

# **CBO TESTIMONY**

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**Statement of  
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Director**

## **A CBO Analysis of the Administration's Prescription Drug Proposal**

**before the  
Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives**

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**CONGRESSIONAL BUDGET OFFICE  
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WASHINGTON, D.C. 20515**

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the President's proposal for a prescription drug benefit for the Medicare program. That proposal recognizes the public's concern that rising drug costs may be placing a large and growing financial burden on Medicare beneficiaries. About 30 percent of those beneficiaries do not have insurance coverage for prescription drugs, and others have only limited coverage. The President's proposal would provide some benefit for most Medicare beneficiaries but, as currently specified, would provide little financial protection for those who face extremely high spending for prescription drugs.

The proposed prescription drug benefit is part of a broader set of policies for Medicare recommended in the President's budget for 2001. Those policies would expand Medicare eligibility to new populations, reduce payments for certain covered services, introduce innovations from the private sector to fee-for-service Medicare, and convert Medicare+Choice into a competitive defined benefit program.

My testimony today will focus on the prescription drug proposal. As background to that analysis, I will briefly discuss spending by Medicare beneficiaries on prescription drugs and the extent of the insurance coverage for that spending. I will then describe the President's proposal and the Congressional Budget Office's (CBO's) most recent analysis of that plan, including a newly revised estimate of the plan's costs. The new estimate is about \$11 billion higher than the one we reported in April in our analysis of the President's budgetary proposals. My statement will conclude with some observations on several design features that affect the cost and effectiveness of a Medicare prescription drug benefit.

## **SPENDING AND INSURANCE COVERAGE FOR PRESCRIPTION DRUGS**

The majority of Medicare beneficiaries spend some money on prescription drugs in a year, and a significant fraction of those beneficiaries have very high expenses. In 1996, for example, the Health Care Financing Administration (HCFA) estimates that, in total, the average Medicare beneficiary spent more than \$670 for prescription drugs. (That includes both out-of-pocket expenses and any insurance reimbursement.) About 87 percent of beneficiaries had some drug spending; about 7 percent had expenditures of \$2,000 or more (see Figure 1).

Several statistics suggest the significance of prescription drug spending by the Medicare population. Because Medicare beneficiaries are elderly or disabled, they use more prescription drugs than the average person. Medicare beneficiaries constituted about 14 percent of the U.S. population in 1996 but accounted for about 40 percent of the \$62 billion spent in the United States on prescription drugs in that year.

In addition, drug spending by Medicare beneficiaries has grown at a more rapid rate than spending on other health services. Between 1995 and 1996, for example, total drug spending by an average Medicare beneficiary grew by 12.2 percent, whereas federal spending for Medicare benefits (on a per-beneficiary basis) grew by 7.2 percent (see Table 1). Those rates compare with 4.6 percent growth in gross domestic product per capita over the same period.

The Medicare program does not cover most prescription drugs that beneficiaries take on an outpatient basis, and to obtain such coverage, many beneficiaries turn to supplemental coverage.<sup>1</sup> In 1996, according to HCFA data, more than two-thirds of beneficiaries had supplemental insurance that provided some drug benefits (see Table 2). The sources of the coverage vary (see Figure 2). Many Medicare+Choice plans offer drug coverage as a supplement to their overall benefit package. Other sources are employer-sponsored and medigap (individually purchased) plans that include drug coverage. In addition, some beneficiaries are eligible for prescription drug coverage under Medicaid or through other public programs.

Many Medicare beneficiaries have the option of enrolling in Medicare+Choice plans that offer prescription drug coverage. In 1996, nearly 95 percent of Medicare+Choice enrollees were in such plans—typically, the coverage included a cap on the maximum benefit, cost-sharing requirements, and a drug formulary. (A formulary is a list of drugs preferred by the plan's sponsor, in part because of their lower prices.) Faced with tightening financial circumstances in the past two years, however, an unusually large number of health maintenance organizations (HMOs) have dropped out of the Medicare+Choice program, and many of the plans offering prescription drug coverage have pared benefits significantly. One analysis suggests that only about three-quarters of beneficiaries enrolled in Medicare+Choice plans had drug coverage in 1998.

