Designing A Medicare Prescription Drug Benefit: Issues, Obstacles, And Opportunities

How do the leading proposals address the difficult issues in designing and administering a drug benefit for Medicare?

by Mark McClellan, Ian D. Spatz, and Stacie Carney

PROLOGUE: When Congress tackles the tough issues surrounding whether to add outpatient prescription drugs to Medicare’s benefit package, legislators will be forced to address similar questions that have vexed the program for years. Who should administer the benefit? Who should be eligible? How broad should the benefit be? And who should pay? Perhaps the most controversial of these issues is how payment should be apportioned in society. It was this very issue that brought repeal of the Medicare Catastrophic Coverage Act of 1988 when Congress differentiated the Medicare Part B premium on the basis of a beneficiary’s income. In this paper the authors explore these questions and more, asserting along the way that the major prescription drug benefit proposals already introduced in Congress “may not be far apart.”

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ABSTRACT: We review the policy concerns underlying some of the most contentious issues that must be resolved prior to the enactment of a Medicare drug benefit. We consider critical issues both in benefit design—targeted versus universal eligibility, benefit subsidies, and benefit comprehensiveness—and in benefit administration, focusing especially on issues involving the administration of the drug benefit in traditional Medicare. Despite the apparent contentiousness of the drug benefit debate, alternative proposals may not be so far apart on these issues.

The current debate over adding a prescription drug benefit to Medicare makes it seem inevitable yet far off. On the one hand, the widespread publicity about problems of cost and availability of prescription drugs for the elderly resembles the situation that existed for physician and hospital insurance in the mid-1960s, prior to the creation of Medicare. With pharmaceuticals expected to become an even more important part of managing diseases in the elderly in the years ahead, a majority of both Democrats and Republicans in Congress seem to support a new subsidized drug benefit for Medicare enrollees. There also is broad consensus that Medicare’s traditional approach to providing health insurance is outdated, at least as a model for a new drug benefit.

On the other hand, the political interests who will surely shape any final legislation appear to have divergent views on the best way to provide a drug benefit while limiting its costs. As a result, the policy debate has often seemed acrimonious, and controversies about how Medicare’s drug benefit should be designed are widely viewed as a significant obstacle to the enactment of legislation.

In this paper we provide a brief guide to some of the most contentious policy issues that must be resolved before a Medicare drug benefit can be enacted. We first consider three key issues in benefit design: targeted versus universal eligibility, benefit subsidies, and benefit comprehensiveness. We then consider some major issues in benefit administration, focusing especially on how the drug benefit would be administered in traditional Medicare—perhaps the most contentious area of debate—but also touching on other administrative concerns. Decisions about these issues will influence not only the extent to which different groups will support a drug benefit proposal, but also the cost and quality of prescription drug coverage, if enacted. Despite the acrimony of the policy debate, we conclude that alternative proposals may not be so far apart.

