Providing Medicare Beneficiaries with a Prescription Drug Benefit

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Providing Medicare Beneficiaries with a Prescription Drug Benefit: Whom Do We Target and How Do We Deliver?

A Public Policy Paper of the American College of Physicians-American Society of Internal Medicine

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EXECUTIVE SUMMARY

ACP-ASIM has issued a number of policy statements on Medicare reform, including preliminary statements on a Medicare prescription drug benefit and consumer protection principles regarding the use of formularies and pharmacy benefit managers. This position paper further details ACP-ASIM policy on a Medicare prescription drug benefit and makes specific recommendations for policymakers to consider when designing such a benefit.

Position 1: ACP-ASIM recommends that the highest priority should go toward providing voluntary prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans.
   a. If sustainable, predictable financing is available, ACP-ASIM supports providing an optional Medicare prescription drug benefit to all beneficiaries, regardless of income and health status. Drug benefit plans should be voluntary, and seniors should be able to opt out of the program and maintain their existing Medicare coverage.
   b. ACP-ASIM recommends that Congress consider: (1) increasing general revenues or payroll taxes to support a Medicare prescription drug benefit, and (2) income-related premium contributions, co-payments, and deductibles to support the program.

Position 2: Because of the increasing use and cost of prescription drugs, ACP-ASIM supports adding a prescription drug benefit under Medicare, provided that it is financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas.

Position 3: The maximum allowable Medicare reimbursement for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products.
   a. Rigid price controls that will discourage innovation and threaten drug supply should be rejected.
   b. ACP-ASIM supports using prudent-purchasing tools in designing a Medicare prescription drug benefit. Like the VA, Medicare should investigate average wholesale drug prices and directly negotiate with manufacturers or wholesalers.

Position 4: Until the safety concerns issued by the FDA and HHS are resolved, ACP-ASIM opposes prescription drug reimportation as a means to reduce retail drug prices.

Position 5: If therapeutic safety and equivalency are established, then generic drugs should be used, as available, for beneficiaries of a Medicare prescription drug benefit. In order to eliminate delays for generic entry into the market and discourage financial arrangements between generic and name brand manufacturers, ACP-ASIM supports closing loopholes in patent protection legislation.

Position 6: ACP-ASIM supports research into the use of evidence-based formularies with a tiered co-payment system and a national drug information system, as a means to safely and effectively reduce the cost of a Medicare prescription drug benefit, while assuring access to needed medications. Demonstration projects should be established before a national program is introduced.
a. ACP-ASIM opposes a Medicare prescription drug formulary that may operate to the detriment of patients, such as those developed primarily to control costs. Decisions about which drugs are chosen for formulary inclusion should be based on effectiveness, safety, and ease of administration rather than solely based on cost.

b. ACP-ASIM recommends that formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically-indicated cause) without cumbersome prior authorization requirements.

c. ACP-ASIM opposes proposals to provide a Medicare prescription drug benefit that limits coverage to certain therapeutic categories of drugs, or drugs for certain diseases.

d. To counterbalance pharmaceutical manufacturers’ direct-to-consumer advertising, ACP-ASIM recommends that insurers, patients and physicians have access to unit price and course of treatment costs for medically equivalent prescription drugs.

**Position 7:** If PBMs are used to administer a Medicare prescription drug benefit, ACP-ASIM supports the following consumer protections:

a. Government regulation and industry self-regulation of PBMs. ACP-ASIM particularly supports close government oversight of mergers between PBMs and pharmaceutical manufacturers.

b. The disclosure to patients, physicians, and insurers of the financial relationships between PBMs, pharmacists, and pharmaceutical manufacturers.

c. Requiring that PBM requests to alter medication regimes should occur only when such requests are based on objective data supported by peer reviewed medical literature, and undergo review and approval by associated MCO/MBHO Pharmacy and Therapeutics Committees.

d. Requiring that, with a patient’s consent, PBMs be required to provide treating physicians with all available information about the patient’s medication history.

**Position 8:** ACP-ASIM believes that switching prescription medications to over-the-counter status should be based on clear clinical evidence that an OTC switch would not harm patient safety, through inaccurate self-diagnosis and self-medication, or lead to reduced access to “switched” drugs because they would no longer be covered under a prescription drug benefit. Manufacturers and other interested parties should be allowed to request such a reclassification.

**Position 9:** ACP-ASIM opposes proposals to convert the entire Medicare program to a defined contribution program. If a Medicare prescription drug benefit administered by private entities is established, ACP-ASIM supports uniform coverage, rules, eligibility and co-payments across plans.