Employer-sponsored insurance is by far the largest source of prescription drug coverage for Medicare beneficiaries. In 1996, more than 11 million Medicare beneficiaries had drug coverage through employer-sponsored plans. But employers often “carve out” drug benefits from their main benefit package, typically subjecting them to more restrictions than are placed on other benefits. Employers and health plans have also turned to pharmacy benefit managers (PBMs), which use formularies,

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1. Under Part B, Medicare now pays for a limited list of outpatient drugs, such as intravenous chemotherapy drugs that must be administered under the direction of a physician.

utilization review, selective contracting with pharmacy networks, and other tools to control the use of prescription drugs.

Medicare beneficiaries may also purchase supplemental drug coverage through medigap plans. Such coverage is limited, however: it requires beneficiaries to pay half the cost of their prescription drugs after meeting a \$250 deductible. Benefits are capped at either \$1,250 or \$3,000 annually. Premiums for medigap plans offering drug coverage are generally higher than for other medigap plans. The higher premiums are partly due to adverse selection (more people with greater need for health care—and thus greater costs—enroll in those plans).

Certain low-income Medicare beneficiaries have access to drug coverage through state Medicaid programs. Such beneficiaries include those who have income lower than 100 percent of the poverty level or medical expenses large enough to meet the program's spend-down requirements. (Individuals may be eligible for Medicaid under a state's spend-down requirement if their monthly income less medical expenses is below some maximum.) The assets that those beneficiaries may own are also limited. Medicare beneficiaries who meet those criteria are generally eligible for full Medicaid benefits, including prescription drug coverage. Other low-income people—those designated as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs)—are eligible for subsidies for some Medicare expenses but are not eligible for full Medicaid services or Medicaid drug coverage. In 1996, about 3.9 million Medicare beneficiaries had supplemental drug coverage through Medicaid.

Coverage for prescription drugs is also available through other sources. Several states have instituted special programs to provide drug coverage for the low-income elderly or people with disabilities. And some Medicare beneficiaries are eligible for drug coverage and other benefits through the Department of Veterans Affairs or the Department of Defense.

People who have supplemental drug coverage consume more prescription drugs than those without such coverage but spend less out of pocket. In 1996, for example, Medicare beneficiaries with coverage spent an average of \$769 compared with \$463 for those without coverage, according to HCFA's estimates. Conversely, those with drug coverage spent less out of pocket: in 1996, beneficiaries with coverage averaged \$253 in out-of-pocket spending on prescription drugs (excluding premiums paid to private insurers or HMOs).

## **THE PRESIDENT'S MEDICARE PRESCRIPTION DRUG PROPOSAL**

The President proposes to create a voluntary, outpatient prescription drug benefit under a new Part D of Medicare. That program would begin in 2003 and be fully phased in by 2009. It would pay half of the cost of prescription drugs, up to a specified cap. The insured half of the benefit would be financed equally by premium payments from enrollees and by general tax revenues. After taking cost sharing and premiums into account, enrollees would pay 75 percent of the cost of covered drugs and the government would pay 25 percent, up to the cap.

The proposed benefit would be administered by a private-sector pharmacy benefit manager in each region of the country, selected through competitive bidding. The PBMs that administer Part D would negotiate lower drug prices, on average, than are currently paid by Medicare beneficiaries. Beneficiaries who enrolled in Part D would receive the benefit of those discounted prices on their prescription drug purchases, including drugs they bought after exceeding the benefit cap.

Although the President's budget suggests earmarking \$35 billion from 2006 through 2010 for a possible catastrophic benefit, no policy is specified. Consequently, CBO's analysis does not focus on a catastrophic benefit, and our estimate does not include the \$35 billion earmark.

### **How the Benefit Would Work**

In 2003, all Medicare beneficiaries would have a one-time chance to sign up for the new benefit. In later years, beneficiaries would be permitted to choose the Part D option only when they first became eligible for Medicare. The only exception involves beneficiaries with certain other prescription drug coverage who lose that coverage involuntarily (for example, when a former employer drops drug coverage for all retirees in its health plan).