Designing A Drug Benefit For Medicare

By early 2000 a number of major prescription drug benefit proposals had been introduced (Exhibit 1). There are several important areas of agreement. All propose a voluntary benefit, to avoid accusations
### EXHIBIT 1
Some Recent Proposals For Medicare Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Sponsor</th>
<th>Eligibility/tariffing of subsidized coverage</th>
<th>Minimum eligible benefit</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>President Bill Clinton President’s Plan to Modernize and Strengthen Medicare for the Twenty-first Century</td>
<td>Essentially one-time option to enroll No premiums or cost sharing for comprehensive drug coverage if income below 135% of poverty Premium subsidy phased down between 135% and 150% of poverty; 50% subsidy for those over 150% Partial subsidy (two-thirds of individual subsidy) for employer-sponsored plans</td>
<td>Capped benefit; no deductible and 50% copayment for drug expenditures up to $5,000 (cap phased in from $2,000 in 2002—actuarial value of around $600—to $5,000 in 2008—actuarial value of around $1,100)</td>
<td>Beneficiaries enrolled in traditional plan would get subsidized benefits through a PBM or former employer Competitive bidding every few years, with at least two benefit management contracts awarded by HCFA in each geographic region Broad range of public and private entities could compete for contract Beneficiaries enrolled in private plans would get subsidized benefits through these plans</td>
</tr>
<tr>
<td>Breaux-Frist Medicare Preservation and Improvement Act of 1999 (S. 1895)</td>
<td>Annual enrollment Full subsidy for least expensive plan in area if income below 135% of poverty Premium subsidy phased down between 135% and 150% of poverty, from a subsidy equal to 50% of premium of least-expensive eligible plan for those at 136%, to 25% of the minimum actuarial value for those over 150% Subsidy treated as taxable income</td>
<td>Eligible plans must have an actuarial value of at least $800 in 2003 No explicit restrictions on type of coverage, but plans would be approved by a new Medicare board to encourage high quality and discourage designs that attract low-cost beneficiaries</td>
<td>Beneficiaries enrolled in traditional plan would choose from subsidized drug benefits offered by a broad range of private entities that meet eligibility standards and are approved by board; eligible entities include PBMs, insurers, pharmacies, former employers Beneficiaries enrolled in private plans would get subsidized benefits through these plans</td>
</tr>
<tr>
<td>Kennedy-Stark Access to Prescription Medications in Medicare Act (S. 841/H.R. 1495)</td>
<td>Likely annual enrollment, like Medicare-Choice No premiums or cost sharing for beneficiaries with incomes below 135% of poverty; all others receive 75% premium subsidy Those with employer coverage equal to or better than the drug benefit could opt to receive the subsidy for their existing coverage</td>
<td>Capped plus catastrophic benefit Capped benefit: $200 deductible, 20% coinsurance up to $1,700 cap Catastrophic stop-loss: 100% coverage of out-of-pocket costs over $3,000 Significantly higher actuarial value than plans listed above</td>
<td>Beneficiaries enrolled in traditional plan would get subsidized benefits through a PBM or former employer Competitive bidding every few years, with at least two benefit management contracts awarded by HCFA in each region as long as there are two or more qualified bidders Broad range of public and private entities could compete for contracts Beneficiaries enrolled in private plans would get subsidized benefits through these plans Low-income beneficiaries would receive benefits through state Medicaid programs</td>
</tr>
<tr>
<td>Snowe-Wyden Seniors Prescription Insurance Coverage Equity Act (SPICE) (S. 1480/H.R. 2782)</td>
<td>Annual enrollment No premiums for least-expensive eligible plan in area if income below 150% of poverty Premium subsidy phased down between 150% and 175% of poverty, to a subsidy equal to 25% of premium of least-expensive eligible plan for those over 175%</td>
<td>Minimum standard for eligible benefits would be specified by a new SPICE board</td>
<td>Beneficiaries enrolled in traditional plan would choose from subsidized drug benefits offered by broad range of private entities that meet eligibility standards and are approved by board; eligible entities include PBMs, insurers, pharmacies, former employers Beneficiaries enrolled in private plans would get subsidized benefits through these plans</td>
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</tbody>
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EXHIBIT 1
Some Recent Proposals For Medicare Prescription Drug Coverage (cont.)

<table>
<thead>
<tr>
<th>Sponsor</th>
<th>Eligibility/targeting of subsidized coverage</th>
<th>Minimum eligibile benefit</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilirakis Medicare Beneficiary Prescription Drug Assistance and Stop-Loss Protection Act (H.R. 2925)</td>
<td>Full premium subsidy for comprehensive drug benefit if income below 200% of poverty, and no cost sharing below 120% of poverty Higher-income beneficiaries with qualified prescription drug coverage would receive free catastrophic coverage States would design low-income subsidies using enhanced federal matching funds for beneficiaries below 150% of poverty and regular matching funds for those up to 200% of poverty</td>
<td>Minimum benefits for low-income plans determined by states; equivalent to Medicaid, the federal employee program, or a private managed-care benchmark Catastrophic stop-loss: 100% coverage of out-of-pocket costs over $1,500 if beneficiary has private policy that meets minimum standards</td>
<td>States would administer funds through drug assistance programs that are independent of Medicaid, or through premium subsidies of private plans that meet state-defined benefit requirements Administration and financing of catastrophic coverage unclear</td>
</tr>
</tbody>
</table>

SOURCES: Bills as noted; National Economic Council and Domestic Policy Council, The President’s Plan to Modernize and Strengthen Medicare for the Twenty-first Century (2 July 1999); and “Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of Selected Proposals as of September 20, 1999,” Kaiser Family Foundation (October 1999), available online at www.kff.org.