**Position 10:** A Medicare prescription drug benefit should minimize administrative hassles, including excessive documentation requirements and overly burdensome rules, for physicians.
Providing Medicare Beneficiaries with A Prescription Drug Benefit: Whom Do We Target and How Do We Deliver?

As the nation struggles to overcome the tragic events of the week of September 11, 2001, Congress must still move forward on other important legislative issues, such as addressing the need for access to health insurance for the uninsured, Medicare prescription drug coverage for the elderly, and preserving the nation’s under-funded health care safety net. We recognize that the nation’s highest priorities are national security and defense, and it will be difficult to fund other domestic programs. However, we anticipate that Congress will soon move forward on these important issues affecting the country, and we look forward to working with the Administration and Congress on improving health care for all Americans.

The American College of Physicians-American Society of Internal Medicine is the largest medical specialty society in the United States, with over 115,000 physician and medical student members. ACP-ASIM has issued a number of policy statements on Medicare reform, including preliminary statements on a Medicare prescription drug benefit and consumer protection principles regarding the use of formularies and pharmacy benefit managers. This position paper further details ACP-ASIM policy on a Medicare prescription drug benefit and makes specific recommendations for policymakers to consider when designing such a benefit.

Who Needs Coverage?

**Position 1**: ACP-ASIM recommends that the highest priority should go toward providing voluntary prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans.

  a. If sustainable, predictable financing is available, ACP-ASIM supports providing an optional Medicare prescription drug benefit to all beneficiaries, regardless of income and health status. Drug benefit plans should be voluntary, and seniors should be able to opt out of the program and maintain their existing Medicare coverage.

  b. ACP-ASIM recommends that Congress consider: (1) increasing general revenues or payroll taxes to support a Medicare prescription drug benefit, and (2) income-related premium contributions, co-payments, and deductibles to support the program.

Depending on whom you ask, the answer to who in the Medicare population needs prescription drug coverage varies. According to one source, in 1998, 73% of non-institutionalized Medicare enrollees had drug coverage at some point during the year (1). The key is the phrase “at some point during the year.” A recent Commonwealth Fund report examined data from the 1996 Medicare Current Beneficiary Survey and found that nearly half of the entire beneficiary population (47.3%) had some period without drug coverage in 1996 (2). Beneficiaries enrolled in Medicare with Medicaid had the most consistent drug coverage, and of those with employer-sponsored plans as their primary source of supplemental coverage, 77.2% reported year-round prescription coverage (2).
For beneficiaries with Medigap supplemental policies, only 24.9% reported year-round drug coverage (2).

In another Commonwealth report, the authors argue that if a broader definition of need were used, to include beneficiaries without continuous and stable coverage, those with high expenditures, and those with multiple chronic conditions, almost 90% of Medicare beneficiaries would qualify as needing prescription drug coverage (3). Given these findings, the report suggests that a legislative proposal targeting beneficiaries up to 150% of the federal poverty level would cover only 40-50% of those who need prescription drug coverage (3).

The number of seniors needing coverage will have an impact on the cost of a Medicare prescription drug program, and as a result, the cost of Medicare as a whole. While Medicare’s financial situation has improved in recent years, problems do exist. Medicare costs per enrollee are expected to rise faster than wages and will ultimately place larger demands on the budget and beneficiaries (4). The Medicare Part A, Hospital Insurance (HI), Trust Fund is projected to remain solvent until 2029 (4). Serious reforms are needed to ensure the HI Trust Funds stability for the future. While the projected cost rate for HI is lower than the income rate (rate of projected HI income from the payroll tax) through 2015, by 2075, the HI cost rate is expected to be more than three times the HI income rate (4). In order to keep Part A viable for the future, the payroll tax needs to be increased to generate more income for the HI Trust Fund, or program costs need to be severely cut, or some combination of the two (4).

Part B, Supplementary Medical Insurance (SMI), is expected to remain solvent for the future, because current law sets financing each year to ensure adequate funds for the next year’s expected costs (4). However, as time goes on, Part B will consume a larger portion of general revenues and require increased beneficiary premiums (4).

The Medicare program as a whole faces a difficult financial future, trying to find a way to adequately finance both the HI and SMI programs for beneficiaries. Greater costs could mean higher premiums for beneficiaries, reduced benefits, or a payroll increase for employers and employees. Adding an expensive Medicare prescription drug benefit for seniors on top of these already stressed financial troubles could prove fatal to the Medicare program. However, by focusing on the neediest beneficiaries and given an adequate budget outlay by Congress, policy makers could design a well-financed drug benefit that helps our most vulnerable seniors.