The new benefit would have no deductible and would generally pay 50 percent of an enrollee's prescription drug costs, up to a maximum benefit of \$1,000 in 2003. That benefit cap would gradually rise to \$2,500 in 2009. Thus, in 2009, a beneficiary who spent \$5,000 or more on prescription drugs would receive the maximum reimbursement of \$2,500. That beneficiary would also pay \$575 in Part D premiums that year. After 2009, the cap would be indexed to annual changes in the consumer price index (CPI). Assuming that the cost of prescription drugs continued to rise more rapidly than the CPI, the real value of the cap would shrink, thus eroding the benefit.

Certain low-income beneficiaries would receive help with drug-related costs through the Medicaid program. Medicaid would pay both the premiums and the cost-sharing expenses under the Medicare drug benefit for participants who were also fully eligible for Medicaid. For these so-called dual-eligibles, Medicaid would pay all drug costs not paid by Medicare, including expenses above the cap. Medicaid would also pay the premiums and cost-sharing requirements for people who had limited assets and income below the poverty line. In both cases, the federal government would reimburse states for those costs at the usual federal/state matching rate, which averages 57 percent.

Another group of low-income enrollees would also receive assistance with their prescription drug costs. The federal government would pay all of the premiums and coinsurance for Part D enrollees with limited assets and income between 100 percent and 135 percent of the poverty line, and part of the premiums for Part D enrollees with limited assets and income between 135 percent and 150 percent of the poverty line. Eligibility for those subsidies would be determined by state Medicaid agencies, but unlike the assistance provided to dual-eligibles, the federal government would pay 100 percent of these costs. Neither the federal nor state governments would be liable for covering any drug expenses above the Part D cap for low-income beneficiaries who were not fully eligible for Medicaid.

The President's proposal also includes an incentive that is intended to retain employer-sponsored drug coverage for retirees. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if the employers' retirees had enrolled in Part D instead. In addition, enrollees in Medicare's managed care plans would receive their prescription drug coverage through those plans, which for the first time would be paid directly for providing such coverage.

### **CBO's Cost Estimate**

The new Part D provisions would add a total of \$160 billion to federal costs through 2010, CBO estimates. Of that total, \$134 billion represents outlays for Medicare (net of premium receipts), and \$26 billion represents federal outlays for Medicaid (see Table 3). States would also face additional Medicaid costs. CBO estimates that the premium for Part D would start at about \$24 a month in 2003 and rise to about \$50 a month in 2010.

CBO's cost estimate assumes that most people who are enrolled in Part B of Medicare would also enroll in Part D. But the estimate takes into account the fact that some beneficiaries who have employer-sponsored drug coverage for retirees would rather

keep that coverage than opt for the new benefit. In addition, CBO assumes that people who are eligible for benefits under Part B but do not actually enroll would also not enroll in Part D. Under those assumptions, nearly 36 million people would sign up for Part D in 2003, representing approximately 88 percent of total Medicare enrollment.

CBO's estimate is about \$11 billion higher than the estimate in our April report, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001*. Two significant revisions have been made. First, we adjusted the data on spending for prescription drugs to recognize the discount that beneficiaries insured by employer-sponsored plans receive through their PBMs.<sup>2</sup> Second, we increased our estimate of the cost of the new subsidies for low-income people.

