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HEALTH & MEDICINE ISSUE PAPER



● MEDICARE ●

PRESCRIPTION DRUG BENEFIT



Introduction

Volumes have been spoken and written about this issue ... but words of substance, specificity or sincerity have been scarce. The Medicare prescription drug benefit issue is a "work in progress". All stakeholders are currently maneuvering for bargaining advantage while the 2000 election year unfolds. This issue can be made infinitely complex; and may be used to intentionally demagogue the uninformed and insecure. It is the intent of this paper to clearly and concisely analyze the debate surrounding the Medicare prescription drug benefit issue and to assist Oklahomans in developing meaningful and informed positions.

A federal budget "surplus" is colliding with a presidential election cycle in 2000. This is a prescription for countless measures to "save" federal social insurance programs; to start new ones; or restructure existing efforts.

Many ideas, proposals and schemes discussed this year were simply not politically or economically feasible just a few years ago. One such proposal is the addition of an outpatient prescription drug benefit to the Medicare program.

The National Bipartisan Commission on the Future of Medicare initially introduced the concept within their broader Medicare reform proposal in 1998. Since the Commission's recommendations, the Executive Branch released a counter-proposal for such a specific benefit in the summer of 1999, but without collateral Medicare reform.

The provision of such a social insurance benefit is a political act. The two parties that must agree are the federal executive and legislative branches.

The proposal by the President will be, by definition, the executive branch position. Senate Bill 1895 (Medicare Preservation and Improvement Act of 1999 introduced by Senators Breaux, Frist and Kerrey) will likely represent the consensus of the Senate and House. It is the product of the National Bipartisan Commission on the Future of Medicare and the forerunner to a proposal sponsored by Senator Breaux (D, LA) and Representative Thomas (R, CA). Breaux and Thomas co-chaired the National Bipartisan Commission on the Future of Medicare.

Disclaimer

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This Issue Paper

The emergence of this national debate is the product of converging of political, scientific, economic, and social forces.

- *The fundamental political factor is the apparent federal budget surplus. There are political forces at work to reduce taxes, reduce national debt, and/or spend on additional social programs.*
- *The scientific advances of pharmacology have developed products that treat previously untreatable conditions, cure previously incurable diseases, and substitute for labor intensive medical care services.*
- *The economic issue is the evolution of outpatient prescription drug therapy as a mainstream treatment modality compared to 30 years ago.*
- *The social consideration is the elderly cohort that is becoming ever larger, is living ever longer, and consuming more medical care than ever before.*

There rarely appears an issue that is so perfect to demagogue and misrepresent. On the other hand, this issue offers the nation a chance to reconsider the true meaning of social insurance, the principles that make it work, and the necessary mechanisms to maintain the long-term viability of these programs.

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MICHAEL LAPOLLA, DIRECTOR

Given these two proposals, other legislators are introducing a myriad of similar measures. Countless industry and advocacy groups are positioning their organizations. They are stating principles, negotiating terms, advocating their views and lobbying their positions. However, none will take a firm position at this time.

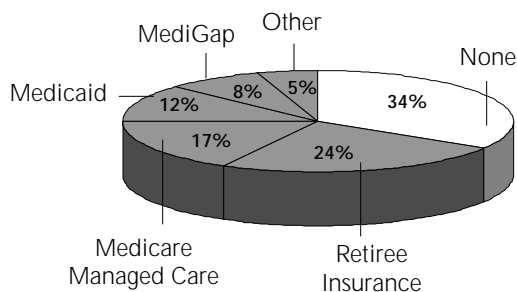
The Need?

The role of outpatient prescription drugs in the practice of modern medicine has changed significantly since Medicare was established. In 1965, these drugs were marginal therapeutic tools. Today they are an integral part of health care therapies. Most seniors have recognized this and have secured prescription drug insurance. Some have not. Proponents of radical reform say "only 24% have 'solid' coverage". The more cautious observe that two-thirds have coverage. The chart below shows the sources of coverage. You decide.

Figure 1

Prescription Drug Coverage for Medicare Beneficiaries

Prescription Drug Task Force, US House of Representatives, 10/28/1999



In his recent State of the Union address, President Clinton said: "No one creating a Medicare Program today would even think of excluding coverage for prescription drugs." On the other hand, if a new Medicare program were created today, it would be structured completely differently in a myriad of ways. In reality, we have what we have and it is from there that we must adjust. This was the intent of the National Bipartisan Commission on the Future of Medicare, an effort the Executive Branch either ignored or sabotaged.

The Enemy?

No contemporary political drama is complete without the designation of an "enemy" or "villain". In the case of this issue, the group that is currently being demonized is the pharmaceutical industry. That industry group is the only major segment of the health care sector not dependent upon public dollars; and the group has been characterized recently by high profits, inducing demand by advertising, and charging U.S. customers much higher prices than those in other countries. If recent experience with the tobacco industry is an example, it is likely that an accommodation between the industry and government will be reached. The current points of difference concern price controls.