**Seniors’ Utilization and Spending Trends**

**Position 2:** Because of the increasing use and cost of prescription drugs, ACP-ASIM supports adding a prescription drug benefit under Medicare, provided that it is financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas.
The cost of a Medicare prescription drug benefit will depend on how many and which drugs physicians are prescribing and seniors are taking. When Medicare was first enacted, the cost and use of prescription drugs was much lower. No one could predict the skyrocketing rates of today. Because of increased research and drug development, seniors are using more drugs at higher costs than ever before.

Generics and older brand-name drugs tend to be less expensive than the newer brand-name medications. As direct-to-consumer advertising increases, consumption of these new, more expensive drugs increases. The top selling drugs in 2000 were almost twice as expensive as all other drugs, averaging a 48% higher price than all other drugs combined (5). As manufacturers advertise new drugs, consumers are asking physicians for them, and based on increases in cost and utilization, it appears that physicians are prescribing the newer and costlier drugs.

Medicare beneficiaries without prescription drug coverage use fewer medications and spend less overall for drugs than covered beneficiaries (1). Non-covered beneficiaries filled 16.7 prescriptions in 1998, a small decline from 1997, and spent $550 on average on prescription purchases, almost the same amount as they did in the previous year. Beneficiaries with drug coverage, however, purchased 24 prescriptions and spent 14% more in 1998 than in 1997 (1). When out-of-pocket spending is examined, those without drug coverage spent $546, and those with coverage spent $325 in 1998 (1). Therefore, while total spending is less for beneficiaries without drug coverage, out-of-pocket spending is clearly higher. Uncovered beneficiaries are spending more for fewer prescriptions.

A recent study by Express Scripts Inc., a pharmacy benefits management firm, found that seniors in private health plans used an average of 29 one-month prescriptions in 1998, at a cost of $1,185 a year (6). This figure is three to four times greater than covering prescription drugs for younger employees in private health plans (6). The Alliance for Retired Americans issued a report detailing the patterns of Medicare beneficiaries prescription drug spending. They found that the average beneficiary fills 18 prescriptions per year, and annual spending per capita in the Medicare population rose from $674 in 1996 to $1,539 in 2000 (7). They estimate that 43% of beneficiaries will have drug expenses over $1,000 in 2001, and 8% will have expenses over $4,000 (7). Beneficiaries without prescription drug coverage spend on average 83% more for their medicines than those with coverage, and almost half of those without coverage have incomes below 175% of poverty (7).

The prices of the 50 most frequently used prescription drugs for seniors rose by more than two times the rate of inflation during 2000 (8). According to a study by the National Institute for Health Care Management, spending on prescription drugs has increased more than 12% a year in seven of the last 13 years (5). The study goes on to report that in 1999, the increase in spending on prescription drugs accounted for 44% of the increase in overall health expenditures, and the rise in drug costs is estimated to account for onethird of the rise in employer-based coverage (5). States are experiencing similar problems; 25 states in 2001 reported that Medicaid costs will exceed budgeted amounts
for FY2002, in part due to rising prescription drug expenditures (5). The increase in spending is due to three factors: utilization or volume increase, availability of new drugs for treating diseases, and rising prices for existing drugs (7).

While seniors spend the most per capita on prescriptions, they actually have one of the lowest rates of overall spending growth, according to a report released by Merck-Medco (9). The rate of increase is highest in the “baby boomer” age bracket, 40-55 (9). This is not too surprising, given that many chronic conditions and diseases present themselves at this time. In addition, many baby boomers are using more prescription medications and switching to newer, more costly medications (9). Given the fact that seniors spend more on drugs, as the baby boomer generation ages, we can only assume that use and costs will skyrocket.

A Medicare drug benefit that covers only the most widely used drugs by seniors could be enacted to reduce costs. Another cost-saving option would be to only cover certain diseases that are prevalent among the elderly population, such as heart disease or diabetes. However, providing a benefit limited in scope by disease or drug type would not be equitable for all seniors. It would ignore the prescription needs of seniors suffering from other illnesses that may not be as politically popular as those to be included in a Medicare drug benefit. While containing costs is necessary, it should not be done at the expense of patients.

Cost Saving Options

A number of methods for containing costs have been examined. Some may prove quite useful if implemented prudently within a Medicare prescription drug benefit.

Price Controls and Prudent Purchasing Power

Position 3: The maximum allowable Medicare reimbursement for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products.

a. Rigid price controls that will discourage innovation and threaten drug supply should be rejected.

b. ACP-ASIM supports using prudent-purchasing tools in designing a Medicare prescription drug benefit. Like the VA, Medicare should investigate average wholesale drug prices and directly negotiate with manufacturers or wholesalers.

