

# LDI *Issue Brief*

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## *The New Medicare Drug Benefit: Much Ado About Little?*

Editor's Note: After many years of debate, Congress recently approved a new, voluntary "Medicare Part D" benefit that provides some coverage for prescription drugs. The goal of this coverage is to reduce financial barriers that might prevent beneficiaries from obtaining needed drugs. The degree to which this goal is achieved depends on how well the benefit reaches seniors with previously unmet needs; conversely, it may do little to improve seniors' health if it replaces existing sources of coverage, or encourages overuse of drugs. This Issue Brief reviews data on current patterns of drug spending among Medicare beneficiaries and summarizes aspects of the new benefit. It explores the likely effect of the coverage on overall use of and spending for prescription drugs and considers whether any additional use is likely to represent needed care that had been forgone because of a cost barrier.

*Some Medicare beneficiaries have high drug spending, but most of them are not poor*

In 2000, Medicare beneficiaries spent an average of \$1500 per person on prescription drugs, about \$550 of which they paid out-of-pocket. However, the majority of drug spending is concentrated among a small group. About 26% of enrollees spent \$2000 or more and accounted for 65% of total drug spending in the Medicare population. Anecdotes about seniors going without needed drugs because of cost provided the impetus for adding coverage for prescription drugs to Medicare.

- Prior to the new benefit, about 75% of Medicare beneficiaries had some drug coverage. In 2000, 30% had drug coverage through employer- or union-sponsored retiree benefits, 16% through Medicaid, 12% through individually-purchased Medigap policies, and 17% through a Medicare managed care plan, or other state or federal program. The extent of this coverage varies, with retiree plans offering more extensive benefits, and Medigap policies providing more limited coverage.
- Compared with those lacking drug coverage, those with coverage fill about 28% more prescriptions per year (32 versus 35) and in 2003 will spend about twice as much on drugs (\$2700 versus \$1400).

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- Not all those lacking drug coverage are poor. About 31% of beneficiaries are poor or near poor [100%-150% of federal poverty level (FPL)], 33% are “tweeners” (between 151% and 300% of FPL), and 35% are not poor (more than 300% of FPL). The proportion without drug coverage is about even across income categories, as Medicaid coverage for the poor group offsets the choice of private drug coverage among the non-poor. About 10% of the Medicare population is both poor and lacking in drug coverage.
  - The poor account for the highest proportion of total drug spending (35%), but because of generous Medicaid coverage, the average percentage paid out of pocket is actually lowest for them (33%, vs. 45% for the “tweeners” and 40% for the non-poor). However, the subset of the poor not covered by Medicaid pay the highest percentage of their drug costs out-of-pocket.

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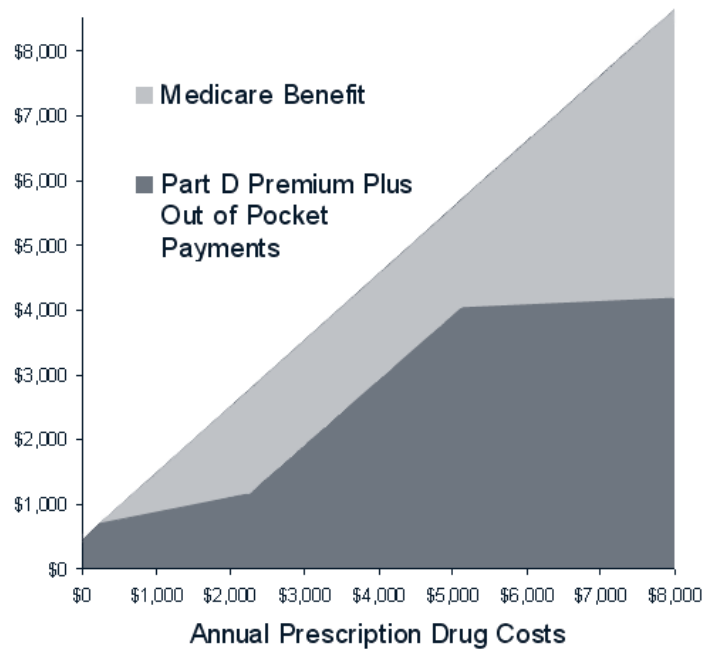
***New Medicare prescription drug benefit leaves “doughnut hole” in coverage***

After an interim period where beneficiaries can buy a discount prescription drug card, the new Medicare Part D provides subsidized drug insurance beginning in 2006. All beneficiaries will have access to coverage through private prescription drug plans that contract with Medicare or through private health plans that offer drug coverage along with other health care services. Enrollment is voluntary.

