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Prescription Drugs Minimum Wage Departure Statement 3/9/00 [2]

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DRAFT MEDICARE PRESCRIPTION DRUG PRINCIPLES

We are committed to passing a meaningful prescription drug benefit this year. This benefit should be:

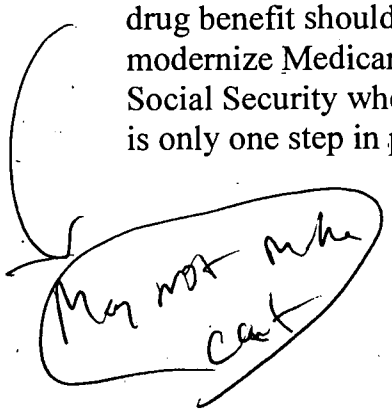
- **Voluntary and provide incentives for private retiree health options:** Medicare beneficiaries who now have dependable, affordable coverage should have the option of keeping that coverage. In fact, any proposal should provide financial incentives for employers to retain and expand retiree health coverage.

- **Accessible to all beneficiaries through a range of options, including traditional Medicare**: A hallmark of Medicare is that all beneficiaries, even those in rural or underserved communities, have access to dependable health care. The same should hold true of the prescription drug benefit: all seniors, regardless of plan choice, should be assured that they have a reliable, accessible benefit for the premium that they pay.

- **Affordable to all beneficiaries and the program**: Medicare should contribute enough towards the prescription drug premium to make it affordable and attractive for all beneficiaries but not so much to make it unaffordable to taxpayers. While subsidies should be provided to all beneficiaries to assure affordability and avoid adverse selection, low-income beneficiaries should receive extra help with prescription drug premiums and cost sharing.

- **Competitively administered, using best private market purchasing techniques**: The management of the prescription drug benefit should mirror the practices employed by private insurers in delivering prescription drugs. Discounts should be achieved through competition, not through regulation or price controls. For competition to work best, it should include a minimum defined benefit that assures access to all medically necessary drugs and uses cutting edge quality improvement tools. Private organizations should negotiate prices with drug manufacturers and handle the day to day administrative responsibilities of the benefit.

- **Considered in the context of broader reform:** The addition of a Medicare drug benefit should be considered as part of an overall plan to strengthen and modernize Medicare. Medicare will face the same demographic strain as Social Security when the baby boom generation retires. Improving its benefits is only one step in preparing Medicare for this new century's challenges.



THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 29, 2000

PRESIDENT CLINTON RELEASES NEW STATE-BY-STATE REPORT DEMONSTRATING URGENT NEED FOR MEDICARE REFORM
February 29, 2000

President Clinton today will release a new report, called America's Seniors and Medicare: Challenges for Today and Tomorrow, providing a state-by-state snapshot of the unprecedented demographic and health care challenges confronting Medicare. It documents the success of the current program and provides new information about its impact on women, Americans over the age of 85, and rural beneficiaries. With this report in hand, the President will urge Congress to move ahead this year to modernize and strengthen Medicare and include in its reforms a long overdue voluntary prescription drug benefit. Among the findings of today's report:

MEDICARE HAS BEEN AN IMPORTANT ANTI-POVERTY PROGRAM FOR MILLIONS OF AMERICANS. Poverty among the elderly has been reduced by nearly two-thirds since Medicare was created. Medicare has contributed to this dramatic improvement by helping seniors pay for the potentially devastating cost of care when they can least afford it.

MEDICARE PROVIDES CRITICAL HEALTH CARE TO 38 MILLION AMERICANS. Over thirty-three million seniors and almost 5 million people with disabilities rely on Medicare. About 11 percent, or 4 million, of Medicare beneficiaries are over the age of 85, and 24 percent, or 9.1 million of them live in rural areas.

- Women beneficiaries outnumber men in all states. Over 57 percent of these Americans -- about 22 million -- are women. This distribution of women to men is consistent across all states, ranging from 51 to 59 percent.

- 10 percent of beneficiaries in 40 states are age 85 or older. These 4 million beneficiaries over 85 have spent almost a quarter of their lives on Medicare. States in the upper Midwest, including North and South Dakota, Minnesota, Nebraska, Kansas, and Iowa, have the highest proportion of seniors over the age of 85.

- In 15 states, more than half of Medicare beneficiaries live in rural areas. In fact, in Mississippi, Montana, North and South Dakota, Vermont and Wyoming, over two-thirds of beneficiaries live in rural areas. The 9 million beneficiaries nationwide living in rural America typically have few to no options for managed care or prescription drug coverage.

MEDICARE PROGRAM ENROLLMENT WILL SURGE, INCREASING THE PRESSURE TO REFORM. About 62 million Americans will be age 65 or older in 2025, compared to 35 million today.

The Medicare Program Continues to Face Demographic Challenges

- In 2025, there will be 30 states with an elderly population that is at least 20 percent of the total population -- compared to no states today. In Florida, where 18 percent of state residents are elderly today, about 5.5 million people -- over 25 percent of residents -- will be elderly in 2025 as the baby boom generation retires. Nationwide, this demographic increase is over 75 percent from 2000 to 2025, and is over 100 percent in 15 states.

- Many older Americans are uninsured or have undependable health insurance. There are 6 million people nationwide age 55 to 65 who have no or undependable health insurance. In eight states, these individuals are more than one third of the population age 55 to 65. They are the fastest growing group of uninsured -- and are at great risk of becoming sick. As the baby boom generation turns 55, there will be an even greater access problem.

Medicare Beneficiaries Need a Prescription Drug Benefit

- Retiree health coverage is declining. Sixteen states have 20 percent or fewer firms offering health insurance to retirees. Nationally, 22 percent of firms offer health insurance to retirees older than age 65. No state has more than 30 percent of firms offering coverage. This will be lower in the future, as 25 percent fewer firms offered retiree health coverage in 1998 than 1994, so that very few seniors will get prescription drug coverage through former employers.

- Individual Medigap insurance with prescription drug coverage costs twice as much in high-cost states. The average premium for a 65-year old for Medigap Plan H that includes drug coverage among other benefits is about $135 but exceeds $150 per month in 9 states. The part of the premium that is attributable to drugs alone can be $90 per month or $1,080 per year -- for coverage that is limited to $1,250 per year with a $250 deductible. Moreover, in most states, insurers "age rate" or increase premiums as people get older, making insurance more expensive when seniors can least afford to pay for it.

- Most seniors are middle income and would not benefit from a low-income prescription drug benefit. About 15.6 million or half (49 percent) of all elderly have incomes between $15,000 and $50,000. Only in the District of Columbia, Louisiana, Mississippi, New Mexico, Rhode Island, South Carolina, and Texas are there more low income than middle class seniors. Nationwide, over half of beneficiaries without drug coverage have incomes above 150 percent of poverty ($12,750 for a single, $15,000 for a couple). Thus, a prescription drug benefit targeted to low-income beneficiaries will not help most seniors.

Health Care Providers Depend on Medicare

- Health care providers depend on over $200 billion a year in Medicare spending, accounting for one-fifth of all funding. This does not even count beneficiary payments which comprise nearly half of their total health spending. Medicare spending exceeds 20 percent of all health spending in 12 states. Nationwide, over 5,100 hospitals, 800,000 physicians and nearly 15,000 nursing homes care for Medicare beneficiaries.

THE NEED IS CLEAR FOR THE PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE. The President's FY 2001 budget dedicates $432 billion over 10 years -- the equivalent of over half of the non-Social Security surplus -- to Medicare. This plan makes Medicare more fiscally sound, competitive and efficient, and modernizes the program's benefits by including a long-overdue prescription drug benefit.

- Making Medicare more competitive and efficient. Since taking office, President Clinton has worked to reduce Medicare growth and fraud and extend the life of the Medicare Trust Fund from 1999 to 2015. He has proposed to build on these efforts and save $71 billion over 10 years by: 1) expanding anti-fraud policies; 2) making Medicare more competitive, efficient and high quality; and 3) constraining out-year program growth.

- Dedicating $299 billion over 10 years to Trust Fund solvency. It is impossible to pay for a doubling in Medicare enrollment through

provider savings or premium increases alone. To address the future financing shortfall, the budget dedicates $299 billion of the non-Social Security surplus to Medicare, helping extend the Trust Fund through 2025, and reducing publicly held debt by preventing funds from being used for tax cuts or new spending.

- Modernizing Medicare's benefits. Unlike virtually all private health plans, Medicare does not cover prescription drugs, and over three in five beneficiaries lack dependable prescription drug coverage. The President's plan:

- Establishes a new voluntary Medicare prescription drug benefit that is affordable to all beneficiaries and the program. The drug benefit, which costs $160 billion over 10 years, would be accessible and voluntary, affordable for beneficiaries, and competitively and efficiently administered. It would also provide high-quality, necessary medications.

- Creates a Medicare reserve fund to add protections for catastrophic drug costs. To build on the President's prescription drug benefit, the budget also includes a reserve fund of $35 billion for 2006-2010, to design protections for beneficiaries with extremely high drug spending. The Administration plans to work with Congress to design this enhanced prescription drug benefit. Absent consensus, the reserve will be used for debt reduction.

- Improves preventive benefits in Medicare. This proposal would: eliminate the existing deductible and copayments for preventive services, such as colorectal cancer screening, bone mass measurements, and mammographies.

- Creates health insurance options for people ages 55 to 65. The plan would allow people age 62 through 65 and displaced workers age 55 to 65 to buy into Medicare. It would require employers who drop previously promised retiree coverage to give early retirees with limited alternatives access to COBRA coverage until they are 65 and can qualify for Medicare. To make this policy more affordable, the President proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in and a similar credit for COBRA.

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THE WHITE HOUSE

Office of the Press Secretary
(Chicago, Illinois)

For Immediate Release June 30, 1999

REMARKS BY THE PRESIDENT ON MODERNIZING MEDICARE

Chicago Cultural Center
Chicago, Illinois

11:15 A.M. CDT

THE PRESIDENT: Thank you very much, ladies and gentlemen, and good morning. I want to say that it's wonderful for me to be back in Chicago. Most of you know how much I love it here, and I am delighted to be here. I bring you greetings from the First Lady who I left on my way here and who was jealous that I was coming and she wasn't, especially since I'm also going to see the Cubs play this afternoon. And I enjoy that. And from the Vice President and all the members of our administration who have worked so hard on this health care issue.

I want to thank Anne Willis for her remarks and her leadership for the aging community here in Chicago. And I know that with me on the stage, and perhaps out in the audience as well, are members of the Mayor's Advisory Council on Aging, the Cook County Board of Commissioners, the Cook County Council, the Chicago City Council -- I thank them all for being here.

I'd like to thank Linda Esposito for speaking on behalf of pharmacists who have to live with the consequences of the absence of prescription drug coverage for our seniors every day and who do their best to serve them well under very adverse circumstances. And I thought she did a very fine job -- I thank her for being here.

And I want to thank Hanna Bratman for having the courage to get up here and tell her story and introduce me. You know, I do this all the time. It's second nature for me. But most people, it's pretty scary to get up in front of all of you and all those cameras and talk about your life and talk about

your circumstances. And I thought she did a fine job, and I thank her for doing that.

I'd also like to thank these ladies on my left, Anne Thomas and her daughters, Lee Hamilton and Laura Peterson, because they represent what I think of as the ultimate test of Medicare, which is whether it's fair and helpful and supportive of families and our intergenerational responsibilities -- parents to their parents to their children. And I'll say more about that, but thank you for joining us today as well.

Ladies and gentlemen, as is so often the case when I get up to speak, the people who spoke before me have said everything that needs to be said. One guy got up -- you know the great story about the last speaker at a long dinner; eight people spoke and he got to speak at 10:00 p.m.; and he said, well, everything that needs to be said has been said, but not everyone has said it. So, relax, I'm going to talk a little bit.

Let me say to all of you that we have an unprecedented opportunity and an unprecedented responsibility to strengthen Medicare and to improve it, to modernize it, so that no one has to make the choice that you have heard talked about, between affording health care and affording other necessities of life; between remaining independent, or relying on your children and undermining their ability to raise your grandchildren.

We have this opportunity because our economy is the strongest in a generation, perhaps ever, because our country is clearly moving in the right direction, a leading force for freedom and peace and human rights around the world, as our wonderful men and women in uniform demonstrated in Kosovo recently. Our social fabric here is mending -- the crime rate is down; the welfare rolls have been cut in half; teen pregnancy is down; drug abuse among our young people is down; and a record 90 percent of our young people are immunized against serious childhood diseases for the first time in the history of our country.

Our cities, which were once thought of as being economically depressed, are thriving again. Chicago is exhibit A -- look at this beautiful building and this beautiful vista we have here.

When I became President, we had a $290 billion budget deficit. The debt of our nation had quadrupled in only 12 years. Today, we are going to be, in 1999, $99 billion in the black. We actually projected yesterday that for the next 15 years, the surplus will be $1 trillion more than we thought it was just six months ago.

Now, this is a great tribute to the ingenuity and the hard work of the American people, and to the disciplined decisions that we have made, starting in 1993, to cut that deficit until we balanced the budget and got into surplus. If we keep going on the plan I have proposed to save Social Security and Medicare and pay down the debt, this country actually can be out of debt -- out of debt -- in 15 years for the first time since 1835.

Now, let me just say, since all of you know it's the strength of the economy that has put people to work and raised their incomes and brought in the revenues that enabled us to save Medicare, the reason it's a good thing for all Americans for us to be out of debt is that if we're out of debt, it means that the government won't be competing with you and the businesspeople to borrow money. It means interest rates will be lower -- for business loans, for car loans, for home loans, for credit cards, for college loans.

It means, therefore, there will be more investment, more jobs, higher incomes. It means we will be less dependent on the world for money to come into this country, so if there is another financial problem, as there was in Asia a couple of years ago, it will have less impact on us. It means people all over the world that we look to to buy products that are produced in Illinois and

throughout the United States will be able to borrow money more cheaply and have more money to buy our products, to help our prosperity as we help theirs, if we get this country out of debt.

So I want to emphasize to you, everything I am proposing to do with Medicare and with Social Security can be done in a way that gets the country out of debt for the first time since 1835. And in a global economy, it is very, very important to our children and our grandchildren that we give them the opportunities they deserve.

Now, how are we going to do that? We have to set aside the bulk, a little more than three-quarters of the surplus, for saving Social Security and Medicare. We need to do that, quite apart from this prescription drug benefit -- let's talk about that. Why do we need to do that? Because we have a high-class problem in America: we're all living longer. Life expectancy is already over 76 in America. For young people growing up, their life expectancy will probably be over 80. Anybody who lives to be 65 in America today has a life expectancy of 85. People over 80 are the fastest-growing group of Americans.

Now, when you put that life expectancy development up next to the fact that the baby boom generation, the biggest generation in American history until the present one in our schools today, is getting ready to retire -- some of them, anyway. I'm the oldest of the baby boomers and I hope I don't have to retire. But, anyway, I'm going to retire from this job, but, generally, I think I should keep working.

But when you look at the fact that with the baby boomers retiring, the oldest of the baby boomers -- that's me, we turn 65 in 2011, not that far away -- there are going to be a lot more people retired relative to the number of people working, which means there will be a lot more people drawing Social Security and a lot more people drawing Medicare relative to the number of people working.

Now, we can make some changes in the program, but I would argue that now that we have this surplus and we project this surplus to last into the future, and if we know it's good for us anyway, for all Americans of all ages, to pay the debt down, we should save this much money now to stabilize Social Security and Medicare and pay the debt off.

Now, I know there are a thousand good uses for this surplus. If I gave each of you a piece of paper and I said name 10 things that you would like to see your country do, we might have 100 different things on that list, and they'd all be good. But I say we should take care of first things first, and we don't have any more important obligation -- not only to seniors, but to their children and their grandchildren -- than to preserve the integrity of Social Security and Medicare, and preserve the long-term economic health of this country. So I hope that all of you will support that.