Health Affairs recently examined the Canadian pharmaceutical cost control system to evaluate its effectiveness. Canada uses its Patented Medicine Prices Review Board (PMPRB), a quasi-judicial body that has federal responsibility for federal price control, to ensure that prices charged by manufacturers are not excessive (10). The PMPRB does not set prices, but it reviews factory-gate prices of individual products to determine if they are excessive by reviewing individual drug prices, conducting investigations and using enforcement mechanisms (10). Drugs are classified into three categories: line extensions, breakthrough, and “me-toos.” Drugs are classified and then reviewed to
determine if prices are excessive. Despite the national system of price review, each Canadian province develops its own formulary. While all provincial governments provide some form of publicly funded drug coverage, the coverage plans and the rules vary by province (10). As a result, price control measures have succeeded to some extent in Canada, but drug expenditures are continuing to rise (10). In addition, access to prescription drugs may be an issue due to the 10 different formularies.

Maine recently enacted a prescription drug program, relying on negotiated rebates with manufacturers to lower costs. However, if the negotiated prices are not “reasonably comparable” to the best prices paid in the state, then the Department of Human Services has the ability to impose price controls (11). The pharmaceutical industry challenged the program in court, but an appeals court ultimately found in favor of the state.

Pharmaceutical manufacturers have argued that price controls would have a negative impact on research and development of new drugs. If price controls were introduced, drug companies would not have the financial incentive to invest in risky research and development at the level that they currently do. In a recent editorial, the pharmaceutical industry claimed that by “failing to reflect the value of innovative drugs, controlled prices would signal to manufacturers of future innovative therapies that they would not be able to charge prices that represent the contributions of their drugs” (12).

However, others argue that the high prices of prescription drugs are not due to high research and development costs, but rather aggressive marketing and advertising campaigns. In a recent study by Families USA, research shows that the nine pharmaceutical companies that market the top-selling 50 drugs for seniors spent more on marketing, administration, and advertising than they did on R&D (26). In fact, eight of the nine companies spent more than twice as much on marketing, administration, and advertising as they did on R&D (26).

Negotiating discounts with pharmaceutical manufacturers may be another method of controlling costs in a Medicare prescription drug benefit. Given the large numbers of Medicare beneficiaries, the federal government could try to negotiate discounts, as it has done for Medicaid and the Department of Veterans Affairs (VA). The federal supply schedule and the prices negotiated off of that schedule by the VA and the Defense Department tend to be the lowest available prices in the country (13). Other institutional organizations negotiate prices with manufacturers, ranging from 5-30% less than that paid by cash payers (13).

In January 2001, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) issued a recommendation that the Health Care Financing Administration (HCFA) reduce the excessive Medicare drug reimbursement amounts (for certain prescription drugs covered under Part B), based on a comparison of Medicare reimbursement to costs incurred by the VA, the physician/supplier community, and Medicaid (14). If price negotiations are not worked out with manufacturers, the currently high prices paid by Medicare could prove detrimental to a prescription drug benefit.
Reimportation

Position 4: Until the safety concerns issued by the FDA and HHS are resolved, ACP-ASIM opposes prescription drug reimportation as a means to reduce retail drug prices.

Last year Congress passed a bill that would allow the reimportation of Food Drug Administration (FDA)-approved prescription drugs into the country, in order to reduce retail drug prices. The Clinton administration did not implement the law, but some members of Congress have asked the Bush administration to implement the measure. HHS Secretary Thompson recently issued his decision to not implement the bill, due to safety and cost concern (15). The FDA also recently cited safety concerns, including improper storage abroad and counterfeit products (16). Congress, however, has been reviewing reimportation measures. The House of Representatives passed a bill in July 2001, and the Senate is expected to take up similar legislation.

Generics

Position 5: If therapeutic safety and equivalency are established, then generic drugs should be used, as available, for beneficiaries of a Medicare prescription drug benefit. In order to eliminate delays for generic entry into the market and discourage financial arrangements between generic and name brand manufacturers, ACP-ASIM supports closing loopholes in patent protection legislation.