Executive Branch Proposal

Discussion

Medicare has a very limited prescription drug benefit. Most beneficiaries have some form of private or public health insurance to cover expenses not met by Medicare. However, many of these plans either do not offer drug coverage or offer very limited protection for drug expenses. As a result, beneficiaries pay approximately half of their total drug expenses out-of-pocket. Some believe that is either unreasonable or a problem. Others are not so sure.

The absence of an adequate prescription drug benefit for the elderly has been of continuing concern to policy makers.

The projected cost of such a benefit has been a major deterrent to its implementation. Seniors spend about 21% of their income on health care; prescription drugs are their second-largest expense after insurance premiums.

Characteristics

The Executive Branch proposal offers the following features:

- Benefit costs are to be paid by premiums (50%); and by federal government subsidy (50%).
- The source of federal subsidy funds is Medicare program "cost savings" and federal budget "surpluses".
- Benefits are to be administered by HCFA.
- There is a "one-size fits all" benefit plan.
- Enrollment is voluntary and is on a one-time basis.
- Price controls are not present, but likely inevitable.
- Many will be eligible for modest benefits.
- There is no catastrophic coverage for those who exceed the benefit ceilings.
- The benefit is not part of collateral Medicare reform.
- The poor receive premium waivers and/or subsidies.

Analysis

The Clinton Administration formed the National Bipartisan Commission on the Future of Medicare to develop recommendation for strengthening Medicare in the 21st century. One of the proposed Commission initiatives was to create a Medicare Prescription Drug Benefit within a significant Medicare restructuring and reform effort.

The Commission needed 11 of 17 votes to approve their recommendations. In part due to the lack of support from the Administration, the Commission could only garner 10 affirmative votes.

After the Commission recommendations were made public, the Clinton Administration proposed the creation of the drug benefit absent collateral reforms. All of the proposed federal funding is to come from budget surpluses or program cost savings. Some of the "cost savings" are proposed reductions in benefits or increases in co-payments.

The limited benefits would be shared by many, but would provide no Medicare relief for the few with catastrophic needs.

Legislative Branch Proposal

In November 1999, Senators Breaux, Frist and Kerrey introduced to the Senate Bill 1895 (Medicare Preservation and Improvement Act of 1999). It is a direct by-product of the work of the National Bipartisan Commission on the Future of Medicare (NBCFMR). The bill outlines the principles of fundamental Medicare reform.

The prescription drug benefit is part of the overall plan to restructure Medicare. It uses the model of the Federal Employees Health Benefits Plan, creates a Medicare Board for seven years and is intended to ensure quality health care at an affordable rate. It emphasizes the use of competitive bidding for benefits packages to seniors. There is a sharing of the risk pool of healthy and high end users. There is also a provision for a stop-loss guarantee where there is a ceiling of \$2,000 out of pocket expenses.

Characteristics

The Congressional proposal offers the following features:

- The benefit is part of an overall reform of Medicare modeled after the Federal Employee Benefits Program.
- Sources of financing are not yet determined.
- Benefits are administered by private sector.
- There are many plan choices for beneficiaries.
- Enrollment is voluntary.
- Price controls are not present, but likely inevitable.
- Many will be eligible for modest benefits.
- Catastrophic coverage provided for those who exceed the ceiling benefit.
- The poor receive premium waivers and/or subsidies.

Analysis

The Senators and Representatives (Breaux, Frist, Kerrey, and Thomas) were involved in the leadership of the NBCFMR. They have emerged as the most committed and analytical Members of Congress concerning this benefit.

Their thoughts are in policy conflict with the executive branch as follows:

- Congress prefers that additional benefits be concurrent with, and contingent upon, significant Medicare restructuring and reform. The President's proposal does not.
- Congress prefers a benefit package embedded within a choice of plans similar to the Federal Employee Benefit Plan choices. The President's proposal is a single additional benefit added to current Medicare benefits.
- Congress prefers offering subsidized coverage for the poor and catastrophic insurance for all. The President's plan covers the poor but establishes a ceiling for all beneficiaries.
- Congress has yet to agree upon funding formulas, subsidies and mechanisms. The Executive Branch plan specifies a benefit financing mechanism.

Generic Proposals

There is only one complete plan "on the table" at this time. That is the Executive Branch proposal. Others, such as the intent of the National Bipartisan Commission on the Future of Medicare, and Congressional resolutions, outline fundamental principles but have not yet been reduced to specific program design. Still other legislators are introducing a variety of incomplete proposals. Industry and advocacy groups are responding loudly and vigorously to the small amount of specific information available.

Therefore this section of principle considerations should be necessary and helpful. It is appropriate to outline the policy choices and features of any plan in order to systematically evaluate future proposals, and mitigate against becoming lost in rhetoric and detail.

Characteristics

A complete plan must specify financing, benefits, limitations, administration, and flexibility.