We can talk more about Social Security later, but if my proposal is accepted, we'll have Social Security solid for way more than 50 years already, and with a few other changes, we could take it out to 75 years; we could do something to deal with the fact that elderly women on Social Security are far more likely to be poor, and they need some extra help; and we could lift the earnings limitation for people on Social Security. I would like to see those things done.

But let's talk about Medicare. We should secure and strengthen and modernize Medicare. It's been around for 34 years now. It's made health care more accessible and more affordable. As you heard Hanna say, it's given millions of American families peace of mind by paying for medical costs that otherwise would have bankrupted families in their later years. It has also freed the children of Medicare's recipients from the painful choice of mortgaging their children's future to provide a decent health care for their parents.

But you've got people living longer and the baby boomers set to retire; therefore, more people drawing Medicare and fewer people paying in. What that means is that the trust fund will become insolvent by the year 2015, 15 years from now.

Now, we've already done a lot to try to stave that off. When I became President in 1993, the trust fund was supposed to become insolvent in 1999 -- this year. We've made a lot of changes. Some of them were difficult and somewhat unpopular, but we have saved Medicare

until 2015.

But that's not enough. Keep in mind, the baby boom generation won't begin to turn 65 until 2011. Then, over the next 30 years, the number of people who are 65 or over will actually double. So we need to lengthen the life of the Medicare trust fund, and we need to do it now. The sooner you deal with these issues, the easier it is to deal with them. The longer we take to deal with them, the more painful and the more expensive it will be to deal with it.

The plan I announced yesterday to secure and modernize Medicare for the 21st century does the following things. First of all, it extends the solvency of the present Medicare program to the year 2027. That is very important. Changes made today can keep it alive until 2027. That will almost completely take in the baby boom generation. Not quite, but nearly. And that gives all of our successors plenty of time to take advantage of all the increases in health care options that I'm convinced will allow people to stay healthier even longer in the years ahead.

To do it, I propose that we use 15 percent of the budget surplus over the next 15 years. Again I say, there are a lot of good uses for the surplus. A lot of people would like to have more money right now. But there is nothing more important than taking care of first things first. Keeping the economy strong by paying the debt off, and saving Medicare and Social Security, I think are the most important things we can do, and we should do them first.

Now, we also plan to modernize the way the program works, to introduce more innovations now used in private sector health plans: To offer seniors the chance to choose between lower cost managed care plans for Medicare and the traditional program without forcing the choice by having unreasonable increases in the premiums in the traditional program. To guarantee that our seniors have the information necessary to make informed choices and that all the available plans have certain core medical benefits necessary to preserve the integrity of the program. To make sure that as we hold costs down, we keep quality up.

But we also, as everybody before me has said, need to modernize Medicare. One of the ways, but not the only way, is with prescription drugs. Think of it this way: Medicine has changed a lot. The whole health care system has changed a great deal since 1965. But Medicare hasn't changed with it. As a consequence, the average senior citizen today is paying a larger percent of his or her income out of pocket for health care than they were paying in 1965 -- before Medicare came in -- primarily because of the prescription drug issue.

But think of the other challenges. A revolution in medical science has brought cures to diseases once thought incurable, provided doctors the tools to prevent diseases from starting in the first place, and given millions of people the chance to live not only longer, but healthier lives.

Once, the cure for many illnesses was a surgeon's scalpel. Now it's just likely to be a pharmacist's prescription drug. Every day new drug therapies are being developed to treat chronic conditions such as diabetes and hypertension. We have to do more to make sure all seniors can take advantage of this medical revolution.

We also have to do more to encourage seniors to take advantage of preventive technologies -- to take advantage of screenings for cancer, for diabetes, for osteoporosis and other diseases. To do that, my plan will eliminate the deductible and all co-payments for these preventive tests.

Just think of it this way: Under Medicare today, very often you can't get Medicare to pay for screening and prevention, but you can get Medicare to pay for the far more expensive hospitalization that would not have occurred in the first place if the screening and prevention had been done. So this will actually save us money in the long run, as well as making people healthier.

We also do have to make prescription drugs more available and more affordable. They are essential to medical care. Just a few statistics: More than four out of five seniors use at least one prescription a year. Now, for most seniors, it's much more than that. And for many seniors, the proper regimen of pills, properly taken, at home, can spell the difference between maintaining and active and independent life, or being hospital- or nursing home- or home-bound for life.

If we were creating the Medicare program today, if we were starting from scratch and it didn't exist, no one would even consider having a program without a prescription drug benefit for the elderly and the disabled.

So what are we going to do? You heard Hanna talk about the cost of her drugs. This is a costly issue. A month's supply of a popular blood pressure medicine costs more than $70 a month. A cholesterol medication probably taken by some of you in this room costs about $100 a month. When you consider that some of the newest drugs costs as much as $15 a pill, that two-thirds -- listen to this -- two-thirds of all people over 65 suffer from two or more chronic diseases, that one in five elderly people takes at least five prescription medications a day, the pharmacy bills can be staggering.

Each year, more than 2 million seniors spend more than $1,000 on medication -- people such as our friend, Anne Thomas, here to my left, whom I mentioned earlier, with her daughters. She's from Oak Brook. Her osteoporosis prescriptions swallow up a sixth of her income, almost 17 percent. Last year, she, too, was diagnosed with asthma, but she chose not to fill her prescription because the $300-a-month price tag was more than she could afford.

Finding the funds to pay for prescription drugs is a struggle for seniors at many income levels, not just the poor. Indeed, of the 15 million seniors in our country that don't have any prescription drug coverage, nearly half are middle-class Americans. And that does not count the millions of seniors who have some prescription coverage, but the coverage is totally inadequate or far too expensive.

The number of plans that offer coverage is declining, and those that charge high prices and offer modest benefits are increasing. Forty percent of all older Americans without prescription drugs -- let me say that again -- 40 percent are middle class. Nearly half the uninsured live in isolated rural areas. And as I said, as drug prices rise and more private insurers drop drug coverage altogether, about 15 million of our seniors will be uninsured within the year.

This is not the way to honor people after a lifetime of work and good citizenship. No American should have to choose between fighting infections and fighting hunger, between skipping doses and skipping meals, between staying healthy and paying the rent. We can do better than that. We are now prosperous enough to do better than that.

And I say again, there are many good uses for the surplus. I have my ideas, the Congress has their ideas. But first things first -- we have to take of this problem, and do it now.

Now, we want to make sure that this plan is financially responsible, that it can be paid for, that it won't break the bank. Here's what we propose to do. My plan will make a prescription drug benefit available to all Medicare recipients, but will provide extra help for those with lower incomes. For people up to 135 percent of the poverty rate, we will waive the co-pay and the monthly premium. But people with incomes a little higher than that, we will have other subsidies, not quite as generous.

But for everyone, for a modest monthly premium, Medicare will pay for half of all the prescription drug costs, over the next few years, up to a ceiling of $5,000. In the first year, we have to start with a ceiling of $2,000, because it's a big program and we've got to put it in and prove we can make it work. But under my plan, I will ask the Congress to approve and fund going to a $5,000 ceiling drug benefit, half of all the costs. Now -- with no deductible.

This drug benefit is one that virtually all of our seniors can afford, and it is constructed in a way America can afford. It will help millions and millions of people. Older and disabled Americans will save even more on prescription drugs under our plan because Medicare's private contractors will get big volume discounts that seniors could never get on their own. So when they pay for half the price, that half will be a much smaller amount than would otherwise be the case.

Now, what I would like to say not only to those of you in this room, where I suppose I'm preaching to the saved, as we say down home, but to all Americans, including those who are not in this room, is that this is something that is important that goes way beyond health care and way beyond money. How can you put a price on being able to see the birth of a grandchild, or to enjoy them as they grow up, or read to them, or take them fishing, or be active with your friends and family? How can you put a price if you are a child on being able to know and spend time with and enjoy your grandparents?

There is no dollar value we can put on providing the best quality of life we can. And I want you all to understand, we can afford this. If this is not done it is because somebody made a different decision to do something else with the money. This is not welfare. This is not some blind gift. This is something we are doing for the integrity of families through the generations.

Our country is in the best shape it's been economically, maybe ever, certainly in a long time. And what we're going to do now will define what kind of country we will be well into the 21st century. Are we going to squander this money we worked so hard for after only six years of effort, turned around an unbelievable record of fiscal irresponsibility, or are we going to pay off our debts in the bank and pay off our debts to our families -- not only to our parents and grandparents, but to future generations. That is the question.

So I want to ask you to join me. You know, Hanna said she didn't know much about politics -- I thought she made a pretty good political speech, myself. But she said something that's really important. She said, you know, I don't understand why this should be a political issue. You know, sometimes when things get real tense in Washington, you know, and some of my friends in the other party get real excited, I say, hey, loosen up, you know. We're all getting older, none of us are going to be here forever. People get a chance to vote every election. Loosen up. Relax. No one escapes time and age. Republicans age just like Democrats.

People who are independents still get sick every now and then, even though they refuse to register in a political party. This is not a political issue -- anywhere in America -- and it should not be a political issue in Washington, D.C. This is something we can do together for the future of America.

I want you to reach out to your representatives from Illinois. You are represented in this state by both Republicans and Democrats in the United States Congress, more or less fairly apportioned. I wish it were different, but there it is. You can write to them. You can call them. You can say, do this not only for us, but do it for our children and our

future. Do it because we're all aging, and it's a high-class problem, that we're living longer.

But we have to prepare for the day when the baby boomers retire. And we should not wait another day to provide the prescription drug benefit. And we have the money to do it. This is simply a matter of choice. I ask you, without regard to your party, to reach out to the members of your congressional delegation and say, this is the right choice for our future.

Thank you very much.

END 11:43 A.M. CDT

Prescription Drug Coverage for Medicare Beneficiaries
A Side-by-Side Comparison of Selected Proposals

(Proposed as of February 15, 2000)

Prepared by Health Policy Alternatives, Inc.
for
The Henry J. Kaiser Family Foundation

March 2000

This report was commissioned by the Henry J. Kaiser Family Foundation (contract #99-1397D).

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MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — SUMMARY TABLE

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
General approach	Universal entitlement to a subsidy for drug coverage provided through Medicare plans, with enhanced subsidies for low-income. Effective January 1, 2003.	Universal entitlement to drug coverage under new Medicare Part D, administered through private entities with enhanced subsidies for low-income. Effective January 1, 2003.	Universal entitlement to drug coverage under Medicare Part B, administered through private entities, with enhanced subsidies for low-income. Effective July 1, 2000.	Universal entitlement to premium subsidies for beneficiaries who purchase drug insurance, with enhanced premium subsidies for low- income ("SPICE" program). Effective January 1, 2000.	Provides matching funds to states for drug coverage for low-income beneficiaries, and establishes new federal reinsurance program to provide enrollees in qualified private plans with stop-loss protection for drug expenses.
PARTICIPATION					
Participation/enrollment	Voluntary. Enrollment process overseen by Medicare Board.	Voluntary. Enrollment process same in manner and timing as Part B.	Voluntary (is part of Part B).	Voluntary. Enrollment overseen by SPICE Board.	Voluntary. State program is voluntary for states and for beneficiaries; enrollment done by states. Stop-loss protection is administered through qualified private plans that provide the up front coverage.
PREMIUMS AND SUBSIDIES					
Beneficiary premiums/ government subsidies	No Part B premium. Government pays 88% of national weighted average premium (NWAP) for core benefits plus 25% of actuarial value of drug benefit. Drug subsidy is taxable as income.	Enrollees pay Part D premium; subsidized 50% by government.	Enrollees pay Part B premium; subsidized 75% by government.	Enrollees pay 75% of SPICE plan premiums; 25% government subsidy.	No beneficiary premiums for either state programs or stop-loss component of private coverage. State programs are subsidized by federal and state dollars. 100% federal subsidy for stop-loss protection.
Government subsidies - Low-income population	For incomes to 135% of poverty, government pays 100% of lowest cost plan with drugs. Sliding scale subsidy of 25 to 50% of actuarial value of drug benefit for incomes between 135-150% of poverty.	100% subsidy for drug premium and cost-sharing for those with incomes to 135% of poverty. Partial drug premium subsidy for those with incomes to 150% of poverty.	100% subsidy for Medicaid "wraparound" coverage (drug premium, cost-sharing, other drugs) for incomes to 135% of poverty.	100% premium subsidy for those with incomes to 150% of poverty. Partial premium subsidy (in addition to the 25% general subsidy) for those with incomes to 175% of poverty.	100% subsidy for low-income up to 200% of poverty in state programs; 100% subsidy for stop-loss for all beneficiaries with qualified private coverage, including the low income.
Financing of low-income subsidies	Existing federal/state match rates apply to Medicaid drug subsidies for cost-sharing assistance for drugs for the fully dual eligible. Otherwise 100% federal.	Existing federal/state Medicaid match rates apply to drug subsidies (premiums and cost-sharing) for those under 100% of poverty, otherwise drug subsidies are 100% federally financed.	Existing federal/state Medicaid match rates apply.	100% federal.	SCHIP match rate for state program for those with incomes below 150% of poverty; Medicaid match rate for those between 150-200% of poverty. Stop-loss is 100% federal.
Collection of premiums and distribution of subsidies	Same as current law for Medicare Part B and QMB/SLMB programs.	Same as for Medicare Part B and for QMB/SLMB programs. New process for group retiree plan subsidies.	Same as for Medicare Part B and for QMB/SLMB programs. New process for group retiree plan subsidies.	Responsibility of SPICE Board.	State program operates like SCHIP. Subsidies for stop-loss provided through contracts with qualified private plans.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — SUMMARY TABLE

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
DRUG BENEFITS					
Standard or variable benefit package	Variable, subject to actuarial value requirement.	Standard.	Standard.	Variable, subject to minimum set by NAIC with SPICE Board approval.	Variable; defined by states subject to federal minimum standards. Stop-loss benefits vary subject to underlying private coverage.
Annual drug deductible	Variable, subject to actuarial value requirement.	None.	$200.	Variable, subject to SPICE Board's minimum package requirements.	None in state programs. Not to exceed $500 (indexed) in private plans underlying stop-loss.
Coinsurance/copayment	Variable, subject to actuarial value requirement.	50%.	Up to 20%.	Variable, subject to SPICE Board's minimum package requirements.	None in state programs for those up to 120% of poverty, not to exceed $5 or 20% for those up to 200% of poverty. Not to exceed 50% in plans underlying stop-loss.
Annual benefit limits or cap	Variable, subject to actuarial value requirement.	$2,000 in 2003, phased-up to $5,000 in 2009, including cost-sharing (indexed after 2009).	Medicare would pay up to $1,700 in drug costs, including cost-sharing, (annually indexed).	Variable, subject to SPICE Board's minimum package requirements.	No durational limits lower than Medicaid in state programs. No limits for stop-loss coverage.
Stop-loss (coverage of drug expenditures over a specified annual threshold)	Drug coverage not included in the stop-loss requirement. May be offered by a plan as part of the drug benefit.	Sets aside $35 billion reserve fund to provide an unspecified benefit for catastrophic drug expenses for years 2006-2010.	Medicare pays 100% of covered drug costs after annual out-of-pocket drug spending reaches $3,000 (indexed).	Variable, subject to SPICE Board's minimum package requirements.	State programs must have $1,500 stop-loss threshold for those subject to coinsurance. Federal stop-loss protection applies once out-of-pocket drug costs reach $1,500 in underlying private plans.
ACCESS TO DRUGS					
Covered drugs	To be defined by plan sponsors. Does not mandate types of drugs that must be covered.	All therapeutic classes of drugs and biologics (with exceptions comparable to those in Medicaid).	FDA-approved prescription therapies including insulin and biologics.	Determined by NAIC, taking into consideration the Medicaid definition.	Scope of covered drugs in state programs must meet Medicaid or other benchmark coverage. Covered drugs for stop-loss is defined by the underlying coverage.
Formulary rules	Formularies permitted. No rules specified.	No government formulary. Contracting entities could use formularies if medically necessary drugs were guaranteed.	No government formulary; benefit managers could use formularies that meet certain conditions.	Formularies allowed if based on the medical needs of enrollees, conforms to other rules, and is approved by SPICE Board.	In state programs, scope and quality must equal benchmark plans. In stop-loss program, defined by underlying coverage.
Appeals process	No provision.	Contracting entities required to have grievance and appeals procedures similar to M+C plans.	Contracting entities required to have grievance and appeals procedures similar to M+C plans.	Private insurers required to have grievance and appeals procedures similar to M+C plans.	In state programs, must comply with scope and quality of benchmark plans. In stop-loss program, defined by underlying coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — SUMMARY TABLE