NOTES: PBM is pharmacy benefit manager. HCFA is Health Care Financing Administration.

of new mandated payments. All propose some subsidies for the cost of coverage for beneficiaries. But there are also some substantial design differences.

- **Targeted versus universal eligibility.** An initial design question concerns whether the new benefit will be a universal one, available to all beneficiaries, or targeted to only low-income beneficiaries. This question reflects a trade-off between uninsurance and limiting government costs. All proposals include free or nearly free comprehensive benefits for low-income households, up to around 120–135 percent of the poverty line—a substantial expansion of the coverage now available through Medicaid. Targeted proposals, such as the initial Breaux-Thomas proposal for the National Bipartisan Commission on the Future of Medicare and the state-administered benefit in the Bilirakis proposal, would phase out eligibility entirely as income rises. The benefits in such a targeted program could be provided by expanding eligibility for state-administered, Medicaid drug coverage (which already provides comprehensive coverage for many very low-income beneficiaries) or by building on state pharmaceutical assistance programs.

The targeted approach has been criticized for several reasons. First, it subsidizes insurance for a critical component of medical care only through programs that are means-tested and state-administered, deviating from the concept of federal social insurance that is a hallmark of all other Medicare benefits. Second, it also would leave many beneficiaries uninsured: While lower-income
beneficiaries are less likely to have coverage today (and are particularly less likely to have good private coverage), lack of insurance is not strikingly correlated with income (Exhibit 2). Finally, if coverage were left to the states, they would have to address many of the same design issues (and costs) that we discuss below for federal benefit programs. For these reasons, most proposals include a universal benefit for Medicare enrollees.

Subsidies. Most proposals provide universal premium subsidies for beneficiaries in addition to comprehensive coverage for low-income beneficiaries, but they vary in magnitude. The disagreement among proposals in how much subsidy to offer reflects differences in how the trade-offs of program costs, uninsurance, and crowding out should be weighed, and has both political and policy implications.

Subsidies are obviously politically appealing because of their popularity with beneficiaries. But they also serve an important policy function in making voluntary drug insurance work: They encourage beneficiaries with relatively low demands for prescription drugs not to forgo coverage and thereby create adverse selection problems in the insurance market. For example, Medicare Part B has near-universal participation (more than 96 percent of those eligible) in large part because it includes a 75 percent premium subsidy.

The practical importance of a potential adverse selection problem is evident: Fewer than 10 percent of beneficiaries purchase voluntary, unsubsidized drug coverage in the individual Medigap market today. Most prescription drug spending by the elderly is for treating chronic diseases, which often require near-lifetime treatment. Consequently, prescription drug spending is largely predictable and

### EXHIBIT 2
Income, Out-Of-Pocket Medical Spending, And Drug Coverage Among The Elderly, 1998

<table>
<thead>
<tr>
<th>Household income</th>
<th>Share of elderly</th>
<th>Median share of after-tax income spent on health care</th>
<th>Share without prescription drug coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>100%</td>
<td>13%</td>
<td>34%</td>
</tr>
<tr>
<td>Below $10,000</td>
<td>18</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>$10,000–$19,999</td>
<td>29</td>
<td>19</td>
<td>38</td>
</tr>
<tr>
<td>$20,000–$29,999</td>
<td>18</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>$30,000–$49,999</td>
<td>18</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>$50,000 and above</td>
<td>17</td>
<td>6</td>
<td>26</td>
</tr>
</tbody>
</table>

**SOURCES:** See below.

b Imputed from Bureau of Labor Statistics (BLS), Consumer Expenditures Survey, 1997, available online at ftp.bls.gov. Median expenditure shares were estimated as median amount spent on health care divided by median reported income.
c Actuarial Research Corporation (ARC), 1999. The ARC income distribution is based on the Medicare Current Beneficiary Survey, which tends to report somewhat less skewed household incomes than the CPS and the BLS survey; as a result, the differences in insurance rates by household income are probably somewhat smaller than the exhibit suggests.
Because it is rational for beneficiaries to purchase coverage only if they expect their insurance benefits to be commensurate with their premiums, only persons who tend to be heavy, chronic users of prescription drugs tend to purchase the policies. As a result, premiums for individual policies are high, and enrollment is low. Because subsidies reduce beneficiary premiums, they would encourage more beneficiaries to purchase coverage, reducing adverse selection and increasing coverage rates.

