The Effects of Congressional Proposals on Prescription Drug Costs for Medicare Beneficiaries

June 19, 2002

Department of Health and Human Services
Office of the Assistant Secretary for
Public Affairs

Overview

- The House Republican plan would provide real relief for seniors and disabled Americans: those who now pay full retail prices would typically see the costs of each prescription cut by 60-85 percent, and their overall out-of-pocket drug costs would fall by as much as 70 percent – in exchange for a stable and affordable premium starting at $34 per month.

    - The savings from the House Republican plan include a substantial price discount, made possible by letting all seniors aggregate their purchasing power for the first time. It's common sense: the first step toward lower prescription drug costs for seniors is to give them the same means to get lower drug prices that are widely used for those under 65.

    - The House proposal also includes generous catastrophic protection for all seniors who have high out-of-pocket drug expenses – targeting this help to those who need it most.

    - It would provide even greater relief for about 17 million seniors with incomes below 175% of poverty – who would generally pay only $2-5 for each prescription. And those with incomes below 150% of poverty would pay no monthly premiums, while those with incomes between 150% and 175% of poverty would pay reduced premiums.[*]

    - This benefit would also yield $40 billion in savings for states over 10 years, helping to ease the serious budgetary problems they face due to rising drug costs in Medicaid.

    - All of this would be done in a manner that is far more fiscally responsible than many drug benefit proposals that have been circulated this year – which have full 10-year price tags of $600-750 billion or even higher.

- A recent Senate Democratic drug proposal sought to reduce its apparent cost by terminating its benefits after 2010 – but this would not provide the secure entitlement contained in the House bill. Even when it is available, its design would actually raise retail prices by 15% or more on the drugs seniors use most – which is one reason it must impose steep co-pays of $40 to $60 for most prescriptions. As a result, most seniors would pay less out-of-pocket for their prescriptions under the House Republican plan than under the Senate Democratic proposal. And the costs of this Democratic plan would quickly exceed $100 billion per year, driving up its true 10-year cost to at least $600 billion and probably more.

- The outline of a drug benefit just released by House Democrats is even more expensive – $750-800 billion over 10 years, if not more – and could lead to even higher drug prices or require government price controls. But this proposal would increase Medicare's financing shortfall by 2% or more of GDP. The added burden would either threaten Medicare's existing benefits or require a new tax on every working American of $2,000 or more by 2030 – just when the Baby Boom is counting on Medicare.

---

[*] In 2005, 150 percent of poverty would correspond to about $14,500 in annual income for a single individual and about $19,500 for a couple. 175 percent of poverty would be about $17,000 for singles and $23,000 for couples.

Background on Current Prescription Drug Coverage and Spending

- About 25 percent of Medicare beneficiaries have no drug coverage during the year, and many others have only partial coverage or have a drug plan – such as a Medigap policy – that does not negotiate price discounts on their behalf.

- As a result, millions of seniors – including those with the least ability to afford it – pay full retail price for their prescriptions. In contrast, the vast majority of Americans who have private insurance coverage pay prices that are as much as 40 percent less for their brand-name prescriptions (as confirmed by a Clinton Administration study of drug pricing).

- The burden of paying full retail drug prices falls hardest on those seniors with incomes between 100 and 175 percent of poverty, since they are 25 percent more likely to lack drug coverage than other beneficiaries. All told, about 4 million Medicare beneficiaries with incomes below 175 percent of poverty lack drug coverage – accounting for nearly 50 percent of those who are uninsured for their drug spending.

- Rural beneficiaries are also at a distinct disadvantage. In non-metropolitan areas, 36 percent of beneficiaries lack drug coverage – and these 3 million seniors and persons with disabilities account for more than one-third of all the Medicare beneficiaries who are uninsured for their drug spending.

- Nearly 90 percent of Medicare beneficiaries fill at least one prescription per year, but the extent of their drug spending varies. In 2005, when a full Medicare drug benefit would take effect, over 50% of Medicare beneficiaries are projected to use less than $2,000 worth of drugs. But about 10% are projected to have costs over $5,000.

- The Congressional Budget Office (CBO) now projects that Medicare beneficiaries will use about $1.8 trillion worth of drugs between 2003 and 2012. About $1.1 trillion will be paid by third parties (including employers, state governments, and Medicare+Choice plans) and about $700 billion will be spent out-of-pocket by beneficiaries.