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
DRUG PRICING					
Drug pricing requirements	No provision.	Discounts obtained by benefit managers would have to be passed through to beneficiaries.	Benefit managers would obtain discounts comparable to those given to large private sector purchasers.	No provision.	State programs may not apply federal rebate systems. Stop-loss program prices determined by underlying coverage.
Access to price discounts once limit is reached	No provision.	Yes.	Yes.	No provision.	Not applicable to either state programs or stop-loss program.
PARTICIPATING ENTITIES AND PHARMACY PROVISIONS					
Contracts with private entities	Private plan sponsors contract with the Medicare Board to provide high-option plans. HCFA must contract with any willing qualified private entities to provide drug benefit for HCFA-sponsored high option plans.	HCFA awards one contract to private entity in each area.	HCFA awards contracts to at least 2 private entities in each area.	Private insurers, M+C plans and group retiree coverage sponsors approved by SPICE Board.	State programs must pay premiums for low-income enrollees in qualified M+C or group plans. HHS must contract with private entities to operate stop-loss program. Entities will contract with sponsors of underlying coverage.
Drug Utilization Review (DUR) requirements	No provision.	Requires DUR.	Requires DUR procedures based on model developed by HHS.	No provision.	State programs must meet quality requirements. DUR for stop-loss determined by underlying plans.
Pharmacy access rules/reimbursement requirements	No provision.	Must contract with all pharmacies meeting standards. Dispensing fees must be high enough to assure most pharmacies participate.	Services must be offered at retail pharmacies throughout the service area. Benefit managers must compensate pharmacists for counseling services.	No provisions.	State programs must meet access requirements of benchmark plans. Access/reimbursement for stop-loss determined by the underlying coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — SUMMARY TABLE

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
FEDERAL GOVERNMENT AND FINANCING					
Federal financing/Trust funds	Combines Part A and Part B Trust Funds. Limits general fund financing to 40% of total Medicare expenditures without Congressional action. No other financing specified.	Establishes Part D account in Part B Trust Fund. Drug benefit funding from budget surplus, Medicare program savings, and premiums.	Finances as part of Part B. Funding options include possible tobacco settlement, increased tobacco taxes, budget surplus or Medicare savings.	Would establish SPICE Trust Fund to receive net revenues from increase in tax on tobacco products and on-budget surplus appropriations.	The bill amends the Public Health Service Act and does not affect Medicare Trust Funds nor create new trust funds.
Administration	Creates Medicare Board as independent agency. HCFA would be reorganized.	HCFA administered through contracts with private entities.	HCFA administered through contracts with private entities.	Establishes a SPICE office in HHS outside of HCFA and administered by SPICE Board.	State program is administered by states. Stop-loss is operated by private entities with HHS contract.
RELATIONSHIP TO EXISTING COVERAGE					
Traditional FFS Medicare	HCFA must offer Medicare FFS as a standard option plan. Also must offer high option plan in all areas.	Adds voluntary drug coverage under a new Part D.	Adds voluntary drug coverage to Part B.	Beneficiaries in FFS Medicare would receive subsidies for purchase of private drug coverage.	Beneficiaries in Medicare FFS may participate in state program or stop-loss if they meet qualifications.
Medicare+Choice (M+C)	Private entities must offer at least a high option plan in areas in which they wish to participate.	M+C plans must include at least the standard drug benefit.	M+C plans must include at least the standard drug benefit.	M+C plans may qualify for subsidy if they include at least the minimum SPICE coverage.	State programs must pay M+C drug premiums for low-income if coverage is qualified. M+C plans may participate in stop-loss if drug coverage is qualified.
Employer-sponsored retiree health coverage	No provision.	Retiree health plans may qualify for partial subsidy if they include at least the standard drug benefit.	Retiree health plans may qualify for subsidy if they include at least the standard drug benefit.	Retiree health plans may qualify for subsidy if they include at least the minimum SPICE coverage.	State programs must pay group plan drug premiums for low-income if coverage is qualified. Group plans may participate in stop-loss if drug coverage is qualified.
Medicare supplemental coverage (Medigap)	Only enrollees in standard option HCFA plan may buy or renew Medigap policies.	Medigap packages changed to conform to new benefits; study of possibility of "gap" drug coverage.	Some Medigap packages revised to provide supplemental drug coverage.	New SPICE drug-only package, with variable benefits, established.	New guaranteed issue rules related to participation in state program. Medigap plans may participate in stop-loss if drug coverage is qualified. Establishes one-time 6 month open enrollment period for purchase of Medigap with drug coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPRISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
PARTICIPATION					
Eligibility for coverage	All aged, disabled, and ESRD beneficiaries enrolled in both Part A and Part B would be eligible to enroll in a high option Medicare plan that includes prescription drug coverage.	All aged, disabled and ESRD beneficiaries would have the option to enroll in a government subsidized prescription drug plan under Part D of the Medicare program.	All aged, disabled and ESRD beneficiaries eligible to enroll in Part B would be eligible for Medicare prescription drug coverage.	All aged, disabled, and ESRD beneficiaries entitled to benefits under Medicare Part A and enrolled under Part B would be eligible for federal assistance in purchasing private prescription drug coverage.	State program: Low-income aged, disabled, and ESRD beneficiaries entitled to Part A, enrolled in Part B, or both. Excludes inmates of state institutions and those eligible for state health benefits. Stop-loss: Beneficiaries entitled to Parts A, B, or C, who are enrolled in qualified drug coverage (i.e, M+C, Medigap, or employer group plan).
Entitlement	All Medicare beneficiaries would be entitled to a subsidy for drug coverage if they enrolled in a high option plan.	All Medicare beneficiaries opting to enroll in Part D would be entitled to drug benefits.	All Medicare beneficiaries opting to enroll in Part B would be entitled to drug benefits.	All Medicare beneficiaries would be entitled to a full or partial subsidy of a private drug insurance premium.	State program: In participating states, low income beneficiaries are entitled to drug assistance as defined by the state in compliance with federal standards. Stop-loss: Beneficiaries with qualified drug coverage would be entitled to stop-loss coverage.
Mandatory or voluntary participation	Voluntary. Beneficiaries would choose from among standard and high option plans offered in their area.	Voluntary, in that beneficiaries would elect to enroll in Part D (the drug coverage) in the same way and at the same time as for Part B.	Voluntary to the extent that Part B is voluntary. Provides a waiver option for those with equal or better private coverage who wish to enroll in Part B without the drug coverage.	Voluntary.	State program: Voluntary for states and for beneficiaries. Stop-loss: Voluntary enrollment. Sponsors of qualified private coverage voluntarily contract with the government to provide the stop-loss coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPRISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Enrollment process	The Medicare Board would establish an enrollment process based on the M+C process including provision for information and open enrollment and disenrollment opportunities. Beneficiaries would have the option to enroll in a high option plan upon becoming eligible for Medicare, during the annual enrollment period, and at other times as specified by the Medicare Board.[1] All plan sponsors, including HCFA, would be required to offer at least one high option plan that includes coverage for outpatient prescription drugs and annual stop-loss protection for the core Medicare benefits.	Beneficiaries would have a one-time opportunity to enroll in Part D (without penalty). For 2003, beneficiaries may enroll during the November 2002 M+C annual election period. After 2002, the option to enroll coincides with enrollment in Part B upon Medicare eligibility. Exceptions apply for active workers or retirees losing retiree coverage who could enroll later without financial penalty.	Beneficiaries enrolled in Part B and not enrolled in a M+C plan, must enroll with a contracting entity in order to receive covered outpatient drugs. The Secretary would establish rules similar to M+C rules for enrollment and disenrollment. The Secretary would develop a procedure for default enrollment of beneficiaries that fail to enroll, and procedures for beneficiaries who reside in more than one area during a year.	The SPICE Board would establish enrollment procedures, using rules similar to rules for M+C enrollment and disenrollment. The SPICE Board would also establish rules for a penalty, in the form of a reduced subsidy amount, for those beneficiaries who enroll in a SPICE plan other than during open enrollment opportunities. No penalty would apply to enrollees in M+C plans that discontinue drug coverage, if the beneficiary enrolls in a SPICE plan at the next available opportunity.	State program: Enrollment would be a state responsibility. Stop-loss: Beneficiaries would enroll in qualified private drug coverage (Medigap, M+C, or group plans) in the same manner as under current law.
Information	The Medicare Board is responsible for providing information to beneficiaries. Information would be disseminated on an annual basis as part of the enrollment process. The Medicare Board must establish standards for information and provide grants to Medicare Consumer Coalitions to conduct information programs coordinated at the federal, state and local levels.	The Secretary would conduct an educational campaign on the new drug benefit during 2002. Drug benefit information would be provided to beneficiaries annually as part of the annual information process.	The Secretary would be required to broadly disseminate information to beneficiaries on the drug coverage.	The SPICE board would disseminate information similar to M+C information activities about SPICE plans and coordinate information activities with the Secretary. Information on the SPICE program would also be provided through the Health Insurance Information, Counseling and Assistance programs.	State program: States must address outreach in their state plans. Stop-loss: No provision.

[1] The bill sponsors have indicated that they intend to require a one-time opportunity to enroll in a high option plan. Once enrolled in a high option plan, a beneficiary could choose to enroll in any high option plan during the annual and special enrollment periods.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPRISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
PREMIUMS AND SUBSIDIES					
Beneficiary premiums	There would be no separate premium for drug coverage. Beneficiaries who enroll in a high option plan would pay the difference between the government contribution (i.e., 88% of the NWAP plus the applicable subsidy for drug coverage) and the premium for the plan of their choice. There would no longer be a Part B premium.	Beneficiaries would pay a premium equal to 50% of the cost of the benefit. The beneficiary premium is estimated by HCFA to be $26 per month in 2003, rising to $51 in 2009. (Premium does not include costs for the potential catastrophic benefit.)	Beneficiaries would pay 25% of the cost of the drug benefit through an increased Part B premium. Beneficiaries with actuarially equivalent drug coverage under another plan could have the portion of the Part B premium attributable to drug coverage waived, unless that coverage was provided by an employer sponsored group health plan of M+C plan that received Medicare payments towards that coverage.	Premiums for the SPICE private insurance products would be determined by the market, subject to applicable state insurance laws. Premiums for coverage under M+C plans would be part of their adjusted community rates. Premiums for employer sponsored coverage would be determined per ERISA rules.	State program: State programs must pay drug portion of M+C or group plan premiums for qualified low-income beneficiaries enrolled in those plans offering qualified drug coverage. Qualified coverage may not otherwise impose beneficiary premiums or enrollment fees. Stop-loss: Beneficiaries must pay any applicable premiums for the required underlying drug coverage; there are no beneficiary premiums related to the stop-loss coverage.
Government subsidies- Medicare population in general	In general, the government contribution for core Medicare benefits would be 88% of the NWAP. There would be an additional subsidy for high option plans (i.e., those with drug and stop-loss coverage) equal to 25% of the actuarial value of the drug benefit. The drug subsidy amount would be taxable as income.	For the Medicare population in general, the government would subsidize 50% of the annual costs of the outpatient drug benefit. (Not known whether this would also apply to the potential catastrophic drug coverage.)	For the Medicare population in general, the federal government subsidy would be the same as for Part B (75% of the annual costs of the benefit).	In general, Medicare beneficiaries would receive a subsidy equal to 25% of the "applicable cost" (i.e., the premium for private coverage; the actuarial value of the drug portion of a M+C plan's adjusted community rate; or the actuarial value of the drug portion of an employer-sponsored plan). If there are insufficient funds in the SPICE Trust Fund, the subsidy will be reduced as necessary but not to less than 10%.	State program: For low-income only, not applicable to the Medicare population in general. Stop-loss: All beneficiaries enrolled in qualified Medigap, M+C, or group plans receive 100% federally subsidized stop - loss coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPRISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
Government subsidies -- Premium assistance for low-income population	Beneficiaries with incomes between 135 and 150% of poverty enrolling in high option plans would receive a sliding scale subsidy of between 25 and 50% of the actuarial value of the drug benefit. Those with incomes below 135% of poverty would receive a subsidy equal to 100% of the premium for the lowest cost high option plan available to them. Medicaid premium assistance requirements for dual eligibles (fully dual, QMB,SLMB, QI1s) for core Medicare benefits would continue similar to current law (see below) and existing federal/state match rates would apply. Subsidies for high option plan benefits (i.e., drugs and stop-loss) for all beneficiaries with incomes below 135% of poverty would be 100% federal.	Medicaid would pay Medicare Part D drug premiums for those with annual incomes to 135% of poverty. Medicaid would provide a partial drug premium subsidy for those with incomes between 135% and 150% of poverty. The Medicaid match rate for costs of those above 100% of poverty would be 100% federal. Existing match rates would apply below 100% of poverty.	Medicare would pay the Part B premium for those with incomes to 135% of poverty (i.e., QMBs and SLMBs). SLMB eligibility in general would be increased from 120% to 135% of poverty beginning July 1, 2000. The category of qualifying individuals (QI1) established in the Balanced Budget Act of 1997 for those between 120% and 135% of poverty would be repealed. The existing federal/state match rates would apply.	Individuals with incomes under 150% of poverty would receive a 100% subsidy for their drug premiums; those with incomes from 150 to 175% of poverty would receive a subsidy based on a sliding scale. If there were insufficient funds in the SPICE Trust Fund, and the general subsidy had been reduced to 10%, the Board would reduce eligibility levels until funds would be adequate. If there were insufficient funds for any enhanced subsidies, the Board would suspend payment of all subsidies and report to Congress.	State program: States choosing to participate must provide assistance to those without Medicaid drug coverage who have incomes below 120% of poverty and meet an asset test no more stringent than under Medicaid. States may extend eligibility and receive federal funds for those up to 200% of poverty. Stop-loss: Low-income beneficiaries would receive subsidized stop-loss coverage only if they were enrolled in a Medigap, M+C, or group plan offering qualified drug coverage.
Government subsidies -- Cost sharing assistance for low-income population	Medicaid programs would have to cover all cost-sharing required by the Medicare plan in which a fully dual eligible beneficiary is enrolled (including cost sharing for drugs). As under current law, Medicaid programs would have to cover additional drug costs for dual eligibles to the extent they are consistent with the state's Medicaid plan. Existing federal/state match rates would apply.	Medicaid would pay drug cost-sharing for those with annual incomes to 135% of poverty. The Medicaid match rate for costs of those above 100% of poverty would be 100% federal. Existing match rates would apply below 100% of poverty.	States would have to provide low-income beneficiaries (i.e, QMBs and SLMBs) wrap-around drug coverage equivalent to the state's Medicaid drug benefit. This means the state Medicaid program would pay the Part B premium and cost-sharing for all Medicare covered drugs, as well as the total costs for all drugs covered by the state's Medicaid program but not covered by Medicare, for beneficiaries with incomes to 135% of poverty. Existing federal/state match rates would apply.	No provision.	State program: State programs may not impose cost-sharing on those with incomes to 120% of poverty, and only limited coinsurance/copayments on those with higher incomes. Stop-loss: There are no special provisions for the low-income. The stop-loss coverage applies after the beneficiary incurs the threshold amount of out-of-pocket drug expenses in a year.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
Collection of premiums and distribution of subsidies	The Medicare Board would be responsible for transmitting information to the Social Security Administration so that beneficiary premium obligations could be calculated and deducted from social security checks. Subsidies would be provided through the process for making payments to plans. Subsidies through Medicaid would flow as under current law.	Premiums would be deducted from Social Security checks the same as they are for Part B premiums. Medicaid subsidies would likely work similarly to current QMB/SLMB program. Retiree plan subsidies would be paid to the sponsor or to the drug benefit manager for the retiree plan.	Premium costs, incorporated into the Part B premium, would be deducted from Social Security checks as they are today for Part B premiums. Low-income subsidies would be administered similarly to the current QMB/SLMB program. No detail provided on how employer subsidies would be paid.	Premiums would be collected by the private insurance issuers, M+C plans, or employer sponsors of retiree coverage. The SPICE Board would establish the manner and time for providing subsidy payments. Subsidies would be paid only if the issuers, M+C plans, or employer sponsors provide assurance that amounts otherwise charged to a beneficiary would be reduced by the amount of the subsidy. For group retiree plan participants in plans that charge a premium less than the subsidy amount, the SPICE Board is to establish a procedure whereby those beneficiaries would receive some financial assistance.	State program: States would pay premiums directly to plans for low-income beneficiaries enrolled in qualified M+C or group coverage. Stop-loss: Plans would collect premiums from beneficiaries for the underlying drug coverage. The Secretary of HHS would contract with one or more private entities to operate the stop-loss program. The private entities would negotiate agreements with sponsors of the qualified underlying drug coverage for benefit payments.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
			DRUG BENEFITS		
Standard or variable benefit package	Plans could vary benefits so long as they meet the tests of actuarial value and are constructed to not encourage adverse selection. In 2003, the actuarial value for drugs in high option plans must equal $800. Thereafter, the amount would be indexed annually to reasonable increases in drug costs.	Standard benefit package for FFS Medicare. M+C or retiree plans must at least provide the standard benefit as a minimum. Some variation in coinsurance payments would be allowed. (See below.)	Standard benefit package, with variations allowed for copayments up to 20% of the costs of the drug. M+C or retiree coverage must meet or exceed the standard minimum benefit.	Variable benefit packages allowed. A "threshold" (i.e., minimum) level of benefits would be defined by NAIC, taking into account drug benefits provided under FEHBP and other large group health plans, and approved by the SPICE Board.	State program: Variable; states define benefits in accordance with federal minimum standards. Stop-loss: Variable; benefits defined by private plan sponsors in accordance with federal minimum standards.
Annual drug deductible	No standard benefit structure; subject to Board approval.	No annual drug deductible.	$200 (not indexed).	No standard benefit structure; minimum benefits to be determined by NAIC.	State program: No deductible allowed for qualified coverage. Stop-loss: Deductible may not exceed $500 in 2000 (indexed annually to the growth in per capita drug spending).
Beneficiary coinsurance/ copayment	No standard benefit structure; subject to Board approval.	50% coinsurance. Contracting entities could offer reduced coinsurance as part of their bid proposal so long as access or quality were not undermined.	Copayments/coinsurance of no more than 20% of the contract-specified costs of drugs would apply until the beneficiary reached the annual benefit limit. (E.g., the beneficiary would pay up to $300 of the first $1,700 of drugs after paying the $200 deductible.)	No standard structure; minimum benefits to be determined by NAIC.	State program: No copays or coinsurance for those with incomes to 120% of poverty; no more than the greater of $5 or 20% coinsurance for those with incomes above 120% of poverty (sliding scale based on family income is permitted). Stop-loss: No copays or coinsurance once the Stop-loss coverage is in effect.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Annual benefit limits or cap	No standard benefit structure; subject to Board approval.	Drug costs (including beneficiary coinsurance): 2003, 2004--$2,000 2005, 2006-- $3,000 2007, 2008-- $4,000 2009 -- $5,000 2010 on --$5,000+CPI	Drug costs (including deductible and beneficiary coinsurance) of $1,700 in 2000 (indexed annually thereafter to the change in per capita Medicare drug costs). Drug costs would be based on the contract specified prices.	No standard structure; minimum benefits to be determined by NAIC.	State program: No maximum annual, lifetime, or other durational limits are allowed unless the limits are no lower than imposed under the State's Medicaid program. Stop-loss: No limits.
Stop-loss (coverage of drug expenditures over a specified annual threshold)	Stop-loss coverage for drugs is not included in the stop-loss coverage required of high-option plans. Presumably stop-loss could be offered by a Medicare plan as part of the high option drug benefit.	No annual stop-loss. In his FY2001 budget, the President has reserved $35 billion over the years 2006-2010 to add protections for catastrophic drug costs. Details are to be negotiated with Congress.	Stop-loss coverage would apply once annual out-of-pocket expenses for covered drugs reached $3,000 (or $4,200 in total drug costs assuming 20% coinsurance), Medicare would pay the entire costs of covered outpatient drugs provided to the beneficiary by their drug benefit manager for the remainder of the year. The stop-loss amount is indexed for years after 2000 to the annual change in per capita Medicare drug costs. The Part B premium would not count towards out-of-pocket expenses for drugs.	No standard structure; minimum benefits to be determined by NAIC.	State program: No stop-loss required for qualified coverage. Stop-loss: Underlying qualified drug coverage must have no more than $1,500 annual out-of-pocket limit (indexed annually to growth in per capita drug spending.)