Only 10 of the 50 most frequently used drugs by seniors are generic drugs (8). However, over the next five years, drugs that account for $20 billion of current drug spending are expected to lose patent protection (17). Once generic versions of popular drugs are introduced, prices should drop considerably, creating greater access to these medications for seniors. In 1984, the Hatch-Waxman Act was passed, making it easier for generics to enter the market by changing FDA testing procedures and patent rules. Critics claim, though, that the bill has several loopholes that need to be fixed in order to further help generic manufacturers bring their products to market and reduce drug costs. Two bills have been introduced to address the loopholes, making it more difficult to delay generic entry into the market and creating disincentives for financial settlements between generic and brand-name drug manufacturers that keep generics off the market for longer periods of time (18). If one of these bills passes, it may mean quicker and easier access to generic drugs for Medicare beneficiaries.

Tiered Formularies and Evidence Based Formularies

Position 6: ACP-ASIM supports research into the use of evidence-based formularies with a tiered co-payment system and a national drug information system, as a means to safely and effectively reduce the cost of a Medicare prescription drug benefit, while assuring access to needed medications. Demonstration projects should be established before a national program is introduced.

a. ACP-ASIM opposes a Medicare prescription drug formulary that may operate to the detriment of patients, such as those developed primarily to
control costs. Decisions about which drugs are chosen for formulary inclusion should be based on effectiveness, safety, and ease of administration rather than solely based on cost.

b. ACP-ASIM recommends that formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically-indicated cause) without cumbersome prior authorization requirements.

c. ACP-ASIM opposes proposals to provide a Medicare prescription drug benefit that limits coverage to certain therapeutic categories of drugs, or drugs for certain diseases.

d. To counterbalance pharmaceutical manufacturers’ direct-to-consumer advertising, ACP-ASIM recommends that insurers, patients and physicians have access to unit price and course of treatment costs for medically equivalent prescription drugs.

A popular model for prescription coverage is a three-tiered co-pay and formulary system. Under the three-tier model, beneficiaries pay the lowest co-pay for generic drugs, a higher co-pay for preferred brand-name medications, and the highest co-pay for off-formulary brand-name drugs. This system encourages physicians and patients to be conscious of the prices of drugs they are prescribing and/or taking. Recent figures show that the number of people enrolled in three-tier plans rose from 7.6 million in 1998 to 32 million in 2000 (19). These numbers will probably grow as insurance companies look to save money on prescription drug benefits, and the number of tiers may also grow. In April 2001, one major health insurer announced the rollout of a four-tier formulary, designed to cut costs (19).

A relatively new method of containing costs has been introduced in Australia, evidence-based pharmaceutical subsidies (20). Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients (21). The Australian government subsidizes certain prescription drugs for its citizens. In order for a drug to be subsidized by the government, it must be proven both clinically effective and cost-effective. Sponsors of new drugs must submit all clinical evidence available to compare the drug to existing pharmaceuticals. The Pharmaceutical Benefits Advisory Committee (PBAC), a committee consisting of physicians, pharmacists, and a consumer representative, makes recommendations for inclusion on the approved list. The program has been fairly consistent in its recommendations and has been somewhat cost-effective, but drug costs are still rising in the country (20).

A national effort to establish a uniform, evidence-based prescription drug system would provide physicians, insurers, PBMs and patients with much needed information about prescription drugs, including which are most beneficial and cost-effective. However, such an analysis would be a huge task and require a great deal of expertise, time and money. It must be independent and unbiased, controlled by an independent body of physicians, patients, and pharmacists appointed by HHS to supply important drug information to all stakeholders. Individual patient needs vary, though, and physicians
must not be limited by the recommendations. Any national effort to design an evidence-based system must be non-restrictive for physicians and patients, in order to provide the best quality health care. An evidence-based formulary could be used in an advisory role, rather than as a mandate for prescribing.

While the Australian model may be useful in designing a Medicare prescription drug benefit, it is not totally applicable to the United States. The Australian system limits subsidies to only those drugs ruled both clinically and cost-effective by the PBAC; all others must be paid totally out-of-pocket by consumers. Evidence-based drug decisions need to be further evaluated to ensure that costs are being contained while needed drugs are being provided to beneficiaries.

**Pharmacy Benefit Managers**

**Position 7**: If PBMs are used to administer a Medicare prescription drug benefit, ACP-ASIM supports the following consumer protections:

a. Government regulation and industry self-regulation of PBMs. ACP-ASIM particularly supports close government oversight of mergers between PBMs and pharmaceutical manufacturers.

b. The disclosure to patients, physicians, and insurers of the financial relationships between PBMs, pharmacists, and pharmaceutical manufacturers.

c. Requiring that PBM requests to alter medication regimes should occur only when such requests are based on objective data supported by peer reviewed medical literature, and undergo review and approval by associated MCO/MBHO Pharmacy and Therapeutics Committees.

d. Requiring that, with a patient’s consent, PBMs be required to provide treating physicians with all available information about the patient’s medication history (23).