Larger subsidies for all beneficiaries also may reduce the undesirable incentive effects of “means-testing” benefits for the elderly. The income-related proposals just described might seem to be fair, in that they do not provide costly new subsidies to beneficiaries who are above modest means and who spend relatively small shares of their incomes on medical care (Exhibit 2). But means-testing effectively creates an additional “tax” on income over the phase-out range, as a result of the reduction in the drug benefit subsidy. The magnitude of the new effective tax is substantial in most proposals, because eligibility for comprehensive coverage is phased down to a limited subsidy over a small income range. Few of the elderly work today, and phasing down rapidly is an attractive way to limit the costs of the drug benefit. But additional means-tested benefits for seniors will add to the disincentives for persons who are approaching old age from saving for retirement or from continuing to work.

However, larger subsidies also raise program costs. The direct cost of the benefit is proportional to the subsidy and the share of beneficiaries who take up the benefit. More-generous subsidies may induce beneficiaries to elect coverage and to choose more costly policies.

Similarly, reducing the cost of drugs to beneficiaries will tend to encourage higher consumption—the so-called moral hazard problem. Many health care experts view this as desirable to some extent, as some beneficiaries report forgoing recommended prescriptions because of their cost. But subsidies undoubtedly will also encourage some additional use of costly drugs of only limited value. In their policy simulations, the Health Care Financing Administration (HCFA) actuaries and the Congressional Budget Office (CBO) are apparently assuming that a 50 percent subsidy is needed to drive uninsurance rates close to zero for plans that would provide some support for most beneficiaries (that is, noncatastrophic plans). The demand for drugs by the elderly is also likely to rise as a result of the lower out-of-pocket payments that result. However, the fact that most proposals feature limited benefits means that the utilization response should be moderate.

Finally, larger subsidies for relatively high income beneficiaries
will inevitably lead to more crowding out of private benefits. Crowding out is a concern because of the considerable private spending on drug coverage, which is now concentrated among higher-income beneficiaries. To the extent that such private spending falls as a result of the new benefit, program costs are likely to rise at a rate disproportionate to those of insurance coverage. Employer-provided prescription drug coverage is by far the most important source of private financing of good drug insurance among Medicare beneficiaries. Around one-fourth of beneficiaries have such coverage today, although coverage rates have declined in recent years in conjunction with the rising cost of prescription drugs. Altogether, around half of Medicare prescription drug insurance is financed by private sources, with the remainder coming from beneficiary copayments and premium contributions.

With a universal subsidy, this private financing would inevitably be replaced by public financing, as employers and beneficiaries would change their drug benefits to take advantage of new subsidies. The most likely response would be for employers to drop their own plans, “buy in” to the new drug benefit, and (if the new subsidized benefit is a lot less generous than the benefit they would otherwise provide) offer “wraparound” coverage. This is exactly what most employers that offer retiree drug coverage do now with respect to existing Medicare benefits.

President Clinton’s proposal explicitly addresses the issue of crowding out by providing a partial subsidy to employers that either offer their own coverage or buy into the new benefit on behalf of their employees and offer wraparound coverage. This partial subsidy is two-thirds as large as the subsidy for individually purchased coverage, so it has the potential to eliminate one-third of the crowding out of private employer financing. Supporters of this proposal note that employers and their workers already benefit from the tax-deductibility of retiree insurance costs and that this tax subsidy in addition to the partial employer subsidy would be large enough to make it worthwhile for employers to continue coverage, rather than dropping coverage and compensating their employees with additional (taxable) income to purchase the new benefit.

Most proposals do not include provisions to reduce crowding out of private financing. Some proposals would allow employers to receive the full new subsidy that individual beneficiaries would receive if they dropped their employer coverage in favor of the new benefit. These proposals would reduce crowding out of the provision of private coverage by firms, but they would not reduce that of private financing. Proposals without employer provisions such as these would crowd out both private provision and financing in the
long run, since employees would have to switch out of their firm’s coverage and into the new benefit to receive the benefit subsidy.