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
ACCESS TO DRUGS					
Covered drugs	Not specified. Presumably would be up to the plans, subject to minimum requirements established by the Medicare Board.	All therapeutic classes of drugs (and smoking cessation drugs). Exceptions based on Medicaid exceptions, such as drugs for weight loss or gain, fertility, cosmetic or hair growth, cough or cold relief, vitamins and minerals and non-prescription drugs.	FDA-approved therapies that are dispensed by prescription, including insulin and biologics, that are reasonable and necessary to prevent or slow the deterioration of, and improve or maintain the health of covered individuals.	To be determined by NAIC, subject to SPICE Board approval. NAIC to take into consideration the definition of covered drugs under Medicaid (which includes insulin and biologics), and, if appropriate, permit optional coverage of drugs (except smoking cessation agents) not covered by Medicaid.	State program: Self-administered outpatient prescription drugs (including insulin and insulin supplies) and excluding items covered by Medicare, not available under the state's Medicaid plan, or furnished for the purpose of causing death. Scope and quality of drug coverage (excluding cost-sharing rules) must be equivalent to state's Medicaid program, a benchmark plan, or approved by the Secretary of HHS. Benchmarks include FEHBP BlueCross/BlueShield standard option, a state employee plan; or HMO plan with greatest commercial enrollment. Stop-loss: Covered drugs are those covered by the underlying qualified Medigap, M+C, or group coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Formulary rules	Formularies are allowed. No other provisions related to formularies are included.	No government formulary but contracting entities could establish formularies. In creating a formulary, the entity would be required to use medical panels with outside experts free of any conflict of interest and objective criteria in selecting drugs for the formulary.	If formularies were used: physicians and pharmacists would have to participate in development of the formulary; at least one drug from each therapeutic class would have to be included; and the entity would have to disclose to beneficiaries and providers the nature of the formulary restrictions, including drugs and copayment amounts for different drugs. Entities could establish higher copays for non-formulary drugs (up to the 20% copay limit) except when the non-formulary drug was determined by the prescribing provider to be medically indicated. Entities could also educate providers about medical and cost benefits of formulary products and request prescribers to consider formulary products prior to dispensing a nonformulary drug, so long as the request did not unduly delay provision of the drug.	Formularies would be allowed if they were based on the medical needs of beneficiaries; there was an appeals process for access to medically necessary drugs not on the formulary; the appeals procedures could not impose a significant financial burden on the beneficiary or delay the provision of medically necessary drugs; and enrollees were notified of any changes in the formulary at least 60 days prior to the effective date of the change. Access on a timely basis to new outpatient prescription drugs as they become available would also be required.	State program: Scope and quality of drug coverage (including exclusions or limitations and the application of any formulary) must be equivalent to state's Medicaid program, a benchmark plan, or approved by the Secretary of HHS. Benchmarks include FEHBP BlueCross/BlueShield standard option, a state employee plan; or HMO plan with greatest commercial enrollment. Stop-loss: Determined by the underlying qualified Medigap, M+C, or group coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
Access to drugs not on formulary	No provision.	Guaranteed when medically necessary.	Contracting entities would have to provide overage of non-formulary drugs when recommended by prescribing providers.	There would have to be an appeals process for access to medically necessary drugs not on the formulary.	State program: Scope and quality of drug coverage (including exceptions to the application of a formulary) must be equivalent to state's Medicaid program, a benchmark plan (see above), or be approved by the Secretary of HHS. Stop-loss: Determined by the underlying qualified Medigap, M+C, or group coverage.
Cost containment strategies	Cost control mechanisms customarily used in employer-sponsored plans are allowed. These include formularies, tiered copayments, selective contracting, and mail order pharmacies.	A contracting entity could establish appropriate incentives for generic substitution; use formularies, and reduce coinsurance (under certain conditions) and use other cost containment strategies subject to limitations and guidelines.	A contracting entity could employ mechanisms to provide benefits economically including the use of formularies, alternative distribution methods, generic drug substitution and use of incentives to encourage beneficiaries to select cost-effective drugs or less costly means of receiving drugs.	Entities could use reasonable cost containment methods, such as formularies, mail order services, and generic substitution, consistent with specific requirements of law.	State program: Scope and quality of drug coverage must be equivalent to state's Medicaid program, a benchmark plan (see above), or be approved by the Secretary of HHS. Federal rebate systems may not be applied. Stop-loss: The Secretary, or private entities operating the stop-loss program, may not deny or limit payment based on the drugs covered by the sponsor of the underlying coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Appeals process	No provision.	Grievance and appeal procedures that apply to M+C plans would apply to the extent they are relevant.	Contracting entities would be required to have procedures to ensure timely review and resolution of denials of care and complaints by enrollees (and those acting on their behalf), providers, and pharmacists in accordance with requirements comparable to those for M+C plans. Enrollees would have to be provided with information on the appeals process at time of enrollment.	There would have to be an appeals process in place for access to drugs not on a formulary which would provide at least the same level of protection as provided with respect to benefits under M+C plans.	State program: Scope and quality of drug coverage (including exceptions to the application of a formulary) must be equivalent to state's Medicaid program, a benchmark plan (see above), or be approved by the Secretary of HHS. Stop-loss: Determined by the underlying qualified Medigap, M+C, or group coverage.
Treatment of outpatient drugs already covered by Medicare	Reimbursements for drugs already covered by Medicare would remain the same as part of the core benefit package.	Reimbursement rates for outpatient drugs covered by Medicare Part B would be reduced to 83% of AWP. Payments for EPO would be reduced by 10%.	Reimbursements for drugs already covered by Medicare would remain the same.	Reimbursements for drugs already covered by Medicare would remain the same.	State program: Drugs covered by Medicare are excluded from State program coverage. Stop-loss: No provision.
Coverage of immunosuppressive drugs under Medicare Part B	No provision.	Permanently extend coverage for immunosuppressive drugs for 48 months. (Beneficiaries could obtain additional months of coverage under Part D with Part D cost-sharing.)	The time limitation on Medicare Part B coverage of immunosuppressive drugs would be eliminated, effective upon enactment.	No provision.	State program: No provision. Stop-loss: No provision.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
DRUG PRICING					
Drug pricing requirements	No provision.	Beneficiaries would get the same discount that the private group purchaser who manages the benefit gets. Prices would be negotiated between contracting entities and the manufacturers. The contracting entity would be paid a fee for managing the benefit.	Contracts would only be awarded if the Secretary determined that the average cost (excluding cost-sharing) for covered outpatient drugs provided through the contract is comparable to the average cost charged (exclusive of cost-sharing) by large private sector purchasers for such drugs.	No provision.	State program: No provision except for prohibition on application of federal rebate systems. Stop-loss: No provision except that the Secretary, or private entities operating the stop-loss program under contract with HHS, may not deny or limit payment based on the drugs covered or the amount paid by the sponsor of the underlying coverage.
Access to price discounts once limit is reached	No provision. Presumably would depend upon the benefit structure of each plan.	Beneficiaries would continue to have access to the discount price after they reached their annual limit.	Beneficiaries would continue to have access to the discount price after they reached their annual limit.	Depends upon benefit structure of each plan.	State program: No provision. Stop-loss: Prices are determined by the underlying qualified policy and terms would not change once the stop-loss coverage became effective.
PARTICIPATING ENTITIES					
Eligible entities	Private entities sponsoring Medicare plans would determine how to provide the benefit. HCFA would be required to contract with private entities including insurers, PBMs, chain pharmacies, groups of independent pharmacies, and other entities deemed appropriate by the Medicare Board.	Pharmacy benefit management companies (PBMs), retail drug chains, health plans, states (through Medicaid mechanisms), or multiple entities in collaboration would be eligible to contract with Medicare to administer the drug benefit.	Any entity the Secretary determined to be appropriate, including PBMs; wholesale and retail pharmacist delivery systems; insurers; other entities; or any combination of entities could contract to administer the drug benefit.	Entities eligible to sponsor SPICE drug coverage would include M+C plans, private insurers, and sponsors of group health plans.	State program: States decide entities, if any, with which to contract to operate State program. Must pay premiums for low-income enrolled in M+C or group plans offering qualified coverage. Stop-loss: Private carriers or other qualified entities.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Contracts with private entities	HCFA would be required to contract with "any willing qualified" entity to provide the drug benefit for the HCFA sponsored high option plans, subject to meeting all requirements and Medicare Board approval. Private entities contracting with HCFA to provide the drug benefit must bear full financial risk for the drug benefit.	Competitive bidding every 2 to 3 years for one contract to be awarded in each geographic area. Areas would be designated so as to have enrollment sufficient to encourage efficiency. A sufficient number of areas would be designated to prevent market domination by only a few entities. The Medicare program would retain the risk for the cost of the benefit, although incentives and risk sharing arrangements are allowed.	HCFA would solicit bids and award contracts to private entities for the provision of outpatient drugs in an area. At least 2 contracts would be awarded in an area, unless only one bidder met minimum standards. Contracts would be for at least 2, and not more than 5, years. Bids would have to specify copayment amounts to be charged for covered drugs. In areas where there were no contracts with eligible entities, HCFA would develop a procedure to provide covered drugs to beneficiaries. Regional areas would be established by HCFA, taking into account the number of eligible beneficiaries in an area in order to encourage participation by entities. Contracts could be based on shared risk, capitation, or performance.	No contracts with private entities are envisioned under this bill. However, drug coverage (provided by M+C plans, SPICE Medicare supplemental policies, or group health plan sponsors) would have to receive approval of the SPICE Board in order for it to qualify for subsidy payments on behalf of enrollees [unclear if this would be a "contract"]. Risk would be borne by each entity offering a SPICE plan.	State program: States could contract with private entities to provide qualified drug coverage. States could retain the risk or contract with risk-bearing entities to provide the coverage. Stop-loss: The Secretary of HHS must contract with carriers or other qualified entities to operate the stop- loss program. Risk would be borne by the federal government.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
Conditions of participation for contracting entities	Existing M+C rules and any additional rules imposed by the Medicare Board would apply to Medicare plans. Private entities contracting to provide the drug benefit for HCFA sponsored high option plans would have to assume full risk for the drug benefit.	Contracting entities would have to meet quality and access standards including, but not limited to: strategies to encourage appropriate use of drugs; use of outside experts to create the formulary; use of objective criteria in selection of formulary drugs; open and fair dealing with manufacturers; publication of cost containment criteria related to patient care; submission of data on costs and utilization; capacity and pharmacy access standards; grievance and appeals processes; and other consumer protections.	Contracting entities would have to comply with the following standards: provide information necessary to carry out the bidding process, including data necessary to determine if drug costs are comparable to those of large purchasers, and data regarding utilization, expenditures, and costs; establish educational programs meeting the Secretary's criteria; ensure that drugs are accessible and convenient, including having emergency services available 24 hours a day, 7 days a week, and having services offered at a sufficient number of retail pharmacies and to the extent feasible, at retail pharmacies throughout the service area; comply with rules for the provision of benefits; and comply with clinical quality standards as determined by the Secretary, developed in consultation with appropriate medical specialty societies and based on current standards of care.	The SPICE Board would establish the application procedures, conditions for approval, and the period (no less than 1 year) for which approval of SPICE plans would be valid. Approval could be denied or revoked in cases where the Board determined the entity offering the coverage was purposefully engaged in favorable risk selection activities. Coverage must be for outpatient drugs only, not otherwise covered by Medicare, and no pre-existing condition exclusions could be applied.	State program: No provision. Stop-loss: No provision.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Drug Utilization Review (DUR) requirements	No provision.	Contracting entities and pharmacies would be required to use DUR and meaningful clinical criteria to assure quality and strategies to encourage appropriate use of medications.	The contracting entity would be required to have procedures in place to ensure appropriate utilization of drug benefits and avoidance of adverse drug reactions. Also, the Secretary would be required to develop a model educational program to assure appropriate prescribing and dispensing of drugs and use of drugs by beneficiaries. The program would have to include on-line prospective review available 24 hours a day, 7 days a week; counseling beneficiaries regarding proper use of drugs and interactions and contra-indications; methods to identify and educate providers, pharmacists and beneficiaries regarding instances of unnecessary or inappropriate prescribing, instances or patterns of substandard care, potential adverse drug reactions, inappropriate use of antibiotics, appropriate use of generics and the importance of following the instructions of the prescriber.	No provision.	State program: Scope and quality of drug coverage must be equivalent to state's Medicaid program, a benchmark plan (see above), or be approved by the Secretary of HHS. Stop-loss: DUR requirements of the underlying private coverage continue to apply once the stop-loss threshold is reached.
Confidentiality	No provision.	No provision.	Contracting entities that maintain individually identifiable health information would be required to safeguard the privacy of the information; and maintain records in an accurate and timely manner; and assure timely access to information by enrollees.	No provision.	State program: No provision. Stop-loss: No provision.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
PHARMACY/PHARMACIST PROVISIONS					
Pharmacy access rules	No provision.	Contracting entities would be required to negotiate and contract with all pharmacies meeting minimum standards. They would be required to have necessary information systems to process transactions electronically.	Services would have to be offered at a sufficient number of retail pharmacies and to the extent feasible, at retail pharmacies throughout the service area.	No provisions specific to pharmacies, however, benefits must be accessible and convenient to all enrollees.	State program: Determined by the state. Stop-loss: Determined by the underlying private plan.
Pharmacy reimbursement	No provision.	Dispensing fees would have to be high enough to ensure participation by most pharmacies.	No provision.	No provision.	State program: Determined by the state. Stop-loss: Determined by the underlying private plan.
Pharmacist counseling reimbursement	No provision.	No provision.	Contracting entities would have to compensate pharmacists for providing counseling.	No provision.	State program: Determined by the state. Stop-loss: Determined by the underlying private plan.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
FEDERAL GOVERNMENT AND FINANCING					
Federal Trust funds	Part A and Part B Trust Funds are merged into the Medicare Trust Fund in 2003. A new "programmatic solvency" test is established whereby the Trust Fund is deemed insolvent in any year in which expenditures exceed the sum of HI taxes, beneficiary premiums, and general fund revenues (capped at 40% of expenditures). Sufficient funds are transferred prior to 2003 from the HI Trust Fund to HCFA to provide initial capitalization and reserves for the HCFA-sponsored plans.	Part D would be established as a separate account in the SMI (Part B) Trust Fund. Premiums for Part B and Part D would be calculated separately.	The new drug benefit would be funded out of the Medicare SMI (Part B) Trust Fund.	A SPICE Trust Fund would be established. Certain provisions related to the HI Trust Fund would apply to the SPICE Trust Fund, except that the SPICE Board and the Secretary of the Treasury would be the Board of Trustees, and the annual report on the status of the Trust Fund would be part of the SPICE Board's annual report.	State program: No trust fund involvement. Stop-loss: No trust fund involvement. Bill is drafted as an amendment to the Public Health Service Act.
Federal financing	Financing comes from the HI tax, beneficiary premium payments, and general revenues. General revenues may not exceed 40% of Medicare program expenditures without Congressional action. Also, the Medicare Board is authorized to assess a fee on Medicare plans to cover the operating costs of the Board. These fees would not be subject to appropriations. No other financing sources are identified.	The new Part D benefit would be financed through beneficiary premiums, federal budget surplus, Medicare provider payment reductions, and from savings in Medicare from implementation of competition and efficiency initiatives.	The bill summary specifies the following options for financing: recovery of Medicare costs attributable to tobacco-related diseases; an increase in the federal tobacco tax; allocation of the budget surplus; or savings from more comprehensive Medicare reform legislation.	An amount of funds equivalent to the net revenues received from an increase in taxes on tobacco products called for in the bill would be appropriated to the SPICE Trust Fund. In addition, on-budget surplus funds would be authorized to be appropriated to the Trust Fund. The increases in taxes on tobacco products would include, among taxes on other tobacco products, a 55 cents per pack increase on cigarettes.	State program: State entitlement directly appropriated from general revenues. States would receive the enhanced SCHIP match rate for beneficiaries with incomes to 150% of poverty; the regular Medicaid match rate for beneficiaries with incomes of 150 to 200% of poverty. The match rate for outreach and administration would be the enhanced SCHIP match rate subject to a limit. Stop-loss: Funds directly appropriated from general revenues.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
Congressional Budget Office (CBO) cost estimate	No estimate available.	1999 CBO estimate: The drug benefit would cost $168.2 billion over 2000-2009 ($136 billion for Medicare and $32 billion for Medicaid).	No estimate available.	No estimate available.	State program: No estimate available. Stop-loss: No estimate available.
Administration	A Medicare Board is established as an independent agency. It would have 7 members, appointed by the President with approval of the Senate, for 7 year terms. The Chair would be elected by the Board. Board staff would be exempt from civil service rules and pay grades. The Board would be exempt from Executive Branch oversight. The Board would oversee the entire Medicare program including enrollment, plan negotiations, beneficiary information and education, etc. The Board would submit an annual report to Congress. HCFA would be reorganized into 2 Divisions: one to run the HCFA-sponsored plans and one to administer Medicaid and other HCFA functions. Until 2008, HCFA would submit an annual business plan to Congress to be acted upon. In 2005, a "fast track" procedure for Congressional action is provided.	HCFA would administer a bidding process and selectively contract with one private entity in each area to administer the drug benefit.	HCFA would administer the bidding process and award contracts with private entities to administer the drug benefit; HCFA would develop a process to administer the benefit in areas where there were no eligible drug benefit managers.	A SPICE Office would be established within HHS outside of HCFA, and run by a SPICE Board. The Board would also conduct a number of ongoing studies related to the SPICE program and issue an annual report including a report on the status of the SPICE Trust Fund, and recommendations regarding the level of financial assistance to be made in the subsequent year. The Board would be composed of 7 members appointed by the President, with the advice and consent of the Senate. Board membership would have to include representation of consumers, private health insurers, HCFA, and state insurance commissioners. The Secretary of HHS would be a non-voting, ex officio member. Members would have 6 year terms (staggered). The Chairperson would be designated by the President (and could not be the representative of HCFA).	State program: Administered by the States. Administrative expenditures are limited to 10 percent of total payments (except the limit is 20% for the first fiscal year). Stop-loss: The Secretary of HHS enters into contracts with private carriers or other qualified entities to operate the program. The private entities negotiate agreements with issuers of qualified coverage (Medigap, M+C, and group health plans) to provide the benefits.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Who bears risk for utilization/cost?	Plan sponsors would have to bear full risk, including HCFA. The risk for the drug benefit provided by HCFA plans must be borne by the entities with which HCFA contracts to provide the benefit. Each HCFA-sponsored plan must be independently self-sustaining.	The federal government would bear most of the risk for cost and utilization. Contracting entities would have some contractual incentives to control cost and utilization. Medicare would test the use of bonuses, withholds, or risk corridors to control costs.	Contracts could be based on shared risk, capitation, or performance.	Risk would be borne by each plan offering SPICE coverage.	State program: State programs would either bear the risk or contract with private risk-bearing entities to provide the drug coverage. Stop-loss: Risk is borne by the federal government.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
RELATIONSHIP TO CURRENT COVERAGE					
Traditional FFS Medicare	Beneficiaries wishing to remain in traditional FFS Medicare would have the option of enrolling in a HCFA-sponsored standard plan (i.e., traditional FFS Medicare) or a HCFA-sponsored high option plan that would have drug and stop-loss coverage in addition to core Medicare benefits. HCFA must sponsor a standard option plan and at least one high option plan throughout the U.S. There would no longer be a Part B premium; instead, beneficiary premium obligations would depend upon the plan chosen and the amount of its premium in relation to the government contribution. Beneficiaries in areas where the only options are HCFA-sponsored plans would be assured of not paying more than 12% of the NWAP for core benefits coverage. Those choosing a high option plan with drug coverage would receive a subsidy for the drug portion of the premium.	Beneficiaries enrolled in FFS Medicare could elect to enroll in Part D and obtain the standard Medicare Part D drug benefit.	Beneficiaries enrolled in Part B of FFS Medicare would be covered by the new Medicare drug benefit unless they had equivalent drug coverage and opted to waive out of the Part B drug coverage.	Beneficiaries enrolled in FFS Medicare could obtain private SPICE drug coverage and a receive a subsidy for its premium.	<u>State program:</u> State drug assistance would be available to low income beneficiaries in FFS Medicare who are not receiving Medicaid prescription drug coverage. <u>Stop-loss:</u> Federally subsidized stop-loss protection would be available to beneficiaries in FFS Medicare who enroll in qualified Medigap or group drug coverage and pay the premiums for the underlying coverage.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Medicare+Choice (M+C)	M+C plans would have to conform to new rules, such as those on benefits and premium bids. M+C plan sponsors would have to offer at least a high option plan in all areas where they wish to participate. They could also offer a standard option plan.	M+C plans would have to offer at least the standard drug benefit and the cost of the benefit would be included in their bid proposals. The same plan payment rules would apply as apply to bids for the non-Rx Medicare benefits (i.e., full payment up to lesser of bid or 96% of cost of government drug benefit). M+C enrollees would have to pay any amounts in excess of the government payment amount.	M+C plan enrollees would be provided a benefit equivalent to or greater than the Medicare Part B benefit through their M+C plan. No specific changes to M+C provisions are included in the bill.	M+C plans could offer SPICE coverage and, if plans obtained approval of the SPICE Board, M+C enrollees would received subsidies for the drug coverage.	State program: State programs must pay any premium for drug coverage for qualified low-income beneficiaries enrolled in M+C plans offering qualified drug coverage. Stop-loss: M+C plans offering qualified drug coverage may enter into agreements with entities operating the federally subsidized stop-loss program. M+C plan must agree to provide necessary information for payment of benefits above the stop-loss threshold for enrollees.
Employer-sponsored retiree health coverage	No provisions directly related to employer-sponsored retiree health coverage.	A subsidy equal to 67% of the government subsidy amount would be given to employers offering drug benefits equal to or better than the standard benefit to all retirees without discrimination based on age or health status. Unsubsidized employer costs would be tax deductible as a business expense on the same basis as current law. Standards would be equivalent to those for M+C plans. Retirees with employer-sponsored drug coverage would not pay the Part D premium. If retiree drug coverage is dropped, retirees would have a one-time option to enroll in Part D without penalty.	If drug coverage under a retiree plan was equivalent or better than Medicare coverage, the retiree plan sponsor could continue that coverage and receive payments from Medicare. Payments could not exceed what would be paid to a private entity serving similar enrollees in the same service area. The employer plan would have to comply with any necessary requirements specified by the Secretary. If there was a contractual obligation on the sponsor to provide drug coverage, to reimburse or compensate beneficiaries during the life of the contract for the drug portion of the Part B premium, or, for plans in existence prior to enactment that provide drug coverage, the employer plan would be required to reimburse the drug portion of the Part B premium for at least one year from the date of participation.	Employer-sponsored retiree health plans could offer SPICE coverage and qualify to receive subsidies if plans obtained approval of the SPICE Board.	State program: State programs must pay any premium for drug coverage for low-income beneficiaries enrolled in group health plans offering qualified drug coverage. Stop-loss: Group health plans offering qualified drug coverage may enter into agreements with entities operating the federally subsidized stop-loss coverage program in which the group plan agrees to provide necessary information for payment of benefits above the stop-loss threshold for enrollees in the group health plan.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON

	Breaux/Frist	Clinton	Kennedy/Stark	Snowe/Pallone	Bilirakis/Peterson
Medicare supplemental coverage (Medigap)	After 2003, only beneficiaries enrolled in the HCFA-sponsored standard option plan could purchase or renew Medigap policies.	The Secretary of HHS and the NAIC would look at the feasibility of providing "gap" drug coverage through Medigap (cover the coinsurance and provide coverage above the annual cap). Medigap packages would be modified to conform with the new drug benefit.	The standard Medigap policies would be revised by the NAIC and the Secretary to add supplementary drug coverage which complements the new Medicare drug benefit to "an appropriate number of policies." They would have to ensure that policies providing such coverage remain affordable for beneficiaries.	Existing Medigap packages would be revised to include an outpatient drug only package, the "SPICE Medicare supplemental policy." Benefits in a SPICE policy could vary above the threshold established by NAIC. No other Medigap packages could include any outpatient drug coverage. New Medigap packages could be substituted for the 3 eliminated packages. Policies issued prior to the effective date of SPICE could be renewed. Nonduplication rules would be clarified to permit SPICE policies to be sold to individuals with Medigap plans without drug coverage and to M+C plan enrollees without drug coverage, and Medigap policies could be sold to those with SPICE coverage. Insurers of existing Medigap plans H, I, and J would have to notify policyholders within 60 days that they could purchase comparable Medigap coverage without drugs, or could retain their current policy but would be ineligible to purchase SPICE coverage. The SPICE Board and NAIC would conduct a study on the feasibility of allowing Medigap plans to include drug coverage and be eligible for SPICE subsidies.	State program: Three changes are called for regarding Medigap guaranteed issue requirements: (1) Medigap issuers must guarantee issue a non-drug Medigap plan to enrollees who have Medigap drug plans and who become eligible for a State program assistance and therefore terminate their Medigap drug coverage; (2) Medigap issuers must guarantee issue a Medigap drug plan to beneficiaries who lose their state drug program eligibility if they had a Medigap drug plan prior to enrolling in the state plan; and (3) Medigap issuers must guarantee issue all Medigap drug plans to aged beneficiaries during a one-time, 6 month open enrollment period designated by the Secretary of HHS. Stop-loss: Medigap insurers offering qualified drug coverage may enter into agreements with entities operating the federally subsidized stop-loss coverage program in which the group plan agrees to provide necessary information for payment of benefits above the stop-loss threshold.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Medicaid	For dual eligibles entitled to Medicare premium assistance under current law (fully dual eligible, QMBs, SLMBs, QI1s), Medicaid programs would pay the lesser of 12% of the NWAP, or the amount of beneficiary obligation for the HCFA-sponsored standard plan in the area in which the beneficiary resides. For the fully dual eligible, Medicaid programs would pay all cost-sharing associated with all benefits in the Medicare plan in which the beneficiary is enrolled, and any additional drug costs to the extent they would be covered under the state's Medicaid plan. State Medicaid programs would not be required to cover cost-sharing for drugs for QMBs. The existing federal/state match rates would apply.	Medicaid would subsidize 100% of the Medicare drug premiums and cost-sharing for drugs for those up to 135% of poverty. Medicaid would pay a partial drug premium subsidy for those between 135% and 150% of poverty. The regular Medicaid federal/state match rate would apply for those up to 100% of poverty; the federal match rate would be 100% for all others.	For the low-income, SLMB eligibility in general would be increased from 120% to 135% of poverty beginning July 1, 2000. The QI1 category established in the BBA for those between 120% and 135% of poverty would be deleted. States would be required to provide QMBs and SLMBs wrap-around drug coverage equivalent to the state's Medicaid drug benefit. This means the state Medicaid program would pay the Part B premium and cost-sharing for all Medicare covered drugs, as well as the total costs for all drugs covered by the state's Medicaid program but not covered by Medicare, for beneficiaries with incomes to 135% of poverty. Existing federal/state Medicaid match rates would apply.	No provisions related to Medicaid.	State program: No changes to Medicaid. Dual eligibles with drug coverage under Medicaid are not eligible for the state drug assistance programs. Stop-loss: Does not affect Medicaid. Stop-loss relates only to beneficiaries with private, qualified Medigap, M+C, or group health plan coverage.
OTHER					
Effective date	The competitive premium system would be effective January 1, 2003. Medicare Board establishment and HCFA reorganization would occur within 6 months of enactment so that transition can take place.	January 1,2003	July 1, 2000 unless otherwise specified for certain provisions.	In general, January 1, 2000.	State program: January 1, 2000. Stop-loss: January 1, 2000.