PBMs would play an integral role in the proposed legislative plans to provide a Medicare prescription drug benefit. PBMs use formularies and other cost-cutting measures to control the drug benefit costs of health plans (22). The mergers of some PBMs with drug manufacturers do raise conflict of interest concerns, and these relationships need to be examined and disclosed to physicians and insurers. While PBMs have been somewhat successful at containing costs, they are not going to be the cure to saving money on a Medicare prescription drug benefit.

**OTC Switches**

**Position 8**: ACP-ASIM believes that switching prescription medications to over-the-counter status should be based on clear clinical evidence that an OTC switch would not harm patient safety through inaccurate self-diagnosis and self-medication, or lead to reduced access to “switched” drugs because they would no longer be covered under a prescription drug benefit. Manufacturers and other interested parties should be allowed to request such a reclassification.
Switching prescription drugs to over-the-counter status has been suggested as a possible means to reduce certain drug prices. Drugs that are deemed safe enough to sell over the counter would be less expensive for consumers and would provide greater access for those without drug coverage. In addition, avoiding a physician-office visit for a prescription could save money. However, switching certain medications to over-the-counter status may have a negative impact too. Critics of OTC switches question the ability of patients to accurately self-diagnosis and self-medicate. Without physician involvement or input, patients run the risks of misdiagnosis and improper dosage. It is also not clear that access would be enhanced, due to the fact that over-the-counter medications are not traditionally reimbursed by health insurance plans, and covered individuals would have to pay high out-of-pocket expenses.

Cost-Sharing
While these cost-containment strategies may be helpful in reducing the costs of a Medicare prescription drug benefit, Congress needs to consider other methods of assuring sustainable financing for drug coverage. A comprehensive plan that looks at long-range costs, as well as the immediate costs, needs to be developed. Formularies and PBMs may help keep costs down, but a larger commitment to funding the benefit is needed.

The Medicare Part A trust fund pays for hospital and other institutional expenses and is funded by a payroll tax on working Americans. Medicare Part B, which pays for physician services, durable medical equipment, and other non-hospital expenses, is funded by a combination of premiums paid by beneficiaries and general revenue. A prescription drug benefit should not be financed by funds already targeted to existing programs. New dollars must be sought to sustain the program.

Cost sharing with beneficiaries could be used to decrease the cost of a benefit, while expanding coverage to more Medicare beneficiaries. Beneficiaries with higher incomes could pay larger premiums, deductibles and co-pays than the low-income Medicare population. While the amount gained from higher rates will not be enough to support a drug benefit, it is a feasible method to generate more revenue to support Medicare prescription drug coverage.

Public versus Private

Position 9: ACP-ASIM opposes proposals to convert the entire Medicare program to a defined contribution program. If a Medicare prescription drug benefit administered by private entities is established, ACP-ASIM supports uniform coverage, rules, eligibility and co-payments across plans.

Position 10: A Medicare prescription drug benefit should minimize administrative hassles, including excessive documentation requirements and overly burdensome rules, for physicians.

If a Medicare prescription drug benefit is enacted, who will administer it? One option is to administer the program through the existing Medicare program. Another is for
administration by competing private plans, which may be more cost-effective. Still another, as proposed by President Bush, is to have the states administer programs. Under a defined contribution plan, the federal government would give beneficiaries a set amount of dollars to purchase drug coverage through private sector plans, with the beneficiary paying the difference between the federal government’s contribution and the cost of the plan (24). While legislative proposals would ensure that low-income beneficiaries have access to a basic drug plan, under a private system, higher-income beneficiaries could pay the difference for a higher-end plan, creating a disparity in coverage between poor and high-income beneficiaries.

ACP-ASIM has opposed turning the Medicare program as a whole into a defined contribution program, and many of the College’s original concerns are applicable to constructing a private drug benefit (24). Medicare was designed as a universal coverage program for all elderly and disabled Americans, providing the same benefits to all beneficiaries. By creating a two-tiered system of drug coverage, the less-wealthy beneficiaries would most likely be forced into plans with less coverage and fewer benefits than the wealthy. Conversely, a program with subsidies only for low-income beneficiaries could leave middle and higher income beneficiaries without coverage. Another concern is the ability of frail beneficiaries to “shop” for coverage and make a good choice among competing plans. Lower-end plans may have high deductibles and co-pays, creating an even bigger financial burden on low-income beneficiaries.