■ **Comprehensiveness.** Benefit design for employer-provided drug coverage is dictated largely by employers’ decisions, in consultation with their employees. In most large-employer plans today, drug benefits are comprehensive. Enrollees typically make small co-payments for generic and on-formulary drugs and pay considerably more for off-formulary drugs, after exceeding a modest deductible. There is no cap on total benefit payments.

Providing significant subsidies for such comprehensive coverage in Medicare would entail large budgetary costs. There are two basic ways in which benefits could be reduced to limit costs. First, a catastrophic benefit with a high deductible (for example, $1,500) would lower costs while still providing the best possible insurance, given a constraint on total spending. From the standpoint of economic theory, this is the best possible insurance given a budgetary constraint: With a catastrophic policy, beneficiaries would be protected against large drug expenses. Unfortunately, catastrophic-only insurance is not widely viewed as politically viable. The median Medicare beneficiary has relatively predictable drug costs of around $600 per year and could continue this pattern of drug use for many years. Thus, many beneficiaries might not be willing to purchase coverage that provides assistance for catastrophic drug expenditures unless it were subsidized at much higher rates than noncatastrophic plans with similar actuarial value—which in turn would raise costs. Indeed, the catastrophic nature of the Medicare drug benefit enacted in the short-lived Medicare Catastrophic Coverage Act of 1988 was one of its least popular features.

In contrast, a capped or “up-front” benefit with a low deductible and little or no coverage in the event of high expenditures also would limit benefit costs, in a way that would undoubtedly be more attractive to more beneficiaries. Such a benefit also could limit the growth in government costs over time: To the extent that drug expenditures grow more rapidly than the scheduled increase in the cap, more beneficiaries will have spending that exceeds the coverage limit and consequently would not be covered. While such a benefit could reduce drug spending for a larger share of beneficiaries, it is important to remember that it is not true insurance.

Most proposals follow this approach. For example, the presi-
dent’s plan explicitly specifies a benefit cap that rises with the Consumer Price Index (CPI). The Breaux-Frist proposal does not specify a particular design. It mandates that all plans have a benefit design of a minimum actuarial value, then caps the low-income subsidy at a fraction of the lowest-cost plan in the area that provides this benefit and provides a universal subsidy equal to 25 percent of the minimum actuarial value. The Snowe-Wyden proposal leaves benefit design to program administrators, subject to approval by an oversight board. These proposals seem to allow both catastrophic and comprehensive benefits in addition to capped benefits. But the fact that their subsidies are capped (so that comprehensive plans would not get additional subsidies), coupled with most beneficiaries’ preference for up-front coverage, suggests that these proposals also would result in capped benefits.

Administering The Drug Benefit

■ Benefit standards. The preceding discussion suggests that the standards imposed on benefits eligible for the subsidy will have a critical effect on the resulting drug coverage. In general, the proposals envision a minimum benefit, to which individual plans could add features. Some proposals (such as the president’s plan and Kennedy-Stark) follow current Medicare practice and specify minimum benefit standards in some detail. Other proposals leave this task to an oversight board, as we describe in more detail below. Specifying the minimum benefit in some detail is critical to assuring that actual coverage reflects policy goals. In a voluntary system in which beneficiaries are paying a substantial part of the cost (and all of the costs above a cap), it will be difficult to sustain more-generous plans. As a result, it seems likely that the minimum benefit will become the predominant benefit. Imposing some standardization on any additional benefits that are offered, analogous to standardization in the individual Medigap market and in the plans offered by many large employers, would both make it easier for beneficiaries to shop for plans and discourage designs that appeal only to the healthy.

■ Limitations on enrollment. Frequent opportunities to enroll and disenroll in the drug benefit, as envisioned in most proposals, provide considerable flexibility for beneficiaries. However, if they can choose frequently whether to participate, beneficiaries are likely to wait until they actually face high drug expenditures before enrolling, which would worsen the problem of adverse selection. With a few exceptions, the president’s plan would provide one enrollment opportunity, generally on first becoming eligible for Medicare Parts A and B. These enrollment restrictions are similar to those now in place for Part B and should encourage more beneficiaries to stay
enrolled, even if they do not expect to use prescription drugs much in the near future. Participating beneficiaries could still be allowed to choose regularly among drug benefit plans, as we discuss below.

