

The Costs Of A Medicare Prescription Drug Benefit

The CBO's estimate of the cost of adding a drug benefit to Medicare exceeded that of the Clinton administration by 24 percent. Here's why.

by Sandra Christensen and Judith Wagner

ABSTRACT: This paper describes a preliminary cost estimate, prepared by the Congressional Budget Office (CBO), of President Clinton's 1999 prescription drug benefit proposal. The CBO estimated that the new benefit would increase net Medicare outlays by \$136 billion between 2002 and 2009, although these estimates are highly uncertain. Because the proposal included an annual cap on the amount of the benefit, it did not require consideration of an important effect of a more comprehensive benefit: higher prices for some drugs. Estimates of future proposals for a Medicare prescription drug benefit may require consideration of that pricing effect.

212**DRUG
BENEFIT
COSTS**

IN JUNE 1999 PRESIDENT BILL CLINTON unveiled his plan to reform Medicare, which included a new prescription drug benefit. That and other legislative proposals for a Medicare prescription drug benefit were a major focus for Congress in 1999, and interest in such plans will probably continue in the coming years.

The Congressional Budget Office (CBO) prepares estimates of federal costs for all bills when reported out of committee and may prepare estimates at other points in the legislative process as well. This paper describes the CBO's estimate for the president's prescription drug benefit proposal.¹ Because legislative language was unavailable, the cost estimate was preliminary and subject to more than the usual amount of uncertainty. Nevertheless, it provides an approximate benchmark for likely costs, and it identifies certain aspects of benefit design that could greatly alter the estimated costs.

This DataWatch focuses only on the proposed benefit's costs to Medicare. However, there would also be costs to Medicaid under the proposal because of its expansion of subsidies to low-income Medicare enrollees.

■ **Overview of the president's proposal.** President Bill Clinton proposed an outpatient prescription drug benefit to be offered under a new voluntary Part D of Medicare, beginning in 2002. Medicare would pay half the cost of covered drugs for Part D enrollees, up

The authors are senior analysts at the Congressional Budget Office in Washington, D.C.

to a specified cap on benefits.² That cap would be set initially at \$1,000 but would rise incrementally to \$2,500 by 2008. Thus, in 2008 a beneficiary who purchased \$5,000 in prescription drugs would receive the maximum reimbursement of \$2,500. After 2008 the cap would be indexed to annual changes in the Consumer Price Index (CPI), which is expected to rise more slowly than drug spending. For those enrolled in Medicare's fee-for-service (FFS) sector, the proposed drug benefit would be administered by a single pharmacy benefit management (PBM) company or other agent in each geographic area, selected through competitive bidding. All Part D enrollees would be entitled to buy covered drugs at whatever price the PBM could negotiate with its network pharmacies, even after they had exceeded the maximum benefit. Medicare+Choice plans would administer the Part D benefit for their enrollees.

Half of Part D costs would be financed by enrollees' premiums, half from general revenues. Thus, taking both cost sharing and premiums into account, enrollees would pay at least 75 percent of the cost of the covered drugs they used (more for those who reached the benefit cap). In 2002 all Medicare enrollees would have a one-time opportunity to enroll in the new Part D. In later years enrollees could opt into the Part D option only when they first became eligible for Medicare, or if their employment-based retiree health plan dropped drug coverage for all retirees. The president's proposal had incentives for employers to keep this coverage. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if retirees had enrolled in Part D instead. Enrollees in Medicare+Choice plans would (if they opted to enroll in Part D) receive their drug coverage through those plans, which for the first time would be paid directly for providing such coverage.

The CBO's Cost Estimate

The CBO estimated that the new Part D provisions would add \$136 billion to federal costs for Medicare through 2009 (Exhibit 1). Medicare benefit costs would be \$238 billion, and subsidies to employers would add another \$19 billion. Those costs would be offset by premium revenues of \$121 billion. The estimated monthly Part D premium would be \$25.20 in 2002, rising to \$55.50 by 2009. In 2002 about 36 percent of participants would have drug expenses exceeding the \$1,000 benefit cap. By 2009, when the cap would be \$2,565, about 26 percent of participants would exceed the cap. Part D benefits per participant would average about \$600 in 2002, rising to \$1,345 in 2009.