While concerns exist for creating a privately administered Medicare drug benefit, there are also some benefits to establishing such a system. By creating a competitive environment, drug plans would be forced to provide the most comprehensive coverage at the best price. Consumers would have a choice of plans, and if information was readily available, they could make the wisest choices based on their own medical history and prescription drug needs. Proponents of defined contribution argue that if an independent body oversees a Medicare prescription drug benefit, then the administrative inadequacies and micromanagement by HHS are eliminated (25).

If private insurers offered high-quality plans with uniform rules and co-pays and portable coverage, then beneficiaries might benefit from private administration. However, the federal government’s contribution would also have to be sufficient to allow beneficiaries to purchase private plans.

Conclusion

While a Medicare prescription drug benefit will be difficult to pass, Congress has allotted $300 billion for Medicare reforms, and each of the major legislative proposals fit into this price range. Since the costs of reform and prescription drug spending are increasing, we hope that Congress can enact legislation that addresses the needs of the Medicare population, while providing adequate funding for national security and defense. Ideally, a prescription drug benefit should cover all Medicare beneficiaries equally. However, if a universal benefit carries too large a price tag, then coverage should be targeted to those most in need—low-income beneficiaries, those with high drug costs,
and those with multiple chronic diseases. To ensure a high quality of life and to eliminate costly, unnecessary hospitalizations, our most vulnerable Medicare beneficiaries must have access to needed prescription medications.

ACP-ASIM supports a number of cost-saving mechanisms described in this paper, but with the condition that patient safety and quality of care should be the primary focus. A benefit that incorporates consumer protections regarding pharmacy benefit managers and formulary use could be both cost-effective and responsive to seniors’ prescription needs. In addition, higher-income beneficiaries should pay higher premiums to increase revenue to the program and allow for subsidies to lower-income recipients.

Further research is needed to examine the effects of evidence-based formularies and the long-term effects of more popular methods of reducing costs, including PBMs, tiered formularies, and price controls. No matter what methods are used to administer a cost-effective Medicare prescription drug benefit, reducing costs should not result in diminished care or poor access to necessary medications. ACP-ASIM recognizes the needs of older Americans, and calls on policy makers to respond with a Medicare prescription drug benefit that addresses those needs as soon as possible.

APPENDIX A- Current Legislative Proposals
If Congress decides to enact a Medicare prescription drug benefit, it will need to determine how to finance the benefit in a way that is predictable and sustainable. There are a number of proposals currently being reviewed by Congress.

**Bush’s Framework to Strengthen Medicare**
Rather than design a specific legislative proposal, President Bush has outlined eight principles for designing bi-partisan Medicare reform legislation:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illnesses.
- Today’s beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should provide better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program’s long-term financial security.
- The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.
- Medicare’s regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

In addition to his eight principles, Bush introduced a plan to provide beneficiaries with Medicare-endorsed prescription drug discount cards. The cards would be offered by competing private entities with a minimal federal contribution. In order to be approved as a Medicare-endorsed card provider, the programs must:

- provide a discount on at least one brand and/or generic prescription drug in each therapeutic class;
- enroll all Medicare beneficiaries wishing to participate;
- offer a comprehensive national or regional network of retail pharmacies (including mail order or Internet service);
- provide customer service to participating beneficiaries; and
- charge no more than $25 for enrollment.

Seniors can only enroll in one drug card program at a time. After six months, beneficiaries are eligible to disenroll and join a new program. The program is optional, and is not expected to provide a comprehensive drug benefit. Instead, the program is designed to provide quick savings for seniors, ranging from 10-25% discounts on retail drug prices.

**Progressive Caucus “Medicare Extension of Drugs to Seniors Plan”**

- **Eligibility:** Beneficiaries with annual incomes up to 135% of poverty - $11,600 for individuals and $15,700 for married couples. Those with incomes between 135% and 150% of poverty would receive sliding scale subsidies.
- **Beneficiaries covered:** Coverage for all Medicare beneficiaries.
- **Coverage for high costs:** Stop-loss coverage would begin after a beneficiary spent $1,600 a year for medications.
- **Effective date:** The provision would be fully implemented five years after its enactment.
Cost: Not available.

Defining feature(s): Medicare Part D would cover 80% of prescription costs; price controls and new requirements for drug reimportation.

The plan would establish a drug benefit under a new Medicare Part D, with the program paying 80% of the cost of a prescription drug. Seniors would pay a monthly premium of $24 in the program’s first year, rising to $50 when fully implemented in five years. Price control mechanisms contained in the proposal would likely reduce drug prices by as much as half, according to the caucus. The caucus proposed volume discount pricing that would allow seniors to purchase drugs at the best price paid by the federal government for the Veterans Administration and Medicaid. In addition, they proposed that drug manufacturers be subject to pricing limits on medications developed with federal funding.