Effects of Prescription Drug Benefit Proposals for Typical Medicare Beneficiaries

- Under the 2002 House Republican bill, CBO's analysis indicates that seniors now paying full retail prices would on average save 20-25 percent on their prescriptions as plans compete to serve them by offering price discounts and other help to lower their drug costs. Seniors would benefit from the efficiencies of private sector management tools and reap the rewards of pooling their purchasing power. In most cases, once seniors meet a modest deductible, they would pay only 20 to 50 percent of these reduced costs – giving them dramatic savings.

    - In the stylized example below, this means that a senior who now pays $100 for each prescription – the full retail price – would generally pay $15-$40 under the House plan, thus saving 60-85%. Her monthly premiums – and the Medicare costs that must be paid by taxpayers – will also be lower due to these competitive savings.

Current Cost per Prescription for Seniors Paying Full Retail Price	**2002 House Republican Bill**		**2002 Senate Democratic (Graham-Daschle) Plan**	
	Full Cost Per Prescription	Typical Co-Pay For Seniors (20-50%)	Full Cost Per Prescription	Typical Co-Pay For Seniors (Brand Name Drugs)
$100	$75-$80	$15-$40	$100	$40-60

- By contrast, under the plan recently announced by several Democratic Senators, drug benefit managers would have little reason to negotiate price discounts for seniors – since they could not pass these savings on to beneficiaries through lower premiums or coinsurance payments. Analysis by CBO suggests that under such a system, the full cost of prescriptions for seniors will *not* be reduced, so beneficiaries and the Medicare program will both end up paying more than is necessary.

    - Specifically, this CBO analysis indicates that the Democratic approach would ultimately result in retail prices that are 15 percent higher for the drugs seniors use most – widely used drugs like Prilosec, Zocor, Lipitor, Norvasc, and Celebrex.

    - This is one reason why the true 10-year cost of the Senate Democrat's plan would be at least $600 billion and possibly much more. Financing the extra costs of that benefit would either hasten Medicare's bankruptcy by a decade or more (if these added costs were funded through Medicare's hospital trust fund) or require massive infusions of general revenues.

    - To reduce the price tag of the Senate Democrat's plan, its sponsors would terminate the drug benefit after 2010 – just when the Baby Boom is starting to enter Medicare. This would not give seniors the reliable drug coverage they need.

- The most recent version of Senate Democrat's plan would replace the 50% coinsurance rate used in previous proposals with co-payments of $40-$60 for brand name drugs. As the table below shows, however, this would generally lead to higher out-of-pocket costs for seniors when they go to purchase the drugs that they use most often.

    - Virtually all seniors will benefit from the 20% coinsurance rate contained in the House Republican bill – which could cut their average costs for these drugs to about $15 per prescription.

    - Even when enrollees have to pay 50% coinsurance, the kind of price discounts that are likely to be available under the House Republican plan mean that their average coinsurance will be the same ($37) as the average co-payments in the Senate Democratic proposal for preferred drugs.

- The examples below are based on publicly available data on drug prices for 2001, but even with some inflation in subsequent years the average senior would pay less out-of-pocket for their drugs under the House Republican plan (even assuming that the price discounts obtained for these drugs are only about 15%).

Comparison of Possible Cost-Sharing for the Drugs Seniors Use Most

Most Popular Drugs for Seniors			House Republican Plan			Senate Democratic Plan	
Spending Rank	**Drug Name**	**2001 Avg. Price ***	**Discounted Price ****	**20% Coins.**	**50% Coins.**	**Co-Pay (preferred)**	**Co-pay (non-pref)**
1	Prilosec	143.68	122.13	24.43	61.06	40.00	60.00
2	Zocor	120.82	102.70	20.54	51.35	40.00	60.00
3	Lipitor	84.96	72.22	14.44	36.11	40.00	60.00
4	Norvasc	58.38	49.62	9.92	24.81	40.00	60.00
5	Celebrex	97.32	82.72	16.54	41.36	40.00	60.00
6	Prevacid	133.20	113.22	22.64	56.61	40.00	60.00
7	Pravachol	104.28	88.64	17.73	44.32	40.00	60.00
8	Atenolol ***	13.79	11.72	2.34	5.86	10.00	10.00
9	Premarin	30.41	25.85	5.17	12.92	40.00	60.00
11 *	Zoloft	83.34	70.84	14.17	35.42	40.00	60.00
	AVERAGE	**87.02**	**73.97**	**14.79**	**36.98**	**37.00**	**55.00**

NOTES: * Price data from "Prescription Drug Expenditures in 2001," National Institute for Health Care Management (www.nihcm.org); data not available for Vasotec, the 10th most used drug among seniors (by total spending). ** Assumes a 15% price discount; discounts could be higher for some drugs. *** Generic drug.