## **CONSIDERATIONS IN DESIGNING A MEDICARE DRUG BENEFIT**

The President's prescription drug proposal has raised a variety of issues regarding the design of such a benefit. The specific features of a drug proposal determine the cost of the program to federal and state governments and the effectiveness of the policy in providing affordable access to pharmaceuticals for Medicare beneficiaries. Some of the important design issues that might be considered in assessing a Medicare drug benefit include:

- *The Nature and Value of the Benefit.* The proposed benefit is limited and does not include stop-loss coverage, which protects beneficiaries against catastrophically high spending on drugs.
- *The Effectiveness of PBMs.* It is uncertain whether PBMs would aggressively use formularies, coinsurance policies, and other methods to limit Medicare costs.
- *Program Participation.* Employers, who have been buffeted by rising drug costs, are likely to reduce their retiree coverage under a Medicare drug benefit instead of accepting a subsidy to retain their programs. Medigap insurers are also likely to restructure their plans to take advantage of the benefit. In addition, a drug benefit would reduce the incentive that Medicare beneficiaries

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2. HCFA will make such a revision in the Medicare Current Beneficiary Survey for 1997. Previously, the survey assumed that beneficiaries in employer-sponsored plans paid the full retail price for prescription drugs.

now have to enroll in managed care plans rather than traditional fee-for-service Medicare.

- *Effects on Medicaid Costs.* The subsidy for low-income Medicare beneficiaries is superimposed on the existing Medicaid structure, which necessarily complicates the new benefit's design and affects the cost of the program to both federal and state governments.

### **The Nature and Value of the Benefit**

Part D is designed to ensure that most enrollees would receive some benefit. However, because of the annual cap, it would not protect enrollees who have chronic conditions and are dependent on prescription drugs from very large out-of-pocket expenses. In 2003, for example, about 33 percent of participants would have drug expenses that exceeded the \$1,000 cap on Part D benefits. By 2010, about 22 percent of participants would have expenditures exceeding the benefit cap of about \$2,560. If drug costs continued to rise faster than the CPI, an increasing proportion of beneficiaries would have drug costs in excess of the maximum benefit cap after 2010.

Because the benefit cap would limit Medicare's exposure to increases in prescription drug spending, it would also limit the value of the benefit to people who have the highest drug costs. A program that did not provide first-dollar coverage but limited an enrollee's out-of-pocket costs to some annual maximum (or stop-loss amount) would better protect beneficiaries with the highest drug spending. Such a program would make larger payments to fewer people than would a program that capped benefits.

However, a redesigned benefit that protected beneficiaries more fully from catastrophic costs could raise prices for some drugs because enrollees whose expenses exceeded the stop-loss amount would be less price-sensitive. The patent system assigns exclusive marketing rights to the makers of most new drugs for some period after their introduction. Drugs with patent protection must compete with other products offering similar therapeutic effects. But manufacturers of particular drugs that primarily benefit the elderly would have greater flexibility in pricing their products under a Medicare drug benefit with stop-loss protection than they have now. Such a pricing effect is likely to be greater for plans that have more generous catastrophic coverage or lower cost-sharing requirements.



A Medicare prescription drug proposal that led to higher drug prices could impose additional costs on other federal programs that purchase drugs (including Medicaid, the Department of Veterans Affairs, and the Department of Defense). Higher drug prices could also increase the costs of private health insurance, leading to higher premiums. In that case, CBO would estimate somewhat lower federal revenues from income and payroll taxes as a larger portion of employee compensation was paid through nontaxed health benefits rather than through taxable wages.

### **The Effectiveness of PBMs**

As noted earlier, the President proposes to administer the prescription drug benefit through private-sector pharmacy benefit management companies, which private health plans use to negotiate price discounts and control utilization. A single PBM, selected through competitive bidding, would administer the benefit in each region. CBO's cost estimate assumes that those PBMs would reduce costs by about 12.5 percent from the level that an uninsured retail purchaser would pay—smaller savings than PBMs now generate for large, tightly managed health plans. The savings are net of the administrative costs incurred by a PBM in processing prescription claims.

PBMs save money for private-sector health plans in four main ways. First, they negotiate discounts with pharmacies that agree to participate in their networks. Second, they obtain rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. Third, PBMs use mail-order pharmacies, which are often better able than retail pharmacies to save money. Mail-order pharmacies are likely to have lower average operating costs, and they may be more likely to substitute generic or other lower-cost drugs for the ones prescribed. Finally, PBMs establish differential copayment requirements that encourage beneficiaries to select lower-priced options such as generic, preferred formulary, or mail-order drugs. Some PBMs also use management techniques such as on-line utilization review and prior approval to evaluate care and encourage the most cost-effective treatment practices. A PBM can generally negotiate larger rebates if it can shift more prescription purchases from one product to a competing product in the same therapeutic class.