Managing benefit costs and quality. Despite the pervasive use of administered pricing in the current Medicare fee-for-service (FFS) program, almost all major proposals are unified in disavowing a “price control” approach to limiting the cost of covered pharmaceuticals in FFS Medicare. Many economists have argued against price controls, especially in industries with rapid technological change, because of concerns that such controls would limit returns for developing new products and thus reduce drug-product innovation. This is a particularly sensitive issue for the pharmaceutical industry, which has emphasized the importance of attracting capital to sustain its very high research costs.

As an alternative to price regulation, current proposals look to private-sector benefit managers to control costs. Most employers contract out their drug management to a pharmacy benefit manager (PBM), and private health plans either contract out or conduct these activities internally. The activities of PBMs are intended both to reduce drug costs (for example, through negotiating aggressively with drug manufacturers and pharmacies for discounts on formulary medications, and providing incentives for doctors and patients to use these drugs) and to improve the effectiveness of drug use (for example, through implementing integrated information systems to help identify adverse interactions and more effective medications).

All proposals generally assume that employers and private plans offering subsidized drug benefits would continue to rely on these mechanisms. The most important administrative difference among the proposals involves how the benefit would be managed in the traditional FFS plan. The proposals generally state that a broad range of entities—PBMs, private Medigap insurers, managed care plans, and pharmacy networks—could manage the benefit in traditional Medicare. However, they differ in the extent to which they seek either to replicate the approach of private employers and plans or to address unique issues arising from the size and government control of the traditional Medicare plan.

For example, the president’s proposal envisions a competitive bidding process for managing the drug benefit in traditional Medicare that resembles the approach used by large employers. HCFA would select one winning bidder every few years for each region to manage benefits for all FFS Medicare beneficiaries who do not receive coverage through their employer or a managed care plan. Drug manufacturers and others have criticized this approach. They contend that because of pressures to limit the cost of the drug benefit,
“Risk adjustment is burdensome but is an essential part of implementing a drug benefit.”

“guarantees” of the best available prices to beneficiaries would find their way into the PBM contract so that Medicare would, in effect, implement price controls via the PBM contract. They also contend that beneficiaries, without a choice of drug plans, would have little recourse other than to leave FFS Medicare in cases where they did not like the quality of the single contractor.

In contrast, the Breaux-Frist and Snowe-Wyden proposals are “any-willing-benefit-provider” proposals. Any entity that meets a set of conditions specified by an oversight board would be allowed to compete for beneficiaries in traditional Medicare, and beneficiaries would choose their own drug plan on the basis of quality and (subsidized) price during an open-enrollment period. This approach gives beneficiaries in the traditional program more choice. It also increases the length of the “arm’s-length” relationship between the benefit managers and the government agency overseeing the traditional plan, reducing the risk of de facto price controls.

Private sponsors of drug coverage do not use this approach, presumably because any-willing-benefit-provider proposals create their own complications. The presence of multiple contractors would make it more difficult for traditional Medicare to work closely and effectively with particular benefit managers to improve overall quality and costs of care. In addition, a single large PBM in a region also might be able to reduce drug costs better than many smaller PBMs could, as a result of increased market power, and would be able to achieve more economies of scale in implementing tools to deliver high-quality prescription benefits. Beneficiaries who already have to choose among health plans may find the additional choice process burdensome. Individual choice also would create more opportunities for risk selection among PBMs that provided different benefits. Risk adjustment of drug costs, which are rather predictable from year to year, and other mechanisms for pooling risk among plans (such as reinsurance for very high cost cases) could help to address this problem. Such steps are burdensome but are probably an essential part of implementing a drug benefit in any case, to limit incentives for selection across health plans. 21

The concerns raised by both single- and multiple-PBM proposals could be addressed by selecting a limited number of PBMs to participate in each region. These plans would be less closely tied to government management of the traditional Medicare plan, thereby
mitigating the concern that exclusive contracts would open the door to price controls. Explicitly relying on a limited number of benefit managers also would reduce the problems associated with the multiple-PBM approach. A limited number of participating managers would make it easier for the traditional plan to coordinate prescription use with other aspects of care. It also would help to reduce the extent of plan variation, leading to fewer opportunities for selection and beneficiary confusion, and simplifying the problems of benefit standardization and risk adjustment.