- These examples show how the lower drug costs that will result from the House Republican bill make its benefits go much farther to help seniors get the drugs they need.
  - These savings would add up for seniors. For instance, under the 2002 House Republican bill, a senior who buys $2,000 worth of drugs today would see their total costs reduced to $1,500-$1,600 – of which they would pay $650-$700 out of pocket. Under the Senate Democrat's drug benefit, the same person would have co-payments of approximately $1,000 – thus paying about 50% more out-of-pocket.
  - In fact, most seniors would pay less out-of-pocket for their drugs under the House bill than under the Senate Democrat's plan, even though the House bill includes a modest deductible. And these savings also help keep beneficiary premiums and government costs down under the House Republican plan.
- The outline of a drug benefit just released by House Democrats is even more expensive – $750-800 billion over 10 years, if not more. Financing the extra costs of this benefit could force Medicare into bankruptcy by 2016 (or possibly sooner), if the Medicare Part A Trust Fund were used to cover these added costs (as suggested by proposal to use the Part A "surplus" toward the drug benefit). Or, if it is financed through massive infusions of general revenue only, it will threaten the security of Medicare's existing benefits.

- The additional general revenue needed for this benefit in 2030, when the Baby Boom is fully counting on Medicare, would amount to more than 2% of GDP – which would correspond to a tax of over $2,000 in today's dollars on every working American. Medicare would face this enormous financing burden at the time when its Part A Trust Fund is projected to be insolvent and when its Part B Trust Fund also requires massive support – thus adding to the threat to all of Medicare's promised benefits.

Protection Against High Drug Costs with a Secure Entitlement

- The House proposal also includes generous catastrophic protection for all seniors who have high out-of-pocket drug expenses – targeting help to those who need it most. It thus would help fulfill President Bush's call to renew the commitment that President Johnson made when Medicare was enacted – so that illness will no longer crush and destroy the savings that older Americans have put away over a lifetime.

    - Such catastrophic protection is the most difficult coverage to obtain today, and filling this gap is a very appropriate target for government support. At the same time, it was noted above that third parties like employers and Medigap policies are projected to pay $1.1 trillion toward the costs of seniors' prescriptions over the next decade. The approach contained in the House Republican plan helps limit the extent to which these liabilities are simply shifted to the Federal budget, and instead focuses government help on reducing the $700 billion in out-of-pocket costs that seniors themselves will have to bear over the next 10 years.

- The CBO analysis of the House bill also makes it clear that beneficiaries will have a secure entitlement to the drug benefit, and that virtually all seniors will have a range of options so they can choose the drug plan that provides standard drug coverage or an improved benefit package in a way that best meets their own needs.

    - To ensure that the premium for this benefit remains attractive and affordable for all seniors, the bill provides a 65 percent premium subsidy. This approach would prevent the kind of "adverse selection" problems that have made drug coverage difficult to obtain for many Medicare beneficiaries.

    - It also provides reinsurance subsidies for drug plan sponsors so that they are not penalized for attracting less healthy enrollees even as they retain appropriate incentives to get the best value for their enrollees and the Medicare program.

    - The bill also makes it clear that this is a secure entitlement for beneficiaries and authorizes the program's administrator to take the steps necessary to ensure that all beneficiaries have a choice of plans.

    - When proposals with a similar structure were analyzed the independent Medicare actuaries, they concluded that these drug benefits would be universally available to those in the traditional Medicare program and through Medicare+Choice plans.

Added Help for Lower-Income Seniors

- Seniors with incomes below 175% of poverty would see even more dramatic savings under the House Republican bill. They would generally pay only $2-5 for each prescription. And those with incomes below 150% of poverty would pay no monthly premium, while seniors with incomes between 150% and 175% of poverty would pay reduced monthly premiums.

- This proposal thus helps more of the neediest seniors. Most previous Congressional proposals – from Republicans and Democrats alike – limited assistance with cost-sharing to those with incomes below 135% of poverty and limited premium assistance to those with incomes below 150% of poverty.

- As a result, a widower with income of 140% of poverty (about $13,500 in 2005) would pay no premiums and limited cost-sharing under the House Republican plan, while under previous Congressional proposals he would have faced the same co-payments as wealthier seniors and would get only a partial premium reduction.

