The Mixed Bag of Medicare Drug Coverage

BY CHARLES GERENA

The Medicare reform bill signed by President Bush last December will help thousands of Medicare recipients by providing drug coverage for the first time. But it comes at a high price in terms of its potential macroeconomic consequences and unintended effects on access to drugs.

Starting in 2006, seniors can choose a stand-alone prescription drug plan (PDP) under Medicare Part D or drug coverage through a Medicare Advantage comprehensive plan (formerly Medicare+Choice or Part C). The standard drug benefit will cover 75 percent of medication costs between $250 and $2,250, then no further assistance will be provided until expenses reach a "catastrophic" level of $5,100. Those with low incomes may qualify for a special drug benefit with no gap in coverage.

Drug coverage will add approximately $534 billion to the cost of Medicare over 10 years. Such a large expansion in an entitlement program carries the risk of pushing the federal budget into structural imbalance, whereby planned government expenses exceed average tax revenues generated by an expected level of economic activity. Entitlements, which already consume more than half of the budget, are much harder to cut than discretionary programs.

What will stop mounting drug prices from ballooning the overall cost of Medicare? Congress hopes the drug benefit will save money by encouraging more seniors to use medications that prevent conditions before they worsen and require expensive treatment. Generally, seniors with insurance are less price sensitive in their demand for drugs. "They don't think very much about the cost," says Roland McDevitt, a senior consultant for Watson Wyatt Worldwide. "They take whatever [the doctor] prescribes and get the latest generation of drugs designed for their condition."

To keep the fiscal burden of the Medicare drug benefit from growing out of control, lawmakers put cost-containment mechanisms into place. For example, as Medicare Part D spending rises, the deductible and the level at which catastrophic coverage starts will rise as well. This will shift more costs onto Medicare beneficiaries.

Will cost shifting help contain overall drug prices as well? Lynn Taylor, senior policy analyst at the Institute for Health Policy Solutions, says the coverage gap will result in the most financial assistance going to occasional users of drugs and frequent users, leaving the average Medicare recipient to pay for their medications out of pocket. "Any time you make people absorb more of the costs, the theory is that it will make them more conservative about what they purchase," explains Taylor. "But to put [a gap] in the middle as opposed to having a high up-front deductible or higher cost sharing, I don't know what the rationale is for that." Most observers believe the coverage gap kept the price tag of Medicare drug coverage at a politically acceptable level.

Another way that lawmakers hope to rein in costs is to bring private-sector competition into the delivery of drug coverage. The federal Centers for Medicare and Medicaid Services will contract with health insurers to provide PDPs and Medicare Advantage plans with drug benefits. The country will be divided into at least 10 regions, and a minimum of two drug plans from different firms will have to be available in each region.

These insurers are expected to negotiate lower prices for drugs, but policy analysts like Edwin Park of the Center on Budget and Policy Priorities have their doubts. Park says the best way for them to secure a discount is to guarantee a certain market share for a drug manufacturer, usually by adding its product to their preferred drug list. But he questions whether this would be achievable. "How much market share are you delivering when you are breaking up [the market] into multiple regions?" Furthermore, Park thinks it's unlikely that firms could get better drug bargains than large government purchasers like the Veterans Administration could.

Private insurers also are expected to use cost- containment tools more aggressively than government agencies could. They won't be subject to political pressures, plus they will be able to use preferred drug lists.

The downside of using such tactics is that some drugs may not be covered or may require a higher co-payment. This won't be an issue if seniors can shop around for drug coverage that includes their medications. Additional payments will be given to health insurers to offer PHPs and Medicare Advantage plans, but Families USA, a healthcare advocacy group, notes that some regions may not get any takers.

All told, seniors will have fewer alternatives if no Medicare-sponsored plan works for them. Medicaid won't be allowed to fill in coverage gaps in the Medicare drug program, while states would be hard-pressed to fill the gaps on their own. Furthermore, employers could eliminate drug coverage for retirees when the Medicare benefit becomes available, despite the availability of federal subsidies. **RF**

Basic Medicare Drug Benefit

Plan Component	Beneficiaries Pay
Premium	$35/month ($420/year)
Deductible	$250
Initial coverage	25 percent of expenses between $250 and $2,250
Coverage gap	All expenses between $2,250 and $5,100
Catastrophic coverage	5 percent of expenses above $5,100, or $2/generic drug and $5/brand-name drug (whichever is greater)

SOURCE: *The New Medicare Drug Benefit: How Much Will You Pay?*, Families USA, Spring 2004