Funding

The primary principles are: to what proportion is the benefit funded by beneficiary premium dollars versus federal subsidy? If there is a federal subsidy, is the source "hard money" such as FICA tax increases ... or "soft money", such as cost shifting and application of unrealized surpluses?

Benefits

Will the benefits be first dollar benefits with an annual ceiling (benefits many) ... or less than first dollar benefits with a catastrophic stop-loss ceiling (benefits few)?

Limitations

What will be the amounts of co-payments and deductibles?

Administration

Will the benefit be administered within the current Medicare infrastructure, or in the private market per consumer choice? Additionally, will the benefit be part of overall reform, or an additional benefit applied in the absence of reform.

Additional Thoughts

Some have suggested that profits by the pharmaceutical industry fuel resentment toward high prices. The industry claims that they must recoup costs before the proprietary patents expire. Given this situation, some policymakers speculate that the most efficient intervention is for the government to purchase the patent rights to successful drugs and allow generic substitutes to appear much sooner.

Others have suggested that it is critical to maintain the integrity of the social insurance aspects of Medicare. This would suggest that all Medicare beneficiaries fully fund the benefit through premium assessments; and that richer beneficiaries of the nation's wealthiest cohort should subsidize the poor as with any social insurance arrangement.

Who Pays?

Few will argue the demonstrable need to address the social spectacle of any Medicare beneficiary choosing between necessary medicine and other life essentials. It is not likely that it happens often, but there is no good reason why it must happen at all.

That said, such a benefit must have a balanced financing construct that will self-regulate against abuse, misuse and manipulation. It must also preclude, as much as possible, governmental rationing and arbitrary regulation. The best method of achieving such a balance is through realistic funding, or financial participation formulas and principles.

Cost

The current cost estimates for this benefit is \$168 billion from 2002-2008. In truth, there is little national confidence in these preliminary estimates. The original Executive Branch estimate was \$118 million; the Congressional Budget Office estimated \$168 billion ... a difference of 42%. Most responsible analysts recognize the softness of these preliminary estimates. Nevertheless, any significant incurred cost must be met by a workable financing mechanism.

Financing

The only proposal that has specifically outlined a financing plan is that from the Executive Branch. That proposal suggests that half of the cost be funded by beneficiary premiums; and the other half by federal government subsidy.

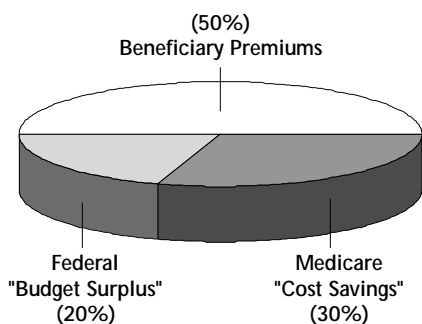
The government subsidy would be a combination of program "savings" by reducing/restructuring current benefits; and by applying a portion of the projected budget "surpluses" between now and 2008.

In other words, the benefit would be funded by cash from the insured and budgetary IOUs from the federal government. This financing mechanism is at the heart of the Executive Branch proposal.

It is the weakest and least defensible aspect of the proposal.

Figure 1
Executive Branch Plan: Who Pays in 2008?

Testimony, Dan L Crippen, Congressional Budget Office, July 22, 1999



We Believe

There is a compelling need to soberly craft a Medicare prescription drug benefit. There is an equally compelling need to do so in a responsible manner that affords flexibility, patient choice, patient responsibility, and only the most essential government subsidy.

The emergence of outpatient prescription drugs as a primary therapeutic tool is one of the most positive aspects of modern medicine. They have helped to significantly reduce costly inpatient services. They have added to the quality of life. And they apply to many diseases and conditions for which there was little treatment a generation ago.

We believe that it is the duty of public officials to responsibly incorporate the benefits of these products into the Medicare health plan. The question is "how"?

We believe that this benefit should be constructed as follows:

- Offered as a choice to Medicare beneficiaries.
- That primary consideration be given to Federal Employees Health Benefit Plans as the enrollment mechanism.
- That the federal government not administer such a benefit through federal agencies.
- That beneficiaries pay a significant portion of the costs through premiums.
- That any government subsidy be through identifiable "hard money" (FICA taxes) and not through non-specific and unidentifiable "future savings" or "budget surpluses".
- That the poor be accommodated through state Medicare/Medicaid programs in a uniform, standardized manner and clinically appropriate manner.

WE CONCLUDE

There are significant, rational and compelling reasons to craft an outpatient prescription drug benefit for Medicare beneficiaries.

It will be a major strategic mistake to simply provide an add-on, one-size-fits-all benefit to be administered by HCFA. It would compound the error to finance this benefit in an illusory manner while ignoring meaningful participation in financing and risk sharing.

And finally, the addition of this benefit will be irresponsible and disingenuous without collateral and significant Medicare reform. This is a timely opportunity to simultaneously correct program design weaknesses that have evolved ... and to add a meaningful benefit whose clinical importance has emerged over time.