyond that limit, all drug costs are covered. But under the House Republican plan individuals must pay 100 percent of their drug expenses between $2,000 and $5,300.

Increasingly, many people on Medicare are ending up in this middle spending range, particularly those who take one or more drugs every day for a chronic condition. Drugs for such common ailments as hypertension, high cholesterol and arthritis cost $1,200 to $1,500 a year, creating a substantial financial burden for the chronically ill.

A viable compromise is to offer comprehensive coverage for those with low incomes and catastrophic help for all other beneficiaries, an approach that seems to be gaining favor in the Senate. But this plan would still cost about $400 billion, while providing little help for most Medicare recipients with chronic illnesses.

Money accounts for only part of the differences between the two parties. A big disagreement is over how the benefit is structured — and the precedent it sets for Medicare's future. The Democratic approach basically would have Medicare pay for drugs the way it now pays for hospital and physician benefits. Republicans want instead to have the benefit offered by private insurers. Compromise on this ideological question is especially difficult.

The Democratic approach is simpler and relies on Medicare's well-tested structure. But drug manufacturers, fearing that Medicare would impose price controls on drugs, are strongly opposed to enlarging Medicare itself to cover drugs.

Supporters of a private insurance structure argue that only competition among plans can achieve substantial control over rising prescription drug costs. But this theory has not been proved in other contexts. The private managed-care option in Medicare, for example, has raised costs to the federal government. Meanwhile, many Medicare recipients have had to suffer with plans that cut benefits or, worse, are withdrawn altogether because the companies offering them have quit the Medicare program entirely for lack of profits.

A privately administered drug benefit would be particularly problematic. If private insurers carry the risk for drug costs, they will probably structure their plans in ways that put high users of drugs at a disadvantage. For example, they can establish a list of preferred drugs (a formulary) and either not cover certain drugs or charge more for drugs that are not on the list. There are, for example, many anti-cholesterol drugs, but a
formulary may not include the drug that works best for a particular patient. Consumers who need many drugs are likely to find it hard to decipher which medications the plans will cover and at what cost.

Ultimately, lawmakers and the rest of us must decide whether we trust government to deliver a new drug benefit effectively. What we do know is that the need for drug coverage is too great to let this issue remain unresolved.

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