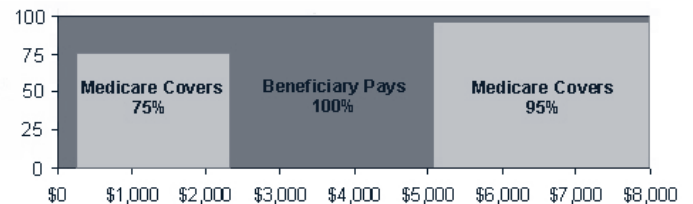
- In 2006, beneficiaries choosing the new benefit will pay a premium of about \$420 per year (\$35 per month), with an annual deductible of \$250. The amounts of premiums, deductibles and copayments are all tied to yearly increases in total drug spending; thus, if total drug spending increases beyond inflation, these out-of-pocket payments will rise as well.
- The standard package provides 75% coverage for the first \$2000 of drug spending beyond the deductible. At that point, coverage stops for the next \$2850 of expenses. After expenses of \$5100 (\$3600 in out-of-pocket costs), nearly complete coverage kicks in, with 95% coverage of additional expenses and minimal per-prescription copayments. This unusual gap in coverage, (often called the “doughnut hole”) was included to limit the federal cost of the new benefit. The graph on page 3 illustrates the benefits provided at different levels of drug spending.
- The benefit provides significant additional assistance for low-income beneficiaries, including those eligible for Medicaid. Beneficiaries with incomes less than 150% of the federal poverty level will pay little or no premiums or deductibles, and will not have the “doughnut hole” in coverage.

**Medicare Part D coverage, for seniors with incomes greater than 150% of Federal Poverty Level**

**Total Costs (Drug Costs + Premium Costs)**



**Prescription Drug Coverage (%)**



**Who benefits from the new benefit?**

The net benefits of Medicare Part D will be different for different types of beneficiaries. Poor or near-poor beneficiaries without previous drug coverage (10% of all beneficiaries) will reap the most benefits because they will not face high premiums, copayments, or gaps in coverage.

- The new coverage will not help the great bulk of beneficiaries with employer- or union-based coverage, most of whom have better benefits and lower premiums. To discourage employers from dropping or limiting drug coverage for retirees, the new law provides a 28% subsidy to employers offering equivalent coverage to Medicare Part D for drug costs between \$250 and \$5000.
- Beneficiaries with existing Medicaid drug coverage will be enrolled in the new Medicare benefit, with minimal per-prescription copayments. However, because of the generosity of most state Medicaid plans, these “dual eligibles” are likely to gain little from having their drug expenses covered under Medicare.
- Those with privately-purchased Medigap policies will likely benefit, because of the high premiums and coverage limitations of most Medigap policies. The new law bans Medigap drug coverage for Medicare Part D

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enrollees, but permits them to enroll in drug plans with more generous coverage than the minimum at higher premiums.

- For “tweeners” and non-poor beneficiaries who previously had no drug coverage, the new Medicare benefit may or may not be helpful. The “magic number” is \$810 in drug expenses per year, the point at which the Medicare benefit received begins to exceed the \$420 premium.

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***Medicare Part D coverage will likely have a very small impact on overall drug spending***

Pauly analyzed the likely impact of the Medicare benefit on drug spending, given existing evidence that people generally use more, and more costly, health services when insurance covers all or part of the cost. Economists call this aspect of insurance the theory of “moral hazard.” Not all moral hazard is undesirable or avoidable, but at least some of it can lead to overuse of drugs of little health benefit.