The CBO's estimate of Medicare costs for the drug proposal was about 24 percent higher than the Clinton administration's estimate,

EXHIBIT 1

Estimates For The President's Proposed Prescription Drug Benefit For Medicare Part D, 2002–2009

Fiscal-year outlays (billions)	2002	2003	2004	2005	2006	2007	2008	2009	2002– 2009
Part D benefits	\$13.0	\$19.3	\$24.4	\$27.7	\$32.1	\$35.5	\$41.0	\$45.2	\$238.1
Part D premiums	-7.1	-9.9	-12.5	-14.1	-16.3	-17.9	-20.8	-22.8	-121.5
Subsidy to retiree health plans	1.1	1.6	2.0	2.2	2.6	2.8	3.3	3.6	19.2
Net Medicare outlays	7.0	11.0	13.8	15.9	18.3	20.4	23.5	26.0	135.8
Calendar-year estimates (dollars per capita)									
Monthly Part D premium	\$25.20	\$26.30	\$34.70	\$36.70	\$43.10	\$45.40	\$52.90	\$55.50	
Part D benefit cap	\$1,000	\$1,000	\$1,500	\$1,500	\$2,000	\$2,000	\$2,500	\$2,565	
Participants at cap	36%	39%	30%	32%	26%	29%	25%	26%	
Average Part D benefit per participant	\$599	\$619	\$825	\$857	\$1,049	\$1,089	\$1,277	\$1,345	
Average cost-sharing liabilities under Part D per participant ^a	\$1,506	\$1,688	\$1,714	\$1,919	\$1,988	\$2,208	\$2,304	\$2,533	
Total drug expenditures per participant	2,104	2,307	2,540	2,776	3,037	3,297	3,581	3,877	

SOURCE: Congressional Budget Office (July 1999 baseline).

^a Medicaid, retiree health, and Medigap plans would cover some of these costs.

which was \$109 billion for 2002–2009.³ The main reason for this difference is that the CBO's estimate of spending under current law for drugs by Medicare enrollees was higher than the estimate used by the administration. Both based their estimates of future drug spending on patterns reported in the Medicare Current Beneficiary Survey (MCBS). Both adjusted the amounts reported by noninstitutionalized people by approximately the same factor to account for underreporting.⁴ However, the CBO also corrected for underreporting by residents of nursing homes; the administration did not.⁵ In addition, the CBO assumed a higher annual rate of growth for drug costs in the near future (11.4 percent) than the administration did (10.3 percent). They also used different methods to account for the increase in the use of drugs to be expected under the new benefit; this difference, by itself, would tend to make the administration's estimate higher than the CBO's, but that effect was swamped by the other differences discussed above.

Critical Assumptions And Uncertainty

The estimates presented in Exhibit 1 are highly uncertain, for a number of reasons. First, many aspects of the proposed benefit were not fully specified. Second, the effects of the new benefit on the behavior of beneficiaries, prescribing physicians, and employers are difficult to predict. Finally, projecting future drug spending is highly

speculative even without new coverage because spending depends partly on the rate and direction of technical change, which cannot be accurately foreseen. Some of the critical assumptions made for the estimate are discussed below.

■ **Baseline spending projections.** Spending for prescription drugs has been growing at double-digit rates in recent years—faster than other components of health care spending.⁶ Whether that rapid growth will continue is uncertain. A number of innovative drugs are likely to be cleared for marketing in the near future, which would tend to increase both the use and the average price of prescription drugs. However, a number of heavily used brand-name drugs are about to lose patent protection, which would allow entry of generic substitutes and tend to reduce prices. The latest spending projections by the Health Care Financing Administration (HCFA) assume that the recent rapid rates of growth in drug spending will slow sharply over the next few years.⁷ Based on a review of insurers' expectations for the near term, the CBO assumed that recent growth trends will decline to match those in HCFA's projections for 2003 and later but that the slowdown will not occur as soon as the projections suggest. In particular, while the HCFA projections show per capita spending for drugs growing at an average annual rate of 10.3 percent from 1998 to 2002, the CBO assumes average annual growth of 11.4 percent over that period.