The President's proposal would constrain the ability of PBMs to use their cost-saving techniques. For example, the proposal calls for dispensing fees to be high enough to ensure broad participation by retail pharmacies. That requirement could limit the discounts that PBMs could negotiate from pharmacies.

Other provisions could hamper the PBMs' ability to negotiate rebates from drug manufacturers. The proposal specifies that beneficiaries would be guaranteed access to off-formulary drugs when medically necessary and coinsurance requirements could not exceed 50 percent. Some private drug plans require enrollees to pay the full difference between the cost of a brand-name drug and its generic equivalent (if one exists) unless the prescribing physician specifically states that the brand-name drug is medically necessary. Such an approach would apparently not be permitted in the Part D program proposed by the Administration.

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. In the absence of financial risk, PBMs might not have a strong incentive to generate savings under the program. Yet, if they were placed at financial risk, PBMs would have to charge higher premiums.

Another issue that needs clarification is how savings would be measured under a Medicare drug benefit. Actual savings could disappear, even though nominal discount and rebate rates were unchanged, if the prices from which discounts and rebates were calculated rose as a result of the new benefit.

Under the President's proposal, a single PBM would administer the benefit in an area. As an alternative, multiple PBMs in the same area could compete for shares of the Medicare market. Such competition might lead to more aggressive cost management, but that outcome is by no means certain. One potential drawback to a multiple-PBM system is that PBMs might keep their prices low by seeking out healthier enrollees with lower drug costs instead of focusing on cost management. In that case, the possible savings to the federal government would be dissipated.

### **Program Participation**

If a Medicare drug benefit was enacted, private insurers would alter the type of drug coverage they offered. CBO's estimate assumes that most people who participate in Part B of Medicare would also participate in Part D. Thus, employer-sponsored plans and medigap insurance would generally offer their enrollees new options for supplemental coverage. Moreover, with a fee-for-service drug benefit in place, managed care plans in the Medicare+Choice program could become less attractive to beneficiaries.

Employers would probably face lower costs for their retiree coverage under the President's proposal. Firms that offered prescription drug coverage with benefits comparable to those under the Part D program would be eligible to receive federal payments equal to 67 percent of the Part D premium subsidy for eligible retirees. That subsidy payment—together with the tax exclusion of their health plan costs—would induce some employers to keep full drug coverage in their retiree health plans rather than eliminating it or wrapping their plans' benefits around the new Part D package. (Under a wraparound plan, Medicare would be the primary payer for prescription drugs; the employer's plan would serve as a supplement.) Few employers would be likely to maintain full drug coverage, however. CBO assumes that about three-quarters of Medicare enrollees who now have drug coverage through a retiree health plan would enroll in Part D.

Part D would offer a more generous drug benefit than standard medigap plans do, and at a lower premium. As a result, the three medigap plans that now offer drug coverage would no longer be competitive. For its estimate, CBO assumed that those plans would be replaced by one that supplemented the coverage offered under Part D by filling in the 50 percent coinsurance "gap."

Another possible effect of a Medicare prescription drug benefit is to reduce the attractiveness of managed care plans, which typically offer prescription drug coverage to their enrollees. That benefit is often cited as an important factor in beneficiaries' choosing managed care over traditional fee-for-service Medicare. Although managed care plans might become somewhat less competitive with enactment of a Medicare drug benefit, the President has proposed other policies that would create new incentives to compete on the basis of price as well as quality through a competitive defined benefit program. However, CBO assumes that offering a drug benefit in the fee-for-service sector would dramatically slow the growth of enrollment in Medicare+Choice. In 2010, for example, CBO projects that enrollment in Medicare+Choice plans would reach 14.1 million under current law but only 11.6 million under the President's proposal.

