



The legislative debate over prescription-drug benefits opened sharp divisions within the senior community eligible for Medicare.

# Medicare Solutions—and Problems

The new prescription-drug benefit is only an uncertain first step.

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**T**HE ADDITION OF prescription-drug coverage to Medicare is the first substantial expansion of benefits since the program was enacted nearly 40 years ago. Here I examine this new benefit through the eyes of Medicare beneficiaries and then through the eyes of taxpayers. Those conflicting perspectives reveal that the recent legislation will not resolve the tensions that gave it birth—far from it. In fact, the political challenges can only be expected to intensify, for reasons of economics and demography, as the aging baby boom generation swells the ranks of Medicare beneficiaries.

This legislation matters a great deal to those beneficiaries, whose annual drug spending averages around \$3,000 per person. In spending this amount the elderly fill 30 prescriptions per year, more than three times the number among younger people. Included in these averages are some big spenders;

the Congressional Budget Office (CBO) estimates that next year one out of six Medicare beneficiaries will spend more than \$5,000 on drugs (factoring in insurance payments on their behalf).

The legislation that the president signed into law last December provides that, starting in 2006, Medicare beneficiaries can, if they choose, enroll in a private drug plan in which the federal government picks up roughly 75 percent of the premium. Those purchasing the plan, however, will be required to pay a substantial amount when they buy drugs, so that overall the government will be covering only a quarter of beneficiaries' drug spending.

## Beneficiaries

MANY MEDICARE BENEFICIARIES currently have insurance that covers some of their drug spending. How the new benefit affects individuals depends critically upon the nature of their existing insurance, if any.

by JOSEPH P. NEWHOUSE

About 30 percent of the beneficiaries now have drug coverage through a retiree health program provided by a former employer. Although most of these policies have traditionally covered drugs reasonably well, the increasing expense of doing so has caused many employers to limit the extent of the coverage and increase retirees' premium cost. (Some employers have also been withdrawing this benefit for current employees, so they will not have such coverage when they retire.) The new legislation encourages employers to continue to provide such retiree plans by offering them a 28 percent subsidy if their plan is actuarially as good as or better than the plan specified in the legislation—a windfall that is now showing up in some firms' financial statements. As a result of this subsidy, the CBO estimates that 80 percent of the retirees who now have employer-sponsored coverage will be relatively unaffected, but this figure—like much else about the new law—is highly uncertain.

A second group whose drug coverage will be only modestly affected by the new legislation are the low-income elderly who are eligible for Medicaid, about 16 percent of all Medicare beneficiaries.

The remaining three groups of Medicare beneficiaries, somewhat more than half the total, are likely to be substantially better off with the new coverage. The roughly 14 percent of Medicare beneficiaries now enrolled in health plans (most of them in health maintenance organizations) should immediately fare better. In recent years, many HMOs cut back or eliminated any drug benefits for Medicare enrollees because their federal Medicare reimbursement rate did not keep pace with the increasing costs of drugs. Some plans withdrew from the Medicare program altogether. Starting in 2006, health plans must provide a drug benefit at least equivalent to that of the new benefit in the traditional (non-HMO) Medicare program to their members who enroll and pay the monthly premium. Moreover, the new legislation considerably increased the rates paid to health plans. As a result, I expect that many plans will provide a more generous and/or cheaper drug benefit than will be available in traditional Medicare.

A fourth group consists of the 11 percent of beneficiaries who use their own money to purchase an individual insurance plan that supplements Medicare and covers drugs. Starting in 2006, these policies will no longer be available to new purchasers. Although those who now have such a policy can keep it if they choose to, almost all of this group will be better off buying the

new policy, because the government will subsidize 75 percent of the premium.

Finally, around a quarter of the beneficiaries now have no drug coverage at all. Like the group who bought individual policies, they, too, will have a chance to buy subsidized coverage. Moreover, poor beneficiaries will receive a substantial additional subsidy for what would otherwise be their share of the cost. Specifically, for individuals with incomes up to 135 percent of the federal poverty line (in 2004, about \$12,600 for a single person and about \$16,900 for a family of two), the legislation allows for full coverage of premium payments with only modest copayments for each prescription (\$1 for a generic drug, \$3 otherwise), and even these copayments are covered for institutionalized low-income individuals.

There is, however, a rather stringent limit on assets as well as income. Lesser subsidies are available for individuals with incomes between 135 and 150 percent of the poverty level.

The CBO estimates that members of these latter three groups with incomes above 150 percent of the poverty line will pay a premium for the new coverage of about \$420 per year, but the figure is uncertain. First, the actual dollar amount that government and beneficiary are splitting will be determined by the premiums that the various private insurers actually charge in 2006, and that figure is

unknown. Second, the competing insurers will likely differ to some degree in their premiums, just as health plans now do, and beneficiaries will pay or receive the full difference between the specific policy they choose and the cost of an average policy. Finally, the estimate of the premium assumes that most elderly buy into the plan or remain on their employers' plans. If a number of elderly who do not expect to spend much on drugs do *not* buy the insurance, premiums for those who do purchase coverage could be substantially higher.