- Overall, 44% of Medicare beneficiaries would face no deductible and substantially reduced cost-sharing and would qualify for at least some additional help with their premiums – and 38% of enrollees would not be liable for any premiums at all.

- All this has been done in the context of a benefit that is far more fiscally responsible than other recent proposals – targeting the most assistance to those beneficiaries who need it most while seeking to ensure that all Medicare benefits remain secure in the future for all beneficiaries regardless of their income.

State-by-State Analysis of Help for Lower-Income Seniors and Savings for State Governments

- The House Republican plan recognizes that seniors with the lowest incomes have the greatest difficulty affording the drugs they need. That is why it offers substantial premium subsidies and only nominal co-payments to those beneficiaries with incomes below 175% of poverty.

- Table 1 (attached) shows that about 15 million elderly and disabled Americans with incomes below 150% of poverty would qualify for full assistance with their premiums and cost-sharing – or about 38 percent of all Medicare beneficiaries. In states with a disproportionate number of lower-income seniors, the share helped is even larger.

- Another 2 million seniors with incomes between 150% and 175% of poverty would also get added help with their drug benefit premiums and would get the same assistance with cost-sharing – so they will face no deductible and will generally have co-payments of $2-5. And the number of seniors helped by these provisions will only grow over time as the total number of beneficiaries enrolled in Medicare increases.

- About 4 million of these lower-income seniors lack any drug coverage today, and thus will see the kind of dramatic reductions in their drug costs highlighted above.

- For more than 5 million seniors and disabled citizens who already get drug coverage through Medicaid, the House Republican plan recognizes that they are Medicare beneficiaries first and poor second – and thus gradually lifts the burden on states of providing this additional help to lower the drug costs for Medicare beneficiaries who are on Medicaid. The resulting savings for states are projected to total $40 billion over 10 years; the last column of Table 1 provides an estimate of how these savings would accrue to each state over the next 10 years.

- In addition, states with their own drug assistance programs for seniors who do not qualify for Medicaid – including Pennsylvania, New York, New Jersey, Connecticut and Massachusetts with larger programs – would see their costs reduced substantially. The same would be true for states like Illinois that have recently received waivers from HHS to use existing funds to expand drug coverage for Medicare beneficiaries with incomes up to 200 percent of poverty.

Illustrative Beneficiary Scenarios

- These savings under the House Republican plan will really add up for seniors who now lack drug coverage, as indicated in the following hypothetical but true-to-life examples:

    - Mary Jones spends about $100 a month on medications to control her blood pressure and cholesterol. Because she has no drug coverage, she pays full retail prices for these drugs. Under the House Republican bill her spending on drugs would fall by 67-68 percent – from $1,200 a year to $392-$380 per year. Even adding in her monthly premium costs, her total drug-related expenditures would be cut by about a third to $800-$812 per year.

    - Mary's sister Beth has the same health problems but paying for her prescriptions is even more difficult because she and her husband live on a fixed income of $18,500 per year. Under the House Republican plan they qualify for full coverage of their monthly drug premiums and would generally have co-payments of only $2-5 per prescription – so her drug spending could fall to under $100 per year.

    - Bob Smith spends about $200 a month on drugs to treat not only his cholesterol and diabetes, but also to treat an early form of prostate cancer and to avoid kidney problems from diabetes. Under the bill his out-of-pocket spending on drugs would drop from $2,400 per year to $800-$860 – about a two-thirds reduction. Even with his premium payments factored in, his total costs for drugs would fall by almost half.

    - John Brown has even higher drug costs – $400 per month. Under the House bill, his out-of-pocket costs would fall to from $4,800 to $2,500-$2,740 per year, even though his drug spending would exceed the bill's initial coverage limit.

- Because the House bill makes their drugs more affordable, some beneficiaries may be able to use some of their savings to purchase additional drugs that they need but were previously unable to afford. This could mean somewhat lower reductions in total drug spending – because seniors are getting more and better drug coverage.

Other Key Provisions of the House Republican Plan

- The discussion above focuses on the savings that seniors will obtain once the full Medicare drug benefit is available. But the bill would generate other benefits as well and would not make seniors wait until 2005 to begin getting help with their drug costs.

- Beneficiaries will also see substantial health gains under the House plan. Not only will they gain more affordable access to the medicines they need, but the legislation also ensures the use of electronic prescribing – which should sharply reduce the substantial number of prescribing errors that occur each year. In addition, beneficiaries' health will be protected – and unnecessary health costs avoided – though disease management programs and the use of automated systems to identify and thus prevent potentially adverse drug interactions.