In other efforts to keep costs down, the caucus plans on closing what they consider “loopholes” in the Prescription Drug Importation Act passed by Congress last year but not implemented by the Clinton Administration. These loopholes include failure to require drug firms to provide reimporters with the Food and Drug Administration-approved drug labeling; failure to prevent drug makers from imposing contract terms on foreign wholesalers that would undermine the intent of the law; and the five-year sunset period, which would discourage private sector investment to set up reimportation systems.

Senator Bob Graham’s Medicare Reform Act of 2001

- **Eligibility:** Full subsidies for beneficiaries with annual incomes up to 135% of poverty - $11,600 for individuals and $15,700 for married couples. Those with incomes between 135% and 150% of poverty would receive sliding scale subsidies.
- **Beneficiaries covered:** Coverage for all Medicare beneficiaries.
- **Coverage for high costs:** Stop-loss coverage would begin after a beneficiary spent $4,000 a year for medications.
- **Effective date:** January 2004
- **Cost:** $318 billion over 10 years
- **Defining feature(s):** Medicare coverage with full subsidies for low-income and sliding scale subsidies up to 150% poverty.

In June 2001, Senator Graham introduced S.1135, the Medicare Reform Act of 2001. The bill was introduced last year, but was defeated by a vote of 53-44. Under the plan, premiums in 2004 would cost approximately $52.80 a month, causing concern among some senior groups.

Breaux/Frist I and II Plans

Breaux/Frist I

- **Eligibility:** Full subsidies for beneficiaries with annual incomes up to 135% of poverty - $11,600 for individuals and $15,700 for married couples. Those with incomes between 135% and 150% of poverty would receive sliding scale subsidies. Those over 150% of poverty will receive a discount of 25% off premiums for drugs within a high-option plan.
• **Beneficiaries covered:** Coverage for all Medicare beneficiaries.

• **Coverage for high costs:** Requires all plans to provide $2,000 in annual stop-loss coverage for current Medicare benefits.

• **Effective date:** January 2004

• **Cost:** Not available

• **Defining feature(s):** Premium support with stop-loss at $2,000; private plans compete with Medicare; Medicare board coordinates; and Medicare premiums linked to national weighted average cost.

**Breaux/Frist II**

• **Eligibility:** Full subsidies for beneficiaries with annual incomes up to 135% of poverty- $11,600 for individuals and $15,700 for married couples. Those with incomes between 135% and 150% of poverty would receive sliding scale subsidies. Offers all beneficiaries a 25% subsidy toward the premium costs of prescription drug coverage.

• **Beneficiaries covered:** Coverage for all Medicare beneficiaries.

• **Coverage for high costs:** Stop-loss protection of $6,000.

• **Effective date:** January 2004

• **Cost:** $176 billion over 10 years

• **Defining feature(s):** Premium support with stop-loss at $6,000; benefits through Medicare+Choice and private plans; new federal agency would link premiums to fee-for-service.

Sens. John B. Breaux (D-La.) and William H. Frist (R-Tenn.) reintroduced two Medicare reform proposals, one that would completely reform the program (S.357) and one that would make more incremental changes (S.358).

Breaux/Frist I, as the comprehensive bill is known, would establish a premium support system in which private health plans and those offered by HCFA would compete on the basis of price and quality, all coordinated by a seven-member Medicare board. Beneficiary premiums would be linked to a national weighted average cost of health plans. Breaux/Frist II would replace the Medicare board with a new federal agency in the federal government and would link beneficiary premiums to fee-for-service. Prescription drug benefits would be offered through existing Medicare+Choice plans and private insurers.

Drug subsidies would be the same under both plans. A full subsidy would be available to those earning less than 135% of poverty, with a sliding scale subsidy in place for those earning between 135% and 150% of poverty. A 25% premium subsidy would be available for everyone else under both proposals.

Critics say that private plans would keep the healthiest, and thus, the cheapest beneficiaries, leaving the sickest and most expensive beneficiaries in traditional Medicare, increasing its costs and threatening its viability. They also claim that private plans cannot be relied on to deliver health care and that Medicare has done a much better job of moderating health care costs than private plans.
Given the allotted $300 billion over ten years for prescription drug coverage and other Medicare reforms in the fiscal 2002 budget resolution, the above proposals are not too far off the mark. Despite the news that the plans now under construction are within the budget range, the costs have been rising.

References