MAJOR MEDICARE PRESCRIPTION DRUG PROPOSALS — DETAILED COMPARISON					
	Breaux/Frist	**Clinton**	**Kennedy/Stark**	**Snowe/Pallone**	**Bilirakis/Peterson**
Studies	The Medicare Board must conduct a study and report to Congress by January 1, 2002, on the need for maintaining enrollment under only Part A or only Part B for some beneficiaries; special rules for ESRD beneficiaries; and the need for a one-time open enrollment period for high-option plans.	No studies are proposed other than for Medigap.	The GAO would be required to conduct a study and report by January 1, 2001, on the implementation of the competitive bidding process, including an analysis of the reduction in hospital visits resulting from outpatient prescription drug coverage, prices paid for drugs by Medicare compared to other private and public sector programs, any other savings resulting from the coverage, and education and counseling activities.	The SPICE Board would be required to conduct ongoing studies on the administration of SPICE; provision of information to beneficiaries on SPICE; ways that drug utilization can be used to improve care; potential savings in federal health programs due to outpatient drugs; trends in premium increases; integration of SPICE into a reformed Medicare; affordability of SPICE coverage; impact of drug coverage provided by M+C plans and group health plans; and the appropriateness of the levels of financial assistance provided for SPICE coverage. The Board is to include a detailed statement on the study issues in its annual reports. The Board is also to study, with NAIC, the feasibility of allowing non-SPICE Medigap plans to offer drug coverage.	State program: No provision. Stop-loss: No provision.
Medicare Payment Advisory Commission (MedPAC)	MedPAC must review and comment to Congress on the business plan submitted to Congress every year by HCFA, as must CBO and GAO.	No provision.	MedPAC membership is increased to 19 members, and expertise on the commission is expanded to include areas of pharmacology and prescription drug benefit programs.	No provision.	State program: No provision. Stop-loss: No provision.

DEFINITIONS

Contracting Entity — This term refers to the pharmacy benefit manager, health insurer, retail drug chain, or other qualified entity that would contract with Medicare under the Clinton or Kennedy/Stark proposals to administer the new Medicare drug benefit.

Dual Eligible — General term for low-income Medicare beneficiaries who qualify for some degree of Medicaid assistance. "Full" dual eligibles qualify for full Medicaid benefits because they are sufficiently poor to meet Medicaid's income and resource eligibility standards (they are receiving cash assistance through Supplemental Security Income (SSI) program or because their medical and long-term care expenses cause them to spend down to Medicaid eligibility levels). For these beneficiaries, states provide the full range of Medicaid benefits as well as typically pay Medicare's Part B premium. Other categories of dual eligibles who qualify for some but not full Medicaid assistance are as follows:

QMB — Qualified Medicare Beneficiary. A Medicare beneficiary with an income below 100% of the federal poverty level and limited assets. Medicaid pays Medicare part B premium and all Medicare required cost-sharing.

SLMB — Specified Low Income Beneficiary. A Medicare beneficiary with an income between 100 and 120% of the federal poverty level and who has limited assets. Medicaid pays the Medicare Part B monthly premium.

QI1 — Qualifying Individual. A Medicare beneficiary with an income between 120 and 135% of the federal poverty level and who has limited assets. Medicaid pays the Medicare Part B monthly premium on a first-come, first served basis.

QI2 — Qualifying Individual. A Medicare beneficiary with an income between 135 and 175% of the federal poverty level. Medicaid pays a portion of the Medicare Part B premium for individuals on a first come, first served basis.

FEHBP — The Federal Employee Health Benefit Program is the program of private health insurance options available to federal employees, annuitants, and dependents.

FFS Medicare — The traditional fee-for-service Medicare program, sometimes referred to as original or traditional Medicare.

HCFA — Health Care Financing Administration. This federal agency is responsible for administering the Medicare and Medicaid programs. It is part of HHS.

HHS — U.S. Department of Health and Human Services.

M+C — Medicare+Choice. Medicare beneficiaries may currently elect to enroll in an M+C plan as an alternative to traditional, fee-for-service Medicare (also known as original Medicare), if one is available in their area. An M+C plan is a private plan that has contracted with HCFA to provide the Medicare benefit package. A majority of M+C plans also offer benefits that are not covered by traditional Medicare, including coverage for outpatient prescription drugs.

Medigap — This is the popular name given to a private health insurance policy designed to supplement the coverage provided by the traditional fee-for-service Medicare program and that meets certain federal standards. Medigap plans fill gaps in coverage resulting from Medicare cost-sharing requirements. They also reimburse for some services not covered by Medicare.

NAIC — The National Association of Insurance Commissioners is the trade association for the nation's state insurance commissioners. The NAIC develops model standards for nsurance policies which are adopted on a voluntary basis by the states.

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Beyond Survey Data: A Claims-Based Analysis Of Drug Use And Spending By The Elderly

Spending for prescription drugs is not distributed evenly across the elderly population; elders with common chronic diseases tend to generate the highest spending.

by Earl P. Steinberg, Benjamin Gutierrez, Aiman Momani, Joseph A. Boscarino, Patricia Neuman, and Patricia Deverka

ABSTRACT: Previous estimates of Medicare beneficiaries' total and out-of-pocket spending on outpatient prescription drugs have largely been based on data from the 1995 Medicare Current Beneficiary Survey and have focused on how expenditures vary among beneficiaries with different demographic characteristics. This paper reports the results of an analysis of prescription claims from 1998 for more than 375,000 elderly persons whose prescription benefit was managed by Merck-Medco Managed Care. In addition to examining how total and out-of-pocket drug spending in a well-insured population varies by age and sex, we report how total and condition-specific drug spending varies for elderly persons with ten common chronic diseases. Our results illustrate the highly skewed nature of prescription drug spending, even among those with drug coverage, and underscore the particularly high cost burden that pharmaceuticals place on elderly people with chronic diseases.

MEDICARE WAS ENACTED IN 1965 with the goal of eliminating economic barriers to the receipt of necessary health care for the elderly. Consideration was given to inclusion of a prescription drug benefit in Medicare at that time, and again in 1967 by a Task Force on Prescription Drugs appointed by President

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Lyndon Johnson. In both cases, however, no such benefit was provided, nor has one been added since then.

From a clinical perspective, the lack of a prescription drug benefit when Medicare was implemented did not constitute as much of a barrier to effective health care as it does today. In the late 1960s comparatively few of the prescription drugs available had clinically significant effects on the chronic diseases that are prevalent among the elderly. Since then, however, researchers have made much progress in understanding the pathophysiology of many chronic diseases. Combined with major advances in our ability to identify and create new pharmaceutical products, this has resulted in an enormous increase in the number of drugs that are available for both chronic and acute diseases.

Most of our current impressions of total and out-of-pocket prescription drug spending by the elderly are based on data collected in the Medicare Current Beneficiary Survey (MCBS).[1] Despite special efforts in the MCBS to minimize errors in beneficiaries' recall, concerns about possible underestimation of expenditures remain.[2] Moreover, even the most recent reports on drug spending by or on behalf of Medicare beneficiaries are based on 1996 MCBS data. In addition, previous reports based on MCBS data provide little insight into the association between particular chronic diseases and drug spending.

To expand the public's understanding of prescription drug use and spending among elderly persons with drug coverage, we analyzed prescription drug claims from 1997–1998 for elderly persons whose drug coverage was managed by a pharmacy benefit management (PBM) firm. In addition to examining drug use and total and out-of-pocket spending by persons in different age and sex categories, we examined patterns of drug spending by elderly persons with common chronic diseases. Our findings thus complement previous analyses and provide insight into the potential economic impacts of alternative designs for a Medicare prescription drug benefit.

Study Methods

■ **Data source.** Our data were obtained from Merck-Medco Managed Care (MMMC) LLC, a PBM that manages prescription benefits for approximately fifty-one million Americans. MMMC clients include managed care organizations, indemnity insurers, corporate employers, organized labor, and government. The specific data used in this analysis are derived from MMMC's Research Convenience Sample (RCS) database, a longitudinal, claims-level database that contains data from a nonrandom sample of MMMC clients. Criteria for inclusion of clients in the RCS are as follows: (1) The client must

have given MMMC permission to use its prescription claims data in aggregate-level analyses; (2) all prescription claims (both retail and mail-order) for the client's beneficiaries must be available; (3) all eligible beneficiaries must be accounted for, even if they did not use their drug benefit during the period of observation; and (4) the age, sex, and geographic distribution of the clients' covered lives should approximate that of MMMC's overall book of business.

Our study sample was drawn from the 1.4 million persons in the RCS, from thirty-five clients, who had continuous drug coverage throughout 1997 and 1998. Only one client had a maximum reimbursable amount (that is, a cap on the amount of coverage it provided) as part of its drug benefit. For this client, beneficiaries who obtained their prescriptions through MMMC still received a discount on their prescriptions after their cap was reached. Consequently, although this cap increased the covered individuals' out-of-pocket spending, it did not affect our estimates of their total drug spending. Beneficiaries from this client accounted for less than 5 percent of our study population.

■ **Eligibility criteria and period of observation.** To be included in our sample, persons had to have had continuous prescription coverage from 1 January 1997 through 31 December 1998 and to have been at least age sixty-five on 1 January 1998. Prescription claims from 1997 were used to select persons for inclusion in analyses of members with particular medical conditions. All other analyses of prescription use by persons in our study sample were performed using 1998 claims. Since all persons in our sample had continuous coverage throughout 1998, we had a full year of observation for each person in our analysis. Thus, the results of our analysis of RCS data were not biased by any seasonal differences in use of drugs.

■ **Particular medical conditions.** We developed algorithms that could be used to identify persons who had any of ten of the most common chronic diseases among the elderly: nonarrhythmic cardiovascular disease, any cardiac rhythm disorder, hyperlipidemia, asthma/chronic obstructive pulmonary disease (COPD), diabetes, arthritis, depression, cancer, osteoporosis (females only), and acid-peptic disease. Three common combinations of chronic diseases also were assessed: nonarrhythmic cardiovascular disease plus (1) COPD; (2) diabetes; and (3) diabetes and hyperlipidemia.

Because diagnosis data were not available for people in the RCS, we used pharmacy claims data to "map" particular drugs to particular medical conditions.[3] To be considered to have a particular condition, a person had to have had two or more drug claims on different days during 1997 for one or more drugs mapped to that condition.

While the use of a particular drug can serve as a specific marker

for a particular disease (as in insulin for diabetes), some drugs are commonly used to treat more than one condition. We therefore defined the medical conditions on which we focused with the various uses of particular drugs in mind. For example, instead of examining hypertension, congestive heart failure, and angina separately, we combined these conditions in a "nonarrhythmic cardiovascular disease" category. Even so, some of the clinical categories we constructed based on prescription claims alone inevitably overestimated the number of persons who have a particular condition. For example, some antidepressant drugs that we used to identify persons with depression also can be used to treat other conditions (for example, pain caused by nerve damage in patients with diabetes).

Reliance on drug codes alone to identify persons with particular chronic diseases also is limited by the fact that some patients with a chronic disease may not take any prescription drug for it. For example, a patient with diabetes that is managed with diet control alone would not be identified as having diabetes using our methodology. We reduced the impact of this limitation by assigning people to a medical-condition category based on their drug use in 1997 and reporting on their use during 1998. As a result, some of those we assigned to particular conditions on the basis of the drugs they used in 1997 had no overall or condition-specific drug use in 1998.

■ **Calculating expenditures.** The total expenditures we report reflect the average wholesale price (AWP) of the drugs that were dispensed, plus a dispensing fee.[4] The out-of-pocket expenses that we report equal the copayment plus any deductible paid by the beneficiary.

■ **Use of generic drugs.** The rate of use of generic drugs was calculated for all drugs that were dispensed and for dispensed drugs that were mapped to particular medical conditions. The former was calculated as the number of prescriptions dispensed that were for generic products as a percentage of all drugs dispensed for which there were both brand-name and generic products available ("multisource" drugs). The rate of use of generic drugs for specific medical conditions was calculated as the number of prescriptions for generic drugs mapped to each condition as a percentage of the total number of prescriptions mapped to each condition, with the analyses restricted to multisource drugs.

Study Results

Although the age and sex distributions of our study sample are similar to those of Medicare beneficiaries age sixty-five and older, our sample is somewhat younger, with a lower proportion of persons age eighty-five and older and a higher proportion of persons

ages sixty-five to seventy-four, compared with all Medicare beneficiaries age sixty-five and above (Exhibit 1). In addition, although we are unable to assess the overall health status and income distribution of persons in our sample, elderly persons with employer-sponsored drug coverage are thought to be healthier and to have higher incomes than the Medicare population as a whole.[5] Both of these differences would be expected to reduce drug spending in our population compared with that of all Medicare beneficiaries.

Many in our study sample were taking medications for the chronic conditions on which we focused. Approximately half of them, for example, used medication for nonarrhythmic cardiovascu-

EXHIBIT 1
Characteristics Of Study Population Compared With Medicare Population As A Whole

	Study population		Medicare population[a]	
Characteristic	**Number**	**Percent**	**Number**	**Percent**
Age (years)				
65–74	220,251	58.6%	18,377,041	53.1%
75–84	126,984	33.8	12,036,056	34.8
85 and older	28,245	7.5	4,214,195	12.2
65 and older	375,480	100.0	34,623,354	100.0
Sex				
Male	174,405[b]	46.4	14,541,808	42.0
Female	198,207[b]	52.8	20,081,545	58.0
Medical condition				
Nonarrhythmic cardiovascular disease	181,207	48.3	Over 40%[c]	
Cardiac rhythm disorder	27,190	7.2	Approximately 10%[c]	
Hyperlipidemia	54,001	14.4	–[d]	
Asthma/COPD	31,895	8.5	6–13%[c]	
Diabetes	28,414	7.6	Approximately 12%[c]	
Arthritis	60,621	16.1	45–50%[c]	
Depression	38,547	10.3	2–3%[e]	
Cancer	12,168	3.2	–[d]	
Osteoporosis[f]	45,493	23.0	30–50%[g]	
Acid-peptic disease	51,644	13.7	Approximately 30%[c]	
Nonarrhythmic cardiovascular plus COPD	21,888	5.8	–[d]	
Nonarrhythmic cardiovascular plus diabetes	21,383	5.7	–[d]	
Nonarrhythmic cardiovascular plus hyperlipidemia and diabetes	6,309	1.7	–[d]	

SOURCES: Authors' analysis of Merck-Medco Managed Care data plus references noted below.
NOTES: Beneficiaries were assigned to medical conditions based on their prescription use in 1997. COPD is chronic obstructive pulmonary disease.
[a] Based on the 1996 Medicare Current Beneficiary Survey (MCBS). The proportion of males and females is among Medicare beneficiaries age sixty-five and older. The estimated prevalence of chronic disease is among persons age sixty-five and older.
[b] Data on the sex of 2,868 persons (0.8 percent) were missing.
[c] National Center for Health Statistics, *Vital and Health Statistics*, Series 10, no. 20 (Hyattsville, Md.: NCHS, 1996).
[d] Not available.
[e] NIH Consensus Conference, "Diagnosis and Treatment of Depression Late in Life," *Journal of the American Medical Association* (26 August 1992): 1018–1024; and B. Lebowitz et al., "Diagnosis and Treatment of Depression Late in Life: Consensus Statement Update," *Journal of the American Medical Association* (8 October 1997): 1186–1190.
[f] Females only.
[g] A. Looker et al., "Prevalence of Low Femoral Bone Density in Older U.S. Women from NHANES III," *Journal of Bone and Mineral Research* (May 1995): 796–802.

lar disorders. Because of the methodology we employed, our estimates of the prevalence of some chronic diseases (such as diabetes and arthritis) are substantially lower than those based on national surveys or epidemiological studies. The most important factor contributing to these differences is likely to be the large number of persons with each of these diseases who are not taking a prescription medication for their disease(s). Some of the difference, however, may reflect better-than-average health among the persons in our sample.