### **Effects on Medicaid Costs**

The President's proposal would increase Medicaid's costs for drugs and other benefits—substantially in the case of federal costs and less sharply in the case of state costs. Although Medicaid would no longer have to pay all drug costs for Medicare beneficiaries who now receive full Medicaid benefits, those savings would be more than offset by additional Medicaid spending on behalf of other Medicare beneficiaries.

Part D would pay for a portion of the drug costs that Medicaid now pays for Medicare enrollees who are fully eligible for both programs. That expansion of Medicare's role would lower both federal and state Medicaid costs by shifting them to Medicare. But the savings would be partly offset by the Part D premiums that Medicaid would have to pay for those dual-eligibles.

Certain low-income Medicare beneficiaries who are not eligible for full Medicaid benefits would also become eligible for assistance to pay for their Part D premiums and cost sharing. To receive that assistance, however, eligible Medicare beneficiaries would have to enroll at a state welfare office, and not all of them would choose to do so.

The President's proposal would increase Medicaid spending for services not related to the new drug benefit. The availability of a free drug benefit, made possible by enrollment in Medicaid, would attract more Medicare beneficiaries into the Medicaid program. In turn, that increased enrollment would boost spending for other benefits that Medicaid pays for as well as the prescription drug benefit.

## **CONCLUSION**

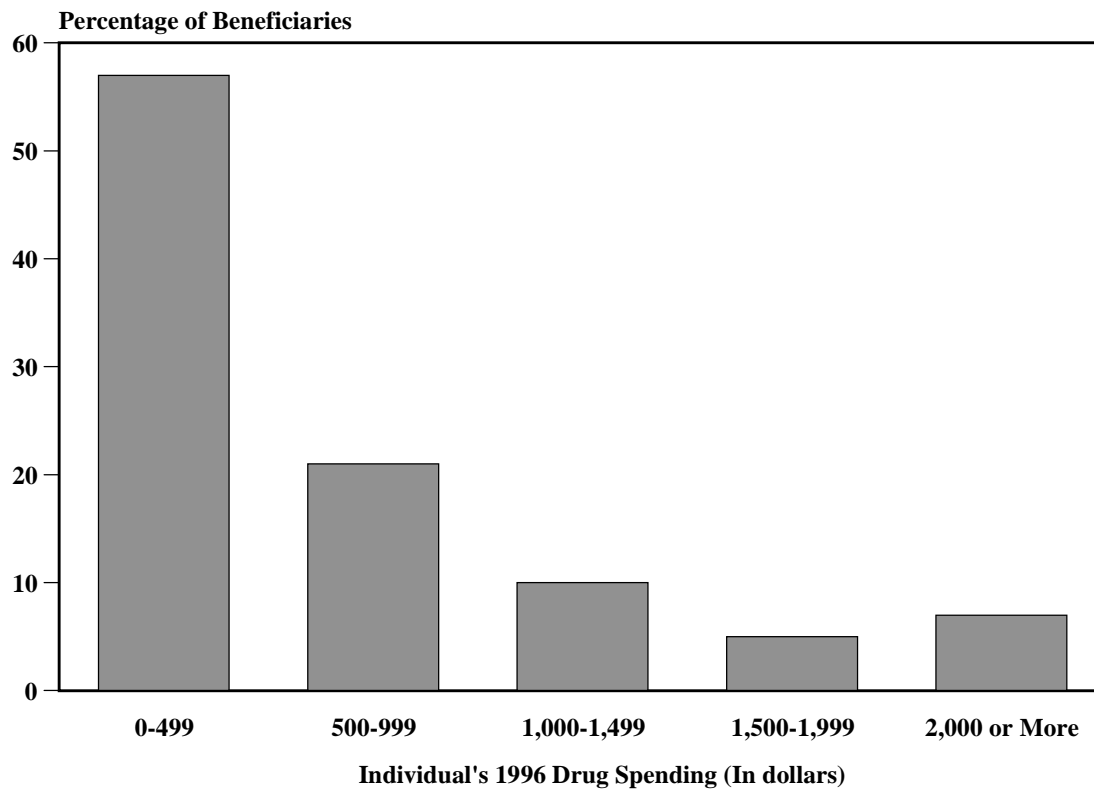
The President's prescription drug proposal has both pluses and minuses that must be weighed in assessing its effects. The proposed coverage would provide some assistance to most Medicare enrollees. Because the benefit is capped, however, the proposal would offer little financial protection to beneficiaries with a high level of drug spending. In 2003, for example, about a third of enrollees in the new Part D drug benefit would spend more than the benefit cap for prescription drugs. And the cost of the proposal would be significant. Spending on prescription drugs is the fastest-growing component of health care costs. Even with a capped benefit, the proposal would increase federal outlays substantially.