Indeed, an any-willing-benefit-provider approach may well end up with a limited number of drug benefit providers. While a number of regional PBMs provide benefits in the private sector today, the national PBM market is quite concentrated, with five large players accounting for tens of millions of covered lives. This presumably reflects, at least in part, the economies of scale and better bargaining capability of large benefit managers. If the large PBMs can provide lower-cost or higher-quality drug coverage for most beneficiaries, they also would come to dominate the new market for drug coverage in FFS Medicare. Conversely, in the “single PBM per area” bidding approach, the overall national coverage of a PBM bidding on the contract would probably be a more important determinant of the drug discounts and other scale economies that they could achieve than would the number of Medicare beneficiaries in the bidding area. Thus, this bidding approach also would be likely to end up with a few dominant PBMs serving most of the Medicare market.

Risk assignment. Although not all details are clear, proposals also appear to differ in the extent to which the private benefit managers of drug plans in FFS Medicare would bear financial risk. Some proposals, including the president’s, would assign all risk to the government while allowing experimentation with risk sharing. In contrast, the Breaux-Frist and Snowe-Wyden bills assign all risk to the PBM. Some large employers assign some risk to PBMs, permitting the employers to take a more hands-off approach to cost control. However, risk sharing by PBMs might discourage high-quality coverage to the extent that the benefit managers are not concerned about losing beneficiaries. The government could limit incentives for skimping by bearing risk, but this would weaken incentives to control costs, and the administering entity probably would have to engage in more detailed oversight to protect the government’s financial interests. As Haiden Huskamp and colleagues discuss in more detail elsewhere in this volume, limited risk-bearing arrangements such as risk corridors represent a way to balance these concerns.

Oversight. Two approaches have been proposed for developing benefit standards and supervising the provision of drug benefits.
in the Medicare program. These two approaches reflect different visions for the Medicare program that are particularly difficult to reconcile. One approach, generally favored by those sympathetic to a Medicare board to perform analogous activities for the Medicare program more broadly, features the creation of a new, largely independent supervisory board to determine benefit requirements and manage the competitive process (develop benefit standards, certify plan eligibility, and provide objective information on plans to beneficiaries). Under this proposal, HCFA would have primary responsibility for managing the drug benefit in the traditional plan only, subject to the board’s oversight. The other approach, endorsed by the president and many congressional Democrats, would give HCFA and the U.S. Department of Health and Human Services authority over the Medicare drug benefit, analogous to their authority over other aspects of the program today.

Advocates of a new oversight board contend that HCFA is ill suited to selecting and overseeing a competitive drug benefit program in Medicare because of its history of closely regulating providers and prices, and that in any case it makes good policy sense to separate management of the traditional plan from management of benefits and competition. In contrast, critics of a new board argue that it would create duplicative bureaucracy, and that Congress and the executive branch are unlikely to leave difficult and politically sensitive decisions about drug coverage or other health care benefits for the elderly to an independent agency.

**Concluding Comments**

We have reviewed some of the important but controversial issues that any drug benefit proposal must address. While controversies remain, the proposals may be less far apart on these issues in practice than they may appear. One possible exception is the unresolved debate over the supervision of the drug benefit, which reflects a more fundamental debate over the most effective way to supervise the overall Medicare program.

The policy debate over the subsidy and nature of the drug benefit seeks to balance a desire for controlling costs, avoiding crowding out of private financing, and limiting any new transfers to wealthier elderly against a desire to reach near-universal coverage and avoid selection problems that lead to high premiums and low benefit quality. Complex as it is, the current debate largely boils down to whether the subsidy will be closer to 25 percent or 50 percent of the cost of a capped benefit. This appears to be an issue where compromise is possible and where the subsidy could be adjusted in the future to address problems of cost, benefit quality, or low participa-
tion. We also prefer coverage with a catastrophic flavor on the grounds that it provides better insurance, but we recognize the cost and political difficulty of enacting such a plan.