■ **Total drug spending.** Approximately 18 percent of our sample did not purchase any prescription drugs during 1998 (Exhibit 2). Interestingly, those age eighty-five and older were much more likely not to have purchased any drugs than those ages sixty-five to eighty-four. Males were 50 percent more likely than females not to have purchased any drugs. In addition, females spent more, on average, than did males at all percentiles, except for the top 1 percent of spenders.

Among all persons in our sample, the average total expenditure for prescription drugs in 1998 was $1,099 (AWP). Among the 82 percent of persons in our sample who filled at least one prescription during 1998, the average total drug spending in 1998 was $1,343, while the median expenditure was $895 (AWP for both). Mean annual spending among persons who did use prescription drugs increased slightly with age; the increase in median expenditures as age increased tended to be a bit higher.

The distribution of total spending among persons who filled at least one prescription during 1998 suggests that the 20 percent of such persons who generated the highest expenditures for prescrip-

EXHIBIT 2
Annual Total Expenditures On Outpatient Prescription Drugs For Insured Elderly Persons, By Age And Sex, 1998

	Percent with no expenditures	Mean expenditures		Distribution among persons with expenditures				
		All persons	Persons with expenditures	20th percentile	50th percentile	80th percentile	95th percentile	99th percentile
Age (years)								
65–69	17.6%	$1,023	$1,242	$210	$771	$1,971	$4,018	$6,752
70–74	16.3	1,119	1,337	260	881	2,134	4,162	6,702
75–84	18.3	1,156	1,415	314	994	2,264	4,164	6,440
85 and older	27.0	1,048	1,436	357	1,045	2,293	4,030	6,127
65 and older	18.2	1,099	1,343	265	895	2,146	4,111	6,597
Sex								
Male[a]	21.4	1,015	1,292	227	834	2,059	4,072	6,705
Female[a]	14.1	1,188	1,383	299	948	2,215	4,143	6,514

SOURCE: Authors' analysis of Merck-Medco Managed Care data.
NOTE: Data reflect utilization in 1998 and average wholesale price.
[a] Age sixty-five and older.

tion drugs that year generated more than $2,000 in drug expenditures. Each of the top 5 percent of spenders generated more than $4,000, while each of the top 1 percent of spenders generated more than $6,500 (all based on AWP).

■ **Spending by disease category.** The percentage of persons with any of the chronic diseases we examined who had no drug spending over a twelve-month period was much lower than that for all persons in our data set and was fairly constant across all of the medical conditions we considered (Exhibit 3). Mean total annual spending on prescription drugs (AWP) by persons with the chronic diseases we examined who filled at least one prescription during 1998 ranged from approximately $1,600 to more than $3,000 and thus were 50–200 percent higher than the mean spending for all persons in the data set. Median total spending within the chronic-disease categories we examined ranged from $1,141 to $2,627. More than 25 percent of persons in the disease categories generated at least $2,500 in total drug spending (AWP) in 1998; each of the top 1 percent of spenders generated $7,000–$10,000.

■ **Out-of-pocket spending.** The percentage of all persons with no out-of-pocket spending (37.5 percent) was approximately twice as high as that of persons who had no drug spending at all (18.2

EXHIBIT 3
Annual Total Expenditures On Outpatient Drugs For Insured Elderly Persons, By Medical Condition, 1998

Medical condition	Percent with no expenditures	Mean expenditures		Distribution among persons with expenditures				
		All persons	Persons with expenditures	20th percentile	50th percentile	80th percentile	95th percentile	99th percentile
Nonarrhythmic cardiovascular disease	2.1%	$1,668	$1,704	$474	$1,243	$2,598	$4,638	$7,174
Cardiac rhythm disorder	2.2	2,009	2,055	592	1,542	3,139	5,397	8,242
Hyperlipidemia	1.7	2,017	2,050	641	1,617	3,109	5,282	7,898
Asthma/COPD	2.0	2,159	2,204	646	1,653	3,376	5,830	8,720
Diabetes	2.0	2,278	2,324	731	1,790	3,548	5,950	8,845
Arthritis	1.6	1,906	1,938	573	1,459	2,968	5,126	7,778
Depression	2.1	2,245	2,293	702	1,760	3,480	5,947	8,921
Cancer	2.4	2,209	2,264	701	1,678	3,240	5,814	9,545
Osteoporosis[a]	1.1	1,591	1,609	424	1,141	2,480	4,561	7,057
Acid-peptic disease	1.8	2,263	2,305	772	1,808	3,471	5,791	8,719
Nonarrhythmic cardiovascular plus COPD	1.7	2,454	2,496	869	1,949	3,766	6,271	9,292
Nonarrhythmic cardiovascular plus diabetes	1.7	2,525	2,567	912	2,057	3,856	6,311	9,228
Nonarrhythmic cardiovascular plus hyperlipidemia and diabetes	1.3	3,057	3,098	1,120	2,627	4,686	7,282	10,000

SOURCE: Authors' analysis of Merck-Medco Managed Care data.
NOTES: Data reflect utilization in 1998 and average wholesale price. Conditions are identified on the basis of prescription claims during 1997. COPD is chronic obstructive pulmonary disease.
[a] Females only.

percent) (Exhibit 4). Even among persons with the common chronic diseases we examined, more than 20 percent had no out-of-pocket spending (Exhibit 5). This is partly because two of the thirty-five clients from whose beneficiaries our sample was drawn (28 percent of our sample) required no copayment under certain circumstances. Only 13.7 percent of the beneficiaries from the other thirty-three clients had no out-of-pocket spending in 1998.[6] Further evidence of the relatively generous drug benefits provided to persons in our sample is our finding that those who had any drug spending spent only $164 per year out of pocket on average ($213 if the two clients without copayments are excluded).

Even with such good coverage, however, more than 5 percent of persons in our data set spent $500 or more out of pocket during 1998. As expected, this percentage was higher for persons with any of the chronic conditions we examined. Of those who spent $1,000 or more out of pocket, 80 percent had nonarrhythmic cardiovascular disease, 20 percent had diabetes, and about one-third had arthritis.

We examined the use of generic versus brand-name drugs, overall and among drugs used to treat the chronic diseases on which we focused. The proportion of all multisource drugs dispensed that were generic products was about 87 percent and was constant across age groups. Also, this proportion decreased slightly as people's annual total and out-of-pocket spending increased, most likely because the most expensive drugs are brand-name drugs. Finally, the proportion of condition-specific multisource drugs that were dispensed as brand-name products varied across the medical conditions we examined. Brand-name use was highest for drugs used to treat diabetes, hyperlipidemia, cardiac rhythm disorders, and osteoporosis, and lowest for drugs used to treat acid-peptic disease and depression.

EXHIBIT 4
Annual Out-Of-Pocket Expenditures On Outpatient Prescription Drugs By Insured Elderly Persons, By Age And Sex, 1998

	Percent with no out-of-pocket expenditures[a]	Mean expenditures		Distribution among persons with expenditures				
		All persons	Persons with expenditures	20th percentile	50th percentile	80th percentile	95th percentile	99th percentile
Age (years)								
65–69	40.3%	$115	$139	$0	$64	$227	$532	$1,005
70–74	39.5	125	149	0	72	248	560	1,031
75–84	34.4	149	182	3	105	297	630	1,139
85 and older	32.9	173	237	45	159	369	726	1,295
65 and older	37.5	134	164	0	86	269	592	1,084
Sex								
Male	42.2	117	149	0	70	245	555	1,058
Female	32.5	150	175	0	99	287	618	1,099

SOURCE: Authors' analysis of Merck-Medco Managed Care data.
[a] Figures reflect the percentage of persons with no pharmaceutical claims in 1998, as well as those who had claims but were enrolled in plans that provided first-dollar coverage.

EXHIBIT 5
Annual Out-Of-Pocket Expenditures On Outpatient Prescription Drugs By Insured Elderly Persons, By Medical Condition, 1998

Medical condition	Percent with no out-of-pocket expenditures	Mean expenditures		Distribution among persons with expenditures				
		All persons	Persons with expenditures	20th percentile	50th percentile	80th percentile	95th percentile	99th percentile
Nonarrhythmic cardiovascular disease	24.0%	$198	$202	$0	$120	$327	$678	$1,214
Cardiac rhythm disorder	22.3	250	256	0	162	410	829	1,476
Hyperlipidemia	28.5	195	198	0	114	334	683	1,227
Asthma/COPD	24.5	240	245	0	143	408	825	1,425
Diabetes	21.2	275	280	0	184	452	889	1,569
Arthritis	23.8	208	212	0	124	349	713	1,272
Depression	21.0	269	274	0	171	450	897	1,516
Cancer	27.9	206	211	0	112	340	739	1,351
Osteoporosis[a]	26.5	197	199	0	116	332	695	1,217
Acid-peptic disease	25.8	228	232	0	130	387	802	1,398
Nonarrhythmic cardiovascular plus COPD	23.2	270	274	0	174	461	891	1,529
Nonarrhythmic cardiovascular plus diabetes	20.8	302	307	0	212	496	951	1,676
Nonarrhythmic cardiovascular plus hyperlipidemia and diabetes	24.9	301	305	0	213	503	954	1,669

SOURCE: Authors' analysis of Merck-Medco Managed Care data.
NOTES: Figures reflect the percentage of persons with no pharmaceutical claims in 1998, as well as those who had claims but were enrolled in plans that provided first-dollar coverage. Data reflect utilization in 1998 and average wholesale price. Conditions are identified on the basis of prescription claims during 1997. COPD is chronic obstructive pulmonary disease.
[a] Females only.

Discussion And Policy Implications

Total spending on prescription drugs in the United States is estimated to have been $90.6 billion in 1998.[7] With elderly persons thought to account for one-third of these expenditures, spending on prescription drugs by Medicare beneficiaries probably exceeded $30 billion in 1998. If, as some have predicted, the increase in drug spending in 1999 compared with drug spending in 1998 turns out to be as high as 18 percent, rather than the 15.4 percent increase experienced between 1997 and 1998, drug spending by Medicare beneficiaries may have exceeded $35 billion in 1999.[8]

Our analysis of prescription drug use and spending in 1998 by elderly persons makes two specific contributions. First, since our analysis is based on actual prescription claims, it complements earlier analyses based on survey data, which were thought to underestimate actual expenditures. Second, we have provided insight into drug spending among elderly persons with common chronic diseases.

Our finding that 18.2 percent of elderly persons with employer-sponsored drug coverage spent nothing on prescription drugs in 1998 is consistent with previous estimates that about 85 percent of Medicare beneficiaries filled at least one prescription in 1992 and that 86.4 percent did so in 1995.[9] The average per capita drug spend-

ing observed for persons in our sample ($1,099 based on AWP), however, is a bit lower than previous estimates. If one assumes that a PBM obtains a weighted average discount off of AWP of 14–30 percent, our observed mean of $1,099 (based on AWP) would correspond to actual expenditures of $769–$945.[10] Based on MCBS data, it was estimated that in 1995 the average total drug spending (actual, not AWP) was $600 per capita for all Medicare beneficiaries and $732 for those with employer-sponsored drug coverage.[11] If one assumes that there was a 13 percent annual increase in per capita drug spending between 1995 and 1998, these estimates would correspond to mean actual expenditures in 1998 for these two groups of $866 and $1,056, respectively.[12] Harvard Pilgrim Health Care, a health plan in Massachusetts, is reported to have spent an average of $1,153 (actual, not AWP) on prescription drugs per Medicare beneficiary in 1998.[13]

Our analysis likely underestimates the average per capita drug costs for a Medicare beneficiary, since our sample does not include any disabled Medicare beneficiaries under age sixty-five and since the persons in our sample, who have employer-sponsored drug coverage, also are likely to be healthier than the Medicare population as a whole.[14] As a result, were those Medicare beneficiaries who lack drug coverage to obtain it, they would likely spend more on prescription drugs, on average, than did those in our sample.

Our analysis also highlights the fact that the distribution of drug expenditures for our sample was highly skewed. For example, our analysis suggests that for 5 percent of the beneficiaries in our sample, drug expenditures in 1998 (measured in terms of AWP) were at least $4,000, and for 1 percent they were at least $6,500. The proportion of persons in our sample who had common chronic diseases and drug expenses above such levels was much higher. Particularly given the high cost of many new medications, it is possible that the proportion of persons who had drug expenses above such levels in 1999 was even higher. For example, a year's supply of Enbrel, a new drug used to treat moderate-to-severe rheumatoid arthritis in patients who have failed to improve after a trial of other so-called disease-modifying agents, has an AWP of more than $14,000.

Our estimates of average out-of-pocket spending by elderly persons with employer-sponsored drug coverage managed by a PBM, based on an analysis of actual deductibles and copayments, are much lower than estimates based on previous surveys.[15] In 1995 the average out-of-pocket drug expenditure by all Medicare beneficiaries was estimated to be $303, while for those with employer-sponsored drug coverage it was estimated to be $224.[16] Using these data, experts have projected that out-of-pocket spending for these two

"Many believe that out-of-pocket spending is likely to rise, even among those with drug coverage."

groups in 1999 was $414 and $320, respectively.[17] The average out-of-pocket expenditures in 1998 observed in our sample, however, are even lower than those estimated in 1995 based on the MCBS.[18] Since our estimates of out-of-pocket spending by insured elderly persons with common chronic diseases also are lower than expected based on the 1995 MCBS, either the drug coverage provided to persons in our sample was considerably better than that held by persons who participated in the MCBS, or respondents in the MCBS overestimated their out-of-pocket spending, or both. Even with relatively generous drug coverage, however, more than 5 percent of Medicare beneficiaries in our sample spent more than $500 out of pocket in 1998, and more than 1 percent spent more than $1,000. Many believe that out-of-pocket spending is likely to rise, even among those with drug coverage, because of the widespread introduction in 1999 of "three-tier" copayment schemes and other cost-control strategies by those that offer drug coverage.[19]

■ **Implications for Medicare drug benefit.** Our findings have implications for the potential cost and design of a Medicare outpatient prescription drug benefit. Patients' drug-purchasing behavior is influenced by the out-of-pocket costs they will incur. Consequently, many aspects of a pharmacy benefit design, including the benefit premium, deductible, copayment, cap, and any ceiling on out-of-pocket spending, affect a patient's use of outpatient drugs and the cost of the benefit itself. PBMs employ several strategies, in addition to these benefit design features, to control the cost of a pharmacy benefit.

The spending estimates based on our analysis reflect the design of the prescription drug benefits provided to persons in our sample, as well as the various strategies employed by MMMC to control pharmacy costs. If, for example, a Medicare drug benefit were provided with a more loosely managed formulary (for example, less tendency to use the least costly effective drug) than was the case for our sample, Medicare drug spending would be higher than we observed. In addition, the cost of a Medicare drug benefit will be influenced by the size of the discounts Medicare obtains from retail pharmacies and drug companies. For example, Medicare now pays 95 percent of AWP for the few categories of drugs that it covers (such as chemotherapy). Were Medicare to pay 95 percent of AWP under a new drug benefit, rather than obtaining discounts of 14–30 percent off of

AWP, as occurs in the private sector, total drug expenditures per beneficiary would be considerably higher than our estimates.