■ **Participation.** The CBO assumed that about 75 percent of all Medicare enrollees would join Part D. Nonparticipants would come from two groups: those who do not enroll in Medicare Part B (about 5 percent of all Medicare enrollees), and those who continue their retiree coverage. Overall, the CBO assumed that nearly 95 percent of Medicare enrollees would benefit from the new program, either directly or indirectly through a former employer.

The CBO assumed that about 75 percent of those with employment-based drug coverage would keep it. That assumption is quite speculative, however. As noted above, employers would receive federal payments equal to 67 percent of the Part D premium subsidy for eligible retirees. That, together with the tax-deductibility of health plan costs, would encourage employers to keep full drug coverage in their retiree plans. For their part, most retirees would probably prefer to continue with those plans rather than joining Medicare Part D, for two reasons. First, they generally would pay a lower premium for equivalent drug coverage in a retiree plan than in Part D because employers typically pay more than half of total premium costs. Second, retiree plans usually provide much more generous coverage than Part D would, and getting all drug benefits through the retiree plan would avoid the problems associated with coordi-

nating benefits. Nevertheless, the CBO assumed that about one-quarter of Medicare enrollees who now have retiree coverage would enroll in Part D, because some employers would eliminate their drug coverage or offer it only as a supplement to Part D.

Part D would offer a more generous drug benefit package than standard Medigap plans now do, and at a lower premium. As a result, the three Medigap plans that now include drug coverage would no longer be competitive. Because of the one-time option to enroll and the 50 percent subsidy of premium costs, the CBO expects that all Part B enrollees with Medigap coverage or with no supplementary coverage would enroll in Part D. People receiving Medicaid benefits under the proposal also would enroll in Part D because states, which are responsible for their drug costs, would sign them up for Part D to reduce their Medicaid expenditures.

■ **Induced utilization.** Another area of uncertainty is the extent to which enrollees' drug use would rise. Half of Medicare enrollees already have drug coverage that is at least as generous as the proposed benefit. For the other half, the CBO assumed that the new Part D coverage would increase utilization—by up to 25 percent for enrollees for whom new low-income subsidies would eliminate out-of-pocket costs, and by lesser amounts for enrollees who would face the new benefit's substantial cost-sharing requirements.⁸

■ **Effectiveness of PBMs.** The proposed benefit would be administered primarily through private-sector PBMs. A single PBM, selected through competitive bidding, would administer the benefit in each geographic area. The CBO assumed that those PBMs would reduce costs below the level that an uninsured retail purchaser would face by about 12.5 percent—savings that are smaller than PBMs now generate for large, tightly managed health plans.

The PBMs chosen to administer Part D might not have as much freedom or incentive to use cost-saving techniques as aggressively as they have for private insurance plans. For example, the proposal specifies that PBMs would have to set dispensing fees high enough to ensure participation by most retail pharmacies, which could reduce their ability to negotiate substantial discounts. It also specifies that beneficiaries would be guaranteed access to off-formulary drugs when medically necessary, reducing PBMs' ability to negotiate rebates from manufacturers.

Indeed, how much incentive PBMs would have to generate savings under the program is uncertain. The president's proposal envisions competitive bidding to select the PBM for each geographic area, but it is unclear what financial risks, if any, the winning PBM would bear beyond the costs of processing claims. The proposal indicates that contractual incentives (such as performance bonuses)

might be used to encourage PBMs to focus more aggressively on generating savings, but those mechanisms have not yet been specified. Nor is it clear how savings would be measured. Actual savings could disappear, even while nominal discount and rebate rates were unchanged, if the prices against which discounts and rebates were calculated rose as a consequence of the new benefit.

■ **Effects on drug prices.** Because of its limited benefits, the president's proposal did not require consideration of an important dimension: A drug benefit that protected beneficiaries more fully from catastrophic costs could raise prices for some drugs. The patent system confers exclusive marketing rights to the makers of most new drugs for some period after their introduction. That monopoly may be imperfect because drugs with patent protection must compete with other products offering similar therapeutic effects. But manufacturers of drugs with unique and sizable therapeutic benefits for the elderly would have greater pricing flexibility under a Medicare drug benefit with protection against high out-of-pocket expenditures than they do now. The extent of the effect would depend on features of the proposal, such as the structure of cost sharing, incentives for or restrictions on active management of the drug benefit by PBMs, and rules governing coverage of new drugs. The CBO's estimates of future drug proposals will consider these aspects of plan design.

■ **Offsetting savings.** Some advocates of Medicare prescription drug coverage believe that improved access to prescription drugs would, by preventing or delaying illness, reduce the use of other services. If such savings exist, they would at least partially offset the extra costs of the drug benefit. However, available evidence rests on studies that are too selective to be generalized. For example, some well-designed studies found that improving access to prescription drugs for Medicaid patients reduced hospitalization rates.⁹ But Medicaid already covers drugs for dually eligible beneficiaries, so their use of drugs would be little changed by a new Medicare drug benefit. Moreover, generalizing from evidence from low-income Medicaid beneficiaries to persons with higher incomes may be inappropriate. For higher-income persons, any utilization increases resulting from better insurance coverage might be more concentrated in drugs with more modest therapeutic benefits. Opportunities for adverse reactions and medication errors also rise as drug use increases.¹⁰ Whether the savings from better access to drugs would outweigh the costs of adverse drug events for Medicare beneficiaries whose access to prescription drugs would improve is an open question. Better information on this question would improve the accuracy of cost estimates in the future.

.....
 The views expressed in this paper are those of the authors and should not be interpreted as those of the Congressional Budget Office.

NOTES

1. Dan L. Crippen, director, Congressional Budget Office, testimony before the Senate Finance Committee, 22 July 1999, available online at www.cbo.gov.
2. Medicare now pays for certain outpatient drugs, such as intravenous chemotherapy drugs that must be administered under the direction of a physician. Those drugs would continue to be covered under Part B rather than Part D.
3. Memorandum written by Richard Foster, Office of the Actuary, Health Care Financing Administration, 9 August 1999, Table 4.
4. The CBO multiplied drug spending reported by noninstitutionalized respondents in the MCBS by 1.33 to correct for underreporting, while HCFA used an adjustment factor of 1.3. This adjustment assumes that underreporting for drugs, on average, was similar to the known underreporting for spending on physician services. The extent of underreporting in the survey on physician and other Medicare-covered services is known because survey responses can be compared with Medicare claims paid for the same person and time period.
5. The CBO used drug spending reported in the MCBS by community residents to impute drug spending for residents of nursing homes, for whom little or no information on spending was available. Nursing home residents were matched to community residents based primarily on the number of limitations they faced in activities of daily living (ADLs). As a result, total spending on drugs by the survey population was increased by about 10 percent.
6. K. Levit et al., "Health Spending in 1998: Signals of Change," *Health Affairs* (Jan/Feb 2000): 124-132, Exhibit 2.
7. Projections of per capita spending on prescription drugs for 1998-2008 were taken from the HCFA Web site, www.hcfa.gov/stats/nhe-proj/proj.1998/tables/table12b.htm (accessed 1 July 1999; still current as of 3 January 2000).
8. The CBO uses an arc elasticity of -0.11 to estimate an individual's change in drug utilization in response to a change in the out-of-pocket costs they would face. See W. Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* (June 1987): 251-277.
9. S.B. Soumerai et al., "Effects of Medicaid Drug-Payment Limits on Admission to Hospitals and Nursing Homes," *New England Journal of Medicine* (10 October 1991): 1072-1077; and S.B. Soumerai et al., "Effects of Limiting Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia," *New England Journal of Medicine* (8 September 1994): 650-655.
10. For a review of the frequency of medication errors, see Institute of Medicine, *To Err Is Human: Building a Safer Health System*, ed. L.T. Kohn, J.M. Corrigan, and M.S. Donaldson (Washington: National Academy Press, 1999).