Medicare’s New Prescription Drug Benefit

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History of Prescription Drug Coverage Under Medicare

• Original 1965 legislation did not include outpatient drug coverage
  – Minor component of out-of-pocket costs
  – Medicare was never designed to cover everything
• Fairly extensive coverage included in Medicare Catastrophic Coverage Act (MCCA) of 1988
  – $600 annual deductible (but indexed; these are 1991 $$s)
  – Just 20% coinsurance paid by patient
  – No out-of-pocket maximum drug expenses, however
• MCCA repealed just 15 months later
DRUGS ARE STILL EXPENSIVE...

MANY ARE NOW COVERED...

NOT AFTER THE FIRST $2,150...

BUT AFTER $5,100, THEY ARE AGAIN.

2003 MEDICARE BILL

STILL, NOT ALL DRUGS ARE COVERED...

THE $400 BILLION COST IS GOING TO BE PAID BY OTHERS!!!

I'M IN!
Medicare Prescription Drug, Improvement and Modernization Act of 2003

• Approved by Congress in November 2003 as part of wild debate
  – Republican majority accused of cheating by: (a) keeping the vote open for several hours to convince some conservative opponents; (b) purportedly bribing at least one Congressman; and (c) withholding key information that the bill would cost $540 billion over 10 years, rather than the reported $400 billion (and threatening to fire Medicare actuary if he told)

• Key to approach: drug coverage is provided through private insurance rather than directly from federal government (Republican victory)
  – Even more controversy over a more fundamental reform called “premium support”; compromise reached
The Many Facets of the Medicare Reform Legislation

- Voluntary coverage for outpatient prescription drugs (our focus)
- Income-related premiums
- Establishes “trigger” when general revenues account for more than 45% of program costs
- Establishes “health savings accounts”
- Subsidies to employers that keep retiree health benefits
- Provides extra preventive benefits
- “Premium support” demonstration project
Outline of Remainder of Talk

- Drug “discount cards” (offered in 2004 & 2005)
- New Medicare drug benefit, available from:
  - Stand-alone plans
  - “Medicare Advantage” plans (HMOs & PPOs)
- Miscellaneous provisions
- Data/enrollment/opinions
- Research questions
- Political outlook
Temporary Discount Cards

- Available in May 2004 – December 2005
- Vendors (about 40) could charge up to $30/year
- Idea: firms offering cards would negotiate discounts with manufacturers and/or retailers
- Beneficiaries with incomes below 135% of poverty level got $600 annual subsidy towards drug purchases
- Article released 4/14/04 in *Health Affairs* by Cubanski, Frank, and Epstein estimate average savings of 17.4% over current retail prices (41% generic, 14% brand), based on the experience of seven previous drug cards. Average = $117/person.
- Enrollment much lower than predicted.

- $250 annual deductible
- 25% coinsurance for next $2,000 in drug spending
- 100% coinsurance (no coverage) for next $2,850 in drug spending (the infamous “doughnut hole”)
- 5% coinsurance for drug spending above $5,100/year
- Everything indexed to per capita growth in Medicare covered drug expenditures
- Plans can instead offer “actuarial equivalent” – and they do.
 Covered Drugs & Formularies

• Covered: most every type of prescription drug except things like weight loss, fertility, cosmetic, hair growth, cough or cold relief, vitamins & minerals, and barbiturates

• Formularies: allowed but must …
  – Be developed & reviewed by Pharmacy & Therapeutics committee that has at least one MD and one pharmacists not in plan, and most of committee must be MDs and/or pharmacists
  – Include drugs in each therapeutic class
  – Have procedures in place to educate enrollees & providers
  – Provide advance notice if drug is removed from list, or tier status is changed
Drug Pricing

• Drug plans negotiate prices with manufacturers and pharmacies
• Pharmacy required to tell beneficiary price difference between prescribed drug and lowest-cost generic in that class
• Government is prohibited from using its bargaining power to negotiate prices
Premiums & Subsidies

- Premiums average about $30 per month
- Estimated government subsidy: 74.5%
- Various forms of assistance for low-income beneficiaries:
  - Eligible if have Medicaid coverage or have income less than $135% of poverty level, and maximum assets of $6,000 (individual) or $9,000 (couple)
  - If eligible, no premiums and only costs are copays of $1-2 (depending on income) for generic drugs, and $3-5 for brand-name drugs
Incentives to Health Plans

• Payments combination of beneficiary premiums and federal government subsidies

• To make plans more willing to participate, government shares risk through reinsurance and risk corridors
  – Reinsurance: government covers 80% of costs when beneficiary exceeds annual out-of-pocket maximum
  – Risk corridors: by 2008, plans within 5% of targeted costs fully at risk; 50% at risk for costs between 5 and 10% of target; and 20% at risk for costs above 10% of target.
“Medicare Advantage” Plans

• Legislation provides subsidies for local HMOs, and for regional PPOs
• Insurers are required to provide at least one plan with same drug coverage as stand-alone plans, or actuarially equivalent benefits
• Medicare HMOs far more common in California than in other states
Miscellaneous Provisions

- Prohibits re-importation of drugs from Canada until the Secretary of HHS certifies their safety
- 1% penalty/month for late enrollment after age 65, to help reduce adverse selection
- Areas without enough plan choices would have fallback plan. Government would contract with private entities to administer and pays their administration costs.
Figure 1. Health Insurance Decisions Facing the Elderly
Experience so far

- LOTS of choices available: 85 plans (47 stand-alone, 38 Medicare Advantage) in L.A. County
- DHHS predicted 39 out of 43 million beneficiaries would have drug coverage. MUCH disagreement about whether this has been achieved.
- June CMS Numbers: 22.5 million had it through stand-alone plans, Medicaid, Medicare HMO/PPO; 10.4 million through employers; 5.4 through VA & other sources, with 5 million having no coverage.
- As of May, only 1.5 of 8.2 million low-income beneficiaries and applied for and been approved for significant subsidies (18%); the rest had no coverage or are paying higher premiums and face the “doughnut hole”
Research & Policy Questions: Supply

- Will market equilibrate with fewer options?
- Will the subsidies to Medicare Advantage plans stem the recent tide of HMO withdrawals from Medicare?
- Will Medicare PPOs enter the market and will many people enroll?
- Will employers continue to offer retiree coverage that includes drug coverage?
Research & Policy Questions: Demand

• What percentage of beneficiaries will choose to purchase drug coverage (stand-alone, and/or through Medicare Advantage)?

• Will beneficiaries be able to understand the choices available? Will certain groups be disadvantaged?
Research & Policy Questions: Market

• Will drug plans successfully negotiate low drug prices? How will these compare to what government (e.g., the Veterans Administration) negotiates?

• Would drugs re-imported from Canada be unsafe? If they are allowed, how would it affect market prices?
Research & Policy Questions: Distribution

• How much will the legislation reduce the out-of-pocket cost burden on low-income beneficiaries?

• How many will be excluded from subsidies due to the “asset test” restriction?
Political Outlook

• May 15, 2006 sign-up deadline came and went
• Unfavorable opinions may lead to some changes:
  – Price negotiations by government?
  – Standardization of stand-alone/HMO benefits?
• Beneficiaries will be hitting doughnut hole before election day
• Wholesale changes only likely with change in Congressional leadership; current benefit was linchpin of administration’s domestic policy once Social Security reform failed