Finally, our results provide insight into the potential impacts on Medicare beneficiaries of the various benefit designs included in several leading legislative proposals.[20] Under President Clinton's plan, for example, Medicare would pay 50 percent of each beneficiary's first $2,000 in drug expenditures in 2002, but beneficiaries would shoulder all of their drug costs that exceeded $2,000 in 2002. The Breaux-Frist proposal would provide Medicare beneficiaries with drug coverage that had an actuarial value of $800 in 2003 but would leave the details of the benefit design to the discretion of health plans. Our analysis suggests that under either of these approaches, many beneficiaries would continue to face high out-of-pocket drug costs. The residual cost burden would be particularly high for elderly persons with severe chronic diseases. Another proposal (Bilirakis-Peterson), in contrast, would provide beneficiaries with stop-loss protection against high annual out-of-pocket drug spending.

CLEARLY, THERE ARE NUMEROUS CHALLENGES associated with design of a Medicare prescription drug benefit. Among these is the fact that trade-offs among the costs, benefits, and political implications of alternative program features will need to be made. As policymakers and the public consider these trade-offs, it will be important not to lose sight of the fact that a prescription drug benefit that increases Medicare beneficiaries' access to effective medications will improve their health status and quality of life. The keys to achieving this clinical benefit at a reasonable cost will be to ensure that cost relief is provided to those who need it most and to employ cost-saving strategies that have proved to be effective in the private sector.

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NOTES

1. M. Davis et al., "Prescription Drug Coverage, Utilization, and Spending among Medicare Beneficiaries," *Health Affairs* (Jan/Feb 1999): 231–243; J. Poisal et al., "Prescription Drug Coverage and Spending for Medicare Beneficiaries," *Health Care Financing Review* (Spring 1999): 15–27; M. Gluck, *A Medicare Prescription Drug Benefit*, Medicare Brief No. 1 (Washington: National Academy of Social Insurance, April 1999); and M. Gibson et al., *How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?* (Washington: AARP Public Policy Institute, September 1999).
2. Davis et al., "Prescription Drug Coverage"; Poisal et al., "Prescription Drug Coverage and Spending"; and M.L. Berk, C.L. Schur, and P. Mohr, "Using Survey Data to Estimate Prescription Drug Costs," *Health Affairs* (Fall 1990): 146–156.
3. We used Specific Therapeutic Class (STC) and Hierarchical Ingredient Code List (HICL) codes to identify persons who had specific diseases. The STC is used to classify drugs according to the most common intended use. The HICL is used to identify a unique combination of ingredients, irrespective of manufacturer, package size, dosage form, drug strength, or route of administration. A summary of the mapping algorithm we used can be obtained from the authors by contacting Benjamin Gutierrez via e-mail, Benjamin_Gutierrez @merck.com
4. We chose to report total drug spending in terms of AWP, rather than actual transaction price, because we believe that it provides a more useful reference point for readers than would actual transaction prices. The latter, of course, would reflect the discounts obtained by MMMC from pharmaceutical manufacturers and retail pharmacies. Numerous factors influence those discounts, including whether both brand-name and generic products are available and, if so, which is being purchased; the number of drugs available (that is, the amount of competition between drugs) in the relevant therapeutic class; whether the drug is being obtained from a retail or mail-order pharmacy; and the negotiating strength of the payer (buyer), which tends to be related to the degree of formulary control. The discount rates obtained by MMMC thus are not necessarily representative of those that others would obtain, and the actual weighted average discount obtained by MMMC for a given population will depend on purchasing behavior (generic-use rate and mail-order use). It also will vary over time because of the introduction of new pharmaceutical products.

   Managed care organizations are reported to have obtained a weighted average discount of 14.3 percent off of AWP for drug purchases in 1998. See "Drug Benefit Design," *Novartis Pharmacy Report* (Totowa, N.J.: Emron, 1999). Others have estimated that the overall average discount off of manufacturer's list price was 16 percent in 1992 and as high as 30 percent for mail-order purchases. See J. Bobula, "A New Era in Pharmaceutical Pricing," *Journal of Research in Pharmaceutical Economics* 7, no. 1/2 (1996): 89–99. PBMs obtain discounts of 14–20 percent for brand-name drugs and 14–90 percent for generic drugs. Based on the distribution of brand-name versus generic, and retail versus mail-order, purchases by persons in our study, we estimate that the weighted average discount for our sample was 14–30 percent. The MCBS applied various pricing factors to AWP to estimate the actual prices paid by respondents who purchased drugs but did not recall their price. The MCBS assumed that retail prices were as high as 272 percent of AWP and that managed care organizations paid 86.1 percent of AWP, on average. See Health Care Financing Administration, Office of Strategic Planning, Information and Methods Group, "Medicare Current Beneficiary Survey CY 1996 Cost and Use,

Public Use File Documentation" (Baltimore: HCFA, 1999).
5. Poisal et al., "Prescription Drug Coverage and Spending."
6. The two clients that did not impose copayments in 1998 have instituted them since then. Increased beneficiary cost sharing is an industrywide trend.
7. K. Levit, et al., "Health Spending in 1998: Signals of Change," *Health Affairs* (Jan/Feb 2000): 124–132.
8. The source for the 18 percent estimate is Congressional Budget Office, *The Economic and Budget Outlook, 1999–2008* (Washington: U.S. Government Printing Office, 1999). The source for the 15.4 percent estimate is Levit et al., "Health Spending in 1998."
9. M. Lashchober and G. Olin, "Health and Health Care of the Medicare Population: Data from the 1992 Medicare Beneficiary Survey" (Rockville, Md.: Westat, November 1996); and Poisal et al., "Prescription Drug Coverage and Spending."
10. See Note 4.
11. Davis et al., "Prescription Drug Coverage"; Poisal et al., "Prescription Drug Coverage and Spending"; and Berk et al., "Using Survey Data to Estimate Prescription Drug Costs."
12. S. Soumerai and D. Ross-Degnan, "Inadequate Prescription-Drug Coverage for Medicare Enrollees—A Call to Action," *New England Journal of Medicine* (4 March 1999): 722–727.
13. Ibid.
14. Poisal et al., "Prescription Drug Coverage and Spending."
15. Ibid.; and Davis et al., "Prescription Drug Coverage."
16. Ibid.
17. Gibson et al., *How Much Are Medicare Beneficiaries Paying?*
18. Davis et al., "Prescription Drug Coverage"; and Poisal et al., "Prescription Drug Coverage and Spending."
19. R. Winslow, "Co-payments Rise for Prescriptions," *Wall Street Journal*, 12 January 1999, B1.
20. M. McClellan, I.D. Spatz, and S. Carney, "Designing a Medicare Prescription Drug Benefit: Issues, Obstacles, and Opportunities," *Health Affairs* (Mar/Apr 2000): 26–41.

Medicare and Prescription Drugs

March 2000

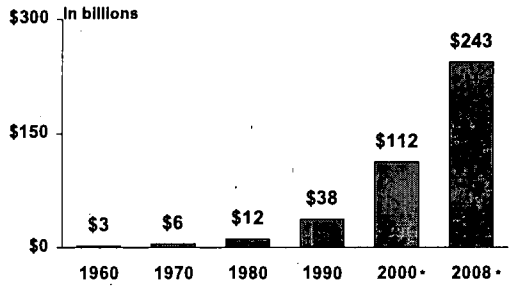
Overview

Prescription drugs are an essential tool for treating and preventing many acute and chronic conditions, but Medicare does not generally cover them on an outpatient basis. When Medicare was first enacted in 1965, pharmaceutical therapies were not as commonly available as they are now. Today, however, they are a primary form of medical care and often substitute for more costly therapies like hospitalization and surgery.

Pharmaceuticals are the fastest-growing component of national health expenditures. In 2000, national drug spending increased by an estimated 11% compared with 7% for physician services and 6% for hospital care. Since 1990, national spending for prescription drugs has tripled. By 2008, that figure is expected to more than double from an estimated $112 billion today to $243 billion by 2008 (Figure 1).

Figure 1

National spending for prescription drugs



Source: Health Care Financing Administration, Office of the Actuary.
*Projected

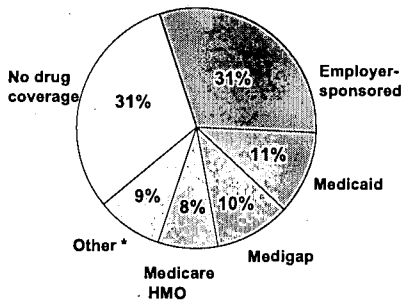
The growing importance and increased use of prescription drugs have had a disproportionate effect on the elderly, who account for 13% of the population but over a third of the nation's total drug expenditures. Lack of drug coverage for some, and limited and diminishing drug coverage for many others, can expose beneficiaries to high out-of-pocket spending that, in turn, may result in under-utilization of prescribed medications and adverse health outcomes.

Sources of Prescription Drug Coverage

Nearly 70% of all Medicare beneficiaries (26 million) had some form of drug coverage through employer-sponsored health plans, Medicaid, Medicare HMOs, and Medigap in 1996, the most recent year for which national data are available (Figure 2). Among those with drug coverage, one in four were covered for only part of the year (Stuart et al., 2000). Drug coverage available to beneficiaries varies widely across plans, is often limited, and is expected to decline in the future.

Figure 2

Prescription Drug Coverage of Medicare Beneficiaries, 1996



Total = 37 million Medicare beneficiaries

Source: Poisal, J.A. and Chulis, G.S., *Health Affairs*, March/April 2000.
Note: Data are based on the noninstitutionalized population.
*Includes people who changed coverage during the year and those with Medicare and "other" coverage.

Employer-sponsored health plans are the leading source of drug coverage, assisting nearly one in three Medicare beneficiaries, generally those with higher incomes. Drug benefits offered by employers, particularly large employers, tend to be relatively generous. Among large employers offering retiree drug benefits, drugs currently account for about half of all health care spending for retirees 65 and older, according to Hewitt Associates. With the rapid increase in retiree health costs generally, and prescription drug costs specifically, there has been a steady and continuing erosion of retiree health benefits. Employers are expected to take more stringent steps to control rising drug costs in the future.

Medigap is a source of drug benefits for approximately 10% of all beneficiaries. There are 10 standard Medigap policies (plans A - J), three of which include prescription drugs. Policies with prescription drug benefits have a $250 deductible and cover 50% of drug costs up to $2,500 (plans H, I) or 50% up to $6,000 (plan J). Premiums for policies that cover prescription drugs have increased rapidly in recent years and tend to be substantially higher than policies that lack drug benefits.

Medicaid plays an important role in providing access to affordable drugs for the poorest segment of the Medicare population, helping more than one in nine pay for their medications. Medicare beneficiaries generally qualify for Medicaid assistance with drug costs if they receive cash assistance under the Supplemental Security Income (SSI) program. However, less than half of all Medicare beneficiaries with incomes below the federal poverty level are covered by Medicaid, and many near poor Medicare beneficiaries are not eligible for Medicaid.

Medicare HMOs assisted 8% of all beneficiaries with their drug costs in 1996. Because Medicare requires plans with costs below the Medicare payment level to return savings to beneficiaries, many HMOs have been able to offer supplemental benefits, like drug coverage, to enrollees. About eight in 10 Medicare HMO enrollees are in plans that offer prescription

drugs. Medicare HMOs generally impose copayments for drugs and a growing number of plans have limits on drug benefits. In 2000, three of four plans cap drug benefit payments at or below $1,000, while nearly one in three limits drug benefits to $500 or less (HCFA, 2000).

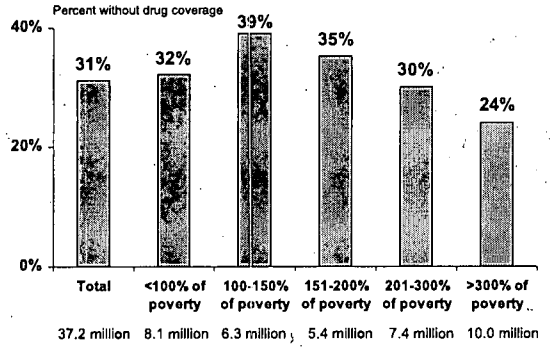
Characteristics of Beneficiaries Lacking Drug Coverage

While two-thirds of beneficiaries have some form of drug coverage, nearly a third (12 million) lack coverage and must pay for their medications out-of-pocket. Some without drug coverage may have some assistance through state pharmacy programs (in 16 states).

In many respects, beneficiaries without drug coverage look similar to the overall Medicare population. Over half of all beneficiaries without drug coverage have incomes above 150% of poverty and more than one in four are in fair or poor health. Still, lack of drug coverage disproportionately affects the near-poor, the oldest-old, and those living in rural areas (Poisal and Chulis, 2000). For example, 39% of beneficiaries with incomes between 100% and 150% of poverty lack drug coverage, compared with 24% of those with incomes above 300% of poverty (Figure 3). Beneficiaries 85 and older are more likely to lack drug coverage than their younger counterparts 65 to 74 (38% vs. 29%). Likewise, beneficiaries in rural areas are far more likely than those in non-rural areas to be without drug coverage (43% vs. 27%).

Figure 3

Medicare Beneficiaries Without Prescription Drug Coverage, by Poverty Level, 1996



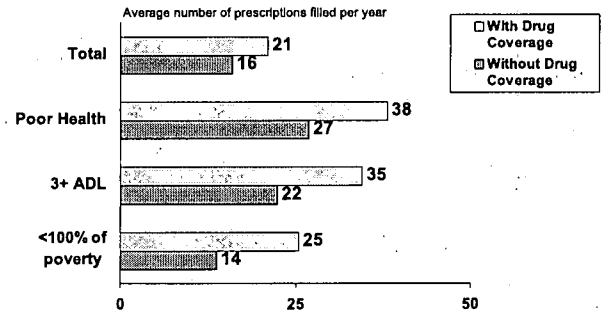
Note: 1996 federal poverty level was $7,740 for individuals; $10,360 for couples.
Source: Poisal, J.A. and Chulis, G.S., *Health Affairs*, March/April 2000.

Why Does Drug Coverage Matter?

Eight out of 10 Medicare beneficiaries report using pharmaceuticals on a regular basis, filling 19.5 prescriptions, on average, in 1996. Having drug coverage significantly influences whether Medicare beneficiaries fill their prescriptions. Beneficiaries without drug coverage average five fewer prescriptions per year than those who have coverage (Figure 4). The disparities are even wider among those in poor health: those who lack coverage average 11 fewer medications than their insured counterparts. Consistently lower utilization levels among those without drug coverage may indicate under-use of prescribed medications, which could have a negative effect on health.

Figure 4

Average Number of Prescriptions Filled by Medicare Beneficiaries, With and Without Drug Coverage, by Selected Characteristics, 1996



Note: ADL = Activity of Daily Living
Source: Poisal, J.A. and Chulis, G.S., *Health Affairs*, March/April 2000.

Total and Out-of-Pocket Spending

Total annual per capita drug spending in 1996 averaged $673 but was lower for Medicare beneficiaries without drug coverage ($463) than for those with drug coverage ($769) (Poisal and Chulis, 2000). Average spending on drugs rose as health status declined, for those with and without drug coverage. Still, beneficiaries in poor health who lacked coverage had substantially lower costs than those with coverage ($749 vs. $1,340).

Out-of-pocket spending for pharmaceuticals is related to a variety of factors, including beneficiaries' health needs, their access to drug coverage and the generosity of that coverage, and price. Average out-of-pocket spending for drugs in 1996 was $318 (Poisal and Chulis, 2000). As might be expected, those with drug coverage in 1996 spent, on average, less for their medicines than those without it ($253 vs. $463). Disparities in out-of-pocket spending between those with and without coverage were even wider among those in poor health ($423 vs. $749).

Out-of-pocket spending for pharmaceuticals is projected to rise in the future, with the continued introduction of new, high-priced breakthrough drugs, increases in direct-to-consumer advertising, and plans imposing higher cost-sharing requirements and caps on drug benefits.

Outlook for the Future

The lack of drug coverage for nearly one in three Medicare beneficiaries, the erosion of drug coverage for many others, and the dramatic increase in drug use and expenditures have focused national attention on proposals to help people on Medicare with medication costs. While the need to assist the elderly and disabled is widely recognized, complex and controversial issues are likely to be debated. For example, should assistance with drug costs be targeted to specific populations or universally available? What strategies should be used to control drug costs? How should new benefits be financed? The outcome of this debate will have significant implications for the nation's aging population.