- Existing research in the non-elderly suggests that individual demand for drugs depends strongly on the out-of-pocket price. Estimates indicate that a 10% drop in the average cost of drugs to consumers can lead to a 3%-4% increase in the quantity of drugs purchased. The Congressional Budget Office estimates that Medicare coverage will have little or no effect on drug prices, as more aggressive bargaining by private drug plans reduces the higher prices typically charged to the uninsured.
- To estimate the likely “moral hazard” effect of Medicare Part D, Pauly assumed no change in coverage (and drug spending) for those with existing Medicaid or employment-based coverage, or for those with managed care plans. He assumed that people without coverage and those with Medigap would enroll in the new program.
- Congress estimated that about 47% of total drug spending by Medicare beneficiaries would be covered by the new Medicare benefit. Pauly assumed that, in the aggregate, the benefit reduces the user (out-of-pocket) price of any drug by 47% for beneficiaries without current drug coverage, and by about 14% on average for beneficiaries with more limited Medigap coverage.
- Using these figures, Pauly estimated that total drug spending for Medicare beneficiaries (if prices were unchanged) would rise by just 5.64%. Use would expand by 20% for those who formerly had no coverage and by 6% for those formerly having Medigap coverage. If the new coverage displaced more generous employer-provided or health plan coverage, the increase in spending would be even smaller.

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*New benefit not likely to have much impact on average health*

Pauly considered how much of this increase in drug spending might be desirable and appropriate, and how much might be “wasted” in terms of overuse of drugs among seniors not facing financial barriers. How would the increase in spending be distributed among the three income categories?

- Pauly estimated that the increase in drug spending would be distributed virtually equally among the three income groups, since the slightly higher percentage uninsured for drugs among the poor is offset by a higher percentage with less generous Medigap coverage among the other two groups.
- The calculations assume that the non-poor (with incomes of more than 300% of FPL) face no financial barriers to needed drugs, and so their 33% of the increase in spending is “wasted.” They also assume that the “tweeners” could afford up to the 25% of spending below \$2000 per year, and so 8% of their spending increase (33% x 25%) is wasted.
- Thus, Pauly concludes that 41% of the small increase in overall Medicare drug spending would be wasted, in terms of increasing use among beneficiaries not facing financial barriers. The remaining 3.3% increase in use and spending would be regarded by this criterion as socially desirable.
- Although the estimates are approximations, the message is one of how small an impact, for good or ill, the prescription benefit program is likely to have. The modest effect on total use means that even under the most optimistic circumstances, the Medicare drug coverage benefit will not, in the aggregate, do much to increase access, improve efficiency in the use of medical care, improve health outcomes, or increase drug company profits. For the small part of the population whose use is affected, there may be modest improvements in health care and health (but probably not as large as if the benefit program were more targeted).

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***POLICY IMPLICATIONS***

Reasonable estimates of the effect of the Medicare drug benefit on drug spending strongly suggest that the spending increase will be small and that some of it will go to beneficiaries who do not face high financial barriers at present. Thus, from the viewpoint of improvements in health or national spending on drugs, effects are minimal. The effects on Medicare’s fiscal future are much more important.

- A sizable portion of the new coverage does not provide protection against catastrophic drug costs, but instead provides “coverage” of much lower value for relatively small and certain drug expenses. Most of the benefit will go to pay for drug expenses that people are already making—but it shifts those expenses from out of the beneficiary’s pocket at the point of use to taxpayers’ pockets. In other words, the main effect of the new benefit will be one of transfers of money, not changes in medical care or health.

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## **POLICY IMPLICATIONS**

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- The new benefit represents a political compromise, in that legislators did not want to offer only catastrophic coverage that they felt would be attractive only to the minority of seniors with very high drug expenses. The current design allows more people to “make money” from insurance even as it imposes higher out-of-pocket costs on some seniors with catastrophic expenses.
- Recent estimates of the 10-year cost of the benefit have risen from \$400 billion to \$536 billion, based largely on higher estimates of the number of beneficiaries who would take the subsidized coverage. It is reasonable to question whether the current benefit, as designed, is the best (or even a good) way to add drug coverage to Medicare.

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*This Issue Brief is based on the following article: M.V. Pauly. Medicare Drug Coverage and Moral Hazard. Health Affairs, January/February 2004, Vol. 23, pp. 113-122.*

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## *Issue Brief*



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