    - The Institute of Medicine has estimated that as many as 98,000 Americans may die each year due to medical errors, with most of these deaths attributable to medication errors. A recent article estimated that, for the country as a whole, the direct costs of preventable drug-related mortality and morbidity exceed $175 billion per year, with drug related hospital admissions accounting for the majority of these costs.

- Finally, under the House Republican plan, seniors would also benefit immediately from discounts of 15 percent or more on their drug purchases through a Medicare-endorsed discount card program – so they will not have to wait until 2005 before they get any help with their drug costs.

TABLE 1

Estimated Number of Beneficiaries in Each State Eligible for Reduced Premiums and Cost-Sharing Under House Republican Medicare Bill (and Resulting State Medicaid Savings)

State	Number of Medicare Beneficiaries (000s)	Number Below 150% of Poverty (000s)	Share Below 150% of Poverty	Number Below 175% of Poverty (000s)	Share Below 175% of Poverty	State Medicaid Savings 2005-12 ($Millions)
United States	*38,286*	*14,627*	*38%*	*16,746*	*44%*	*40,459*
Alabama	677	332	49%	376	56%	448
Alaska	40	13	33%	14	35%	66
Arizona	658	192	29%	237	36%	727
Arkansas	436	208	48%	239	55%	299
California	3,837	1,516	40%	1,664	43%	5,104
Colorado	458	129	28%	158	34%	366
Connecticut	512	181	35%	210	41%	729
Delaware	110	31	28%	43	39%	77
DC	76	33	43%	37	49%	60
Florida	2,771	1,019	37%	1,168	42%	3,198
Georgia	898	370	41%	410	46%	856
Hawaii	162	56	35%	58	36%	121
Idaho	161	52	32%	63	39%	86
Illinois	1,629	459	28%	549	34%	1,902
Indiana	845	289	34%	335	40%	82
Iowa	476	149	31%	174	37%	337
Kansas	389	124	32%	138	35%	330
Kentucky	615	267	43%	306	50%	549
Louisiana	597	289	48%	311	52%	686
Maine	213	75	35%	84	39%	235
Maryland	635	279	44%	301	47%	572
Massachusetts	954	310	32%	367	38%	1,592
Michigan	1,389	462	33%	538	39%	1,176
Minnesota	648	252	39%	261	40%	586
Mississippi	414	229	55%	254	61%	419

(continued)

TABLE 1
(continued)

State	Number of Medicare Beneficiaries (000s)	Number Below 150% of Poverty (000s)	Share Below 150% of Poverty	Number Below 175% of Poverty (000s)	Share Below 175% of Poverty	State Medicaid Savings 2005-12 ($Millions)
Missouri	854	278	33%	314	37%	1,064
Montana	135	42	31%	50	37%	71
Nebraska	252	90	36%	99	39%	243
Nevada	229	90	39%	107	47%	96
New Hampshire	167	54	32%	63	38%	188
New Jersey	1,195	445	37%	517	43%	1,511
New Mexico	229	139	61%	146	64%	87
New York	2,694	1,215	45%	1,372	51%	4,496
North Carolina	1,111	526	47%	573	52%	1,171
North Dakota	103	51	50%	60	58%	62
Ohio	1,692	544	32%	649	38%	1,834
Oklahoma	504	208	41%	247	49%	76
Oregon	484	143	30%	169	35%	1,250
Pennsylvania	2,088	668	32%	819	39%	1,436
Rhode Island	170	74	44%	84	49%	215
South Carolina	555	257	46%	303	55%	395
South Dakota	119	38	32%	45	38%	78
Tennessee	815	326	40%	368	45%	565
Texas	2,223	1,070	48%	1,227	55%	1,994
Utah	201	53	26%	72	36%	91
Vermont	88	37	42%	41	47%	124
Virginia	876	343	39%	398	45%	983
Washington	725	254	35%	291	40%	797
West Virginia	336	148	44%	169	50%	162
Wisconsin	777	194	25%	239	31%	830
Wyoming	64	24	38%	29	45%	38

NOTES: Beneficiary counts based on 1999 data from the Medicare Current Beneficiary Survey, Current Population Survey, and administrative records. State Medicaid savings estimates based on CBO scoring of Medicaid effects and administrative data on state drug spending for dually eligible beneficiaries; for several states with missing or incomplete data, figures were imputed. Actual savings may vary depending on the distribution of drug spending in each state and other factors.