In fact, these healthier elders *have* stayed away from the current supplementary policies that cover drugs, with the result that only those spending a great deal on drugs buy them. In turn this makes such policies expensive and worthwhile only for those with high spending. The legislation, trying to forestall this vicious circle of "adverse selection," establishes a penalty in the form of much higher premiums if beneficiaries do *not* purchase the new drug policy when they are first eligible (an increase of at least 1 percent per month of delay in purchasing coverage). Thus,





those who do not purchase the policy and who do not have coverage from their prior employer are effectively making a bet that they will not spend much on drugs over their lifetimes, because even if they face only average spending, they are better off buying the policy (because of the subsidy).

Atop the premium, the bill requires the (non-poor) elderly to pay something when they buy drugs, in a rather odd schedule of cost sharing: an initial annual deductible of \$250; followed by a region of drug spending in which there is 75 percent coverage (\$250 to \$2,250 worth of drugs); followed by another region in which there is no coverage at all (\$2,250 to \$5,100); and finally, spending above \$5,100, where there is 95 percent coverage. Most insurance for those under 65 is not structured this way. Instead, it uses copayments, such as \$10 for a month's supply of a drug. Often these copayments are lowest for generic drugs, somewhat higher for drugs that are on patent but also "preferred" (usually meaning the insurer has gotten a favorable price from the manufacturer for that drug), and highest for drugs that are on patent and not preferred.

It seems likely to me that most insurers will offer this type of policy rather than the strange cost-sharing specified in the legislation, although provisions in the law will likely force something of a hybrid plan. The relevance of the cost-sharing structure in the legislation will only be clarified when the Department of Health and Human Services issues regulations later this year. Copayments could, however, be substantially higher than in the under-65 market, because the insurer will have to generate approximately the same amount of money from the copayments as would have been raised from the cost-sharing in the bill.

## Taxpayer Impact

HOW MIGHT A TAXPAYER VIEW THIS BILL? First, paying even a quarter of the elderly's drug bills is not cheap, but just how much that tab will come to is highly uncertain. Consider just the official estimates: the CBO says the new legislation will cost taxpayers \$395 billion between now and 2013, whereas the administration's Office of Management and Budget (OMB) puts the cost at \$534 billion. Because other changes to Medicare in the legislation are estimated to save money, each agency estimates that the cost of the drug benefit itself is somewhat *greater* than these figures.

A perhaps more reliable number than either 10-year cost estimate is the CBO's calculation that in 2006 the new benefit will increase the government's Medicare costs by 12 percent. But here, too, the OMB estimates a higher number, in part because the CBO assumes those eligible for the low-income subsidy will not all initially claim it. Both agencies agree, however, that *almost* all those eligible *will* ultimately claim it, so the long-run budget impact of the drug benefit on Medicare will be more than 12 percent. Even a 12 percent increase occurs in a very large program; Medicare already accounts for one-eighth of the federal budget (\$294 billion in fiscal year 2004), and that share will almost surely grow after 2010 as the baby boomers reach eligibility.

These longer-run estimates can be little more than educated

guesswork because the costs will depend on the rate of new drug introduction for diseases affecting the elderly, which in turn will depend on both the progress of science and any serendipitous discoveries that certain chemical compounds are effective in treating various maladies. Furthermore, costs will depend on the prices that insurers are able to negotiate with drug companies. In order to preserve their incentive to continue to invest in new drug development, the legislation *prohibits* the government from negotiating discounts or otherwise interfering in drug pricing decisions; it is problematic whether the government will maintain such a hands-off policy if costs start to escalate.

Importantly, no new taxes were provided to cover these additional costs, so when the program begins in 2006, its funding will simply be part of what the CBO now projects will be a deficit of \$269 billion in that year, a little more than 10 percent of government outlays. (Other respected analysts estimate an even larger deficit.) Because deficits add to the national debt, on which interest must be paid, at a minimum taxes will go up or other programs will be cut back to pay the additional interest on the debt. Already this interest accounts for 7 percent of federal spending; by 2006 the CBO estimates that it will account for 9 percent.

The deficit is financed by selling bonds; if the buyers of those bonds, especially foreign governments and

banks, decide they do not wish to add further to their American bond holdings, interest rates could rise substantially. They would rise even more if the current bond owners decided to reduce their holdings. If this happened, it seems likely that taxes would rise, despite the substantial opposition in many quarters.

At the same time, there undoubtedly will be substantial pressure from Medicare beneficiaries to increase the generosity of the benefit. Among other arguments, they will rightly say that the Medicare program leaves them paying much *more* for drugs than they most likely paid under the employment-based policy they had when they were under 65. The large and politically powerful American Association of Retired Persons has already indicated it will push for a benefit expansion.

The administration and the Congress will therefore be in the middle between the elderly on the one hand, many of whom will still be paying substantial sums for drugs compared with their income and asking why the government is so niggardly, and taxpayers on the other, many of whom oppose any additional taxes. The pressure will only increase when the baby boomers begin to claim their Social Security and Medicare benefits. That, plus the interest to finance the deficits we are now running, will place further burdens on future taxpayers, especially after 2020. However the mix between additional benefits and additional taxes is decided, there are likely to be angry voters. ▽

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