The specific details of a prescription drug proposal greatly affect the program's costs and value to beneficiaries. The level of coinsurance, the existence of a benefit maximum versus a stop-loss provision, the split in financing between beneficiary premiums and taxpayer subsidies, and the nature and degree of subsidies for low-income beneficiaries and employers all drive the value of the benefit and its costs. The role of the PBMs is equally critical. In attempting to create a competitive environment, the President's drug proposal establishes geographically exclusive PBMs but limits the scope of their activities. As a result, their effectiveness in managing costs is uncertain.

Developing a prescription drug benefit in the Medicare program raises numerous difficult issues. Since the inception of Medicare in 1965, the cost of prescription drugs and their clinical importance have grown dramatically. As drugs became a critical component of modern health care, more than two out of every three Medicare beneficiaries turned to some form of supplemental coverage for their drug expenses. Those arrangements have led to very large variations across beneficiaries in the comprehensiveness, cost, and financing of their prescription drug spending. That variety complicates the task of rationalizing prescription drug coverage and makes developing such a benefit for Medicare a complex policy challenge.

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FIGURE 1. DISTRIBUTION OF TOTAL SPENDING FOR PRESCRIPTION DRUGS  
BY MEDICARE BENEFICIARIES, CALENDAR YEAR 1996

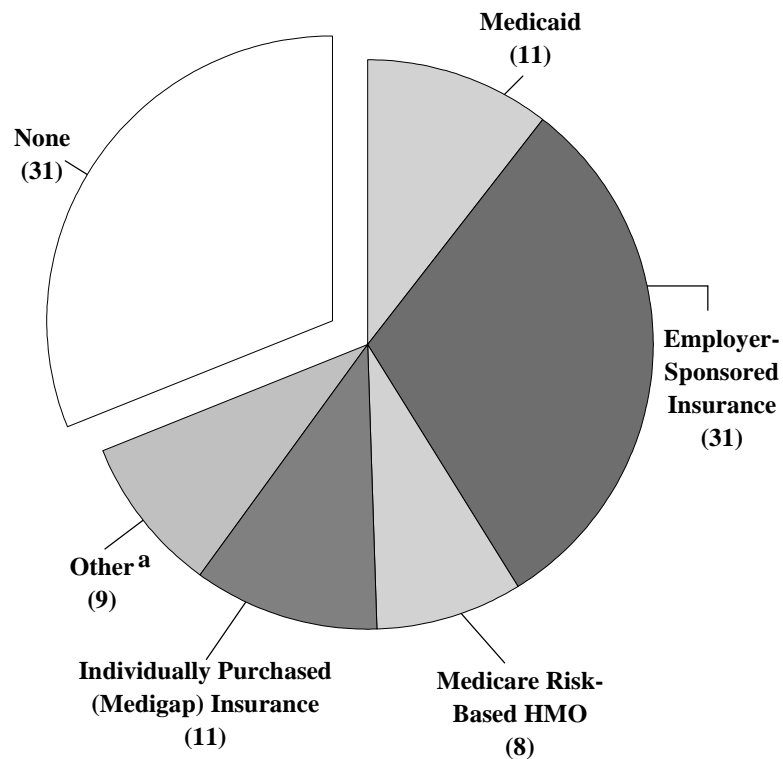


SOURCE: Congressional Budget Office using unpublished data from the Health Care Financing Administration's Medicare Current Beneficiary Survey Cost and Use File, 1996.