The policy debate over how the drug benefit would be managed in the traditional Medicare plan seeks to balance a desire to adopt practices that have worked well in the private sector against unique concerns about potential risks of de facto price controls and new government regulation. A proposal that features participation by a few PBMs in each region provides a way to balance these concerns. Regardless of the approach taken, careful attention to defining a minimum drug benefit package and to standardizing additional drug benefit offerings, along with good risk adjustment and other steps to reduce adverse selection, will improve the drug benefit’s chances of success.

The opinions expressed in this paper are those of the authors and do not represent the views of the U.S. Department of the Treasury or Merck and Company Inc. We thank Ernest Berndt and Joseph Newhouse for helpful discussions and John Calfee, the editors, and two anonymous reviewers for useful comments on an earlier draft.

NOTES

1. In 1999, poverty levels were $8,240 for singles and $11,060 for couples.
2. The Bilirakis proposal also includes a catastrophic insurance component for which all beneficiaries who purchased “qualified” basic prescription drug plans would be eligible. This benefit would be administered through the private sector and paid for by the federal government.
3. Approximately fifteen states provide assistance to elderly persons using state funds.
4. One important exception is the Breaux-Thomas proposal to the Medicare commission, which provided only low-income coverage. However, the more recent Breaux-Frist proposal includes a universal subsidy, as noted in the text.
5. Most proposals would provide subsidies as direct government expenditures, as the subsidies for Medicare Parts A and B are now provided. A few proposals envision subsidies delivered through the tax system via a tax deduction or credit. Because about half of the U.S. elderly have no tax liability at all, a refundable tax credit is the only tax option that is likely to reach the beneficiaries who are least able to afford coverage. Such refundable credits create particularly difficult administrative problems (the Internal Revenue Service is not well suited to verify eligibility, individuals may not be certain of their tax liability and thus appropriate withholding, and so on).
8. Gluck notes that the individual Medigap plans that include drug coverage
have much higher premiums than do similar plans without drug coverage, which apparently reflects the high use by the small share of beneficiaries who join the plans. Gluck, A Medicare Prescription Drug Benefit.

9. For example, in the July 1999 description of the president’s plan, the total estimated premium of the proposed drug benefit in 2003 was $576 ($48 per month). The 100 percent subsidy and full coverage of copayments for beneficiaries with incomes up to 135 percent of poverty for this policy would be reduced to a 50 percent premium subsidy only for beneficiaries with incomes over 150 percent of poverty. For singles, the premium subsidy phasedown amounts to a loss of $288 (50 percent times $576) for an additional $1,400 in income; the value of the lost copayment coverage is likely to be at least as high. Couples would face even greater benefit losses. The problem is more substantial for proposals that phase down to lower subsidy levels; for example, the Breaux-Frist proposal (which phases down to a 25 percent capped premium subsidy) would create an implicit tax rate for this income range more than 20 percent higher.

10. See, for example, V. Fuchs, “Medicare Reform: The Larger Picture,” Journal of Economic Perspectives (Spring 2000).

11. In the RAND Health Insurance Experiment, outpatient drug expenditures were more than 80 percent higher in the free-care plan than in the plan with close to 100 percent copayments. J.P. Newhouse and the Insurance Experiment Group, Free for All? Lessons from the RAND Health Insurance Experiment (Cambridge, Mass.: Harvard University Press, 1994), 165–171. However, drugs were less important in medical practice when the experiment was performed in the late 1970s, and the expenditure difference was largely mediated by the effect of the plan on likelihood of office visits, not on choice of drugs given the occurrence of a visit. As noted elsewhere, private-sector PBMs have encouraged use of less costly drugs through both price and nonprice mechanisms; the costs of a Medicare benefit could also be reduced if such tools were applied to limit utilization.


13. The president’s proposal provides a 50 percent capped subsidy that is reduced by a third (to 33 percent) for employers who offer coverage or buy in to the new drug benefit on behalf of their employees. Firms could respond in one of three ways to the new subsidy. First, they could drop coverage. Because retiree drug benefits generally are much more generