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A Drug Benefit: The Necessary Prescription For Medicare

The question is not whether to include a drug benefit, but rather how to structure such a benefit, says the AARP’s legislative director.

by John Rother

As the thoughtful and provocative paper by Lynn Etheredge recognizes, the time has arrived to include prescription drug coverage in Medicare. Prescription drugs and biotechnology will surely be the keys to twenty-first-century medical care. Without them Medicare will not have the tools it needs to offer effective care; nor will it be as efficient as it should be.

Today the elderly and disabled are the groups most in need of prescription drugs. Yet one-third of Medicare beneficiaries lack any drug coverage, and most of those with coverage are at risk of facing reduced benefits or of losing coverage entirely. Those now enjoying employer-based coverage may not have it in the future. The share of employers continuing to offer retiree health coverage fell from 35 percent in 1995 to 30 percent in 1998, and further erosion in coverage is likely.

Those who have coverage through a Medicare health maintenance organization (HMO) are likely to see those drug benefits cut back, according to recent industry predictions, because of payment pressures from reimbursement changes in the Balanced Budget Act (BBA) of 1997 and rising prescription drug costs. Finally, those with individually purchased supplemental (Medigap) insurance that provides limited drug coverage (Plans H, I, and J), who already pay high premiums because of adverse selection, face premium increases that threaten the affordability of that coverage.

The financial burden of pharmaceutical costs is high and likely to rise even higher. Even beneficiaries with some type of existing coverage often have surprisingly high out-of-pocket costs. Those with individually purchased Medigap policies, for example, face an average of $570 in out-of-pocket drug costs in 1999. Beneficiaries without any coverage at all incur out-of-pocket costs of $590, on average. These beneficiaries are far more likely to have low or moderate incomes than those who do have drug coverage. Those without coverage whose drug expenses exceed $1,000 per year are disproportionately female and disproportionately in fair or poor health.

Ironically, beneficiaries without drug coverage pay the highest prices because they do not have access to the group-purchase discounts available to most Americans through their health plans.

Given statistics such as these, the question is how best to structure a prescription drug benefit, not whether one is desirable or necessary. Several key challenges exist.

- **Eligibility.** Any drug benefit should protect all beneficiaries, not just certain subgroups. A benefit design that segments the Medicare population by income, health status, or other criteria could lead to significant adverse selection. Similarly, a voluntary drug benefit could pose serious risk selection problems unless it is designed, like Part B, to attract near-universal participation. Limiting the benefit to only those enrolled in HMOs would ignore the needs of 85 percent of bene-
ficiaries, discriminate in the benefit guarantee, and undermine the principle that Medicare beneficiaries have a choice of delivery systems.

- **Affordability.** A drug benefit will, in all likelihood, require additional premiums and cost-sharing features. Given the profile of those most reliant upon drugs to maintain health or functioning, cost sharing must be reasonable. Existing protections for low-income beneficiaries need to be expanded. Poorly conceived and burdensome cost sharing will be counterproductive.

- **Existing coverage.** As Etheredge notes, one of the central challenges in designing a Medicare prescription drug benefit is how to incorporate existing drug coverage without incurring substantial costs that largely replace private financing with public. Asking better-insured beneficiaries to pay substantial new costs for a benefit they already had was the major political problem that undid the Medicare catastrophic coverage initiative in 1988. Any new program clearly will need to recognize the range of patchwork coverage already in place and avoid disruptive or abrupt transitions. A voluntary approach might be one solution but, again, only if structured to attract very broad enrollment.

- **Cost containment.** Direct government-industry price negotiations, such as practiced in Canada and Western Europe, seem politically unlikely in the United States. Fortunately, the existence of private-sector intermediaries—such as pharmacy benefit management (PBM) firms—may hold promise for both cost constraint and quality improvement. The pharmaceutical industry should not object to a Medicare drug benefit that is administered in ways similar to other health plans, where pricing decisions are kept in the private sector or where private-sector prices are the standard for Medicare payments. Since PBMs usually limit access to some drugs, a choice of PBMs may be appropriate. There also should be appropriate oversight of the process by which PBMs limit access to drugs, so that consumers can be assured that limited access is based on cost-effective medical practices rather than simply an attempt to reduce the PBM’s costs.

- **Financing.** In the end, as in most health policy, the key challenge is financing. A completely self-contained financing structure, in which beneficiaries pay the full cost of a new benefit, is neither affordable for most beneficiaries nor politically realistic. Outside sources of income are necessary, from savings elsewhere in Medicare or from sources such as tobacco settlements or the federal budget surplus. Beneficiaries clearly are willing to pay their fair share, provided that the benefit itself is perceived as meaningful.

**How do we move this debate forward?**

The public is already strongly supportive. Majorities of younger as well as older Americans support expanding Medicare to include prescription drugs, even given higher total costs for Medicare. The AARP is committed to working with leaders on both sides of the aisle, as well as the industry and health plans, to promote a reasonable, workable, and overdue plan.
NOTES


4. Ibid.

5. Ibid.


9. Among persons under age sixty-five, 71 percent supported expanding Medicare to include prescription drugs, “even though it means higher costs for the Medicare program,” as did 58 percent of those age sixty-five and older. Kaiser Family Foundation/ Harvard University National Survey on Medicare Policy Options, August–September 1998.