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FIGURE 2. SOURCES OF PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES (In percent)



SOURCE: Congressional Budget Office based on John A. Poisal and George S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs*, vol. 19, no. 2 (March/April 2000), p. 251.

a. Includes Medicare beneficiaries who switched their source of coverage during the year; those eligible for benefits through other public programs such as Department of Veterans Affairs, Department of Defense, or state pharmaceutical assistance for low-income elderly people; and those enrolled in non-risk-based health maintenance organizations (HMOs).

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TABLE 1. GROWTH OF DRUG SPENDING AND MEDICARE BENEFITS  
PER BENEFICIARY, CALENDAR YEARS 1995-1996

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	Average Spending per Beneficiary (Dollars)		Percentage Change from 1995 to 1996
	1995	1996	
Drug Spending	600	673	12.2
Medicare Benefits	4,953	5,312	7.2
<b>Memorandum:</b> Gross Domestic Product per Capita	28,130	29,430	4.6

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SOURCE: Congressional Budget Office based on the Health Care Financing Administration's unpublished tabulations of the Medicare Current Beneficiary Survey Cost and Use File, 1995 and 1996.

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TABLE 2. MEDICARE BENEFICIARIES, BY TYPE OF SUPPLEMENTAL INSURANCE AND DRUG-COVERAGE STATUS, CALENDAR YEAR 1996

Type of Supplemental Insurance	Number of Beneficiaries (Millions)	Number of Beneficiaries with Drug Coverage (Millions)	Percentage of Beneficiaries with Drug Coverage
Medicare Risk-Based HMO	3.2	3.1	95
Medicaid <sup>a</sup>	4.4	3.9	89
Employer-Sponsored Coverage <sup>b</sup>	12.9	11.4	89
Individually Purchased Coverage Only	9.8	3.9	40
All Other Supplemental Coverage <sup>c</sup>	0.7	0.6	81
No Supplemental Coverage	2.9	0	0
Switched Coverage During the Year <sup>d</sup>	<u>3.3</u>	<u>2.7</u>	83
All Medicare Beneficiaries	37.2	25.6	69

SOURCE: Congressional Budget Office based on John A. Poisal and George S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs*, vol. 19, no. 2 (March/April 2000), p. 251.

NOTE: HMO = health maintenance organization.

- a. Includes Medicare beneficiaries receiving full Medicaid benefits as well as qualified Medicare beneficiaries and specified low-income Medicare beneficiaries.
- b. Includes Medicare beneficiaries with both employer-sponsored and individually purchased supplemental insurance.
- c. Includes other public programs such as Department of Veterans Affairs, Department of Defense, and state pharmaceutical assistance programs for low-income elderly people, as well as non-risk-based HMOs (cost and health care prepayment plans).
- d. Includes Medicare beneficiaries who did not spend 100 percent of their Medicare-eligible months in one insurance category.

TABLE 3. CBO'S ESTIMATE OF THE COST OF THE PRESIDENT'S PROPOSAL  
FOR A PRESCRIPTION DRUG BENEFIT IN MEDICARE  
(By fiscal year, in billions of dollars)

	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2003- 2010
Medicare Spending <sup>a</sup>	15	21	26	30	35	38	44	48	257
Part D premium receipts	-8	-11	-13	-15	-17	-19	-22	-24	-129
Subsidy to health plans for retirees	*	1	1	1	1	1	1	1	6
Medicaid Spending	<u>1</u>	<u>2</u>	<u>3</u>	<u>3</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>5</u>	<u>26</u>
Net Effect on Federal Spending	8	13	17	19	22	24	27	30	160
<b>Memorandum:</b>									
Monthly Part D Premium (Dollars)	24.00	24.80	32.10	33.30	39.90	41.50	47.90	50.70	n.a.

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add up exactly to totals because of rounding.

\* = less than \$0.5 billion; n.a. = not applicable.

a. Includes administrative costs of \$0.4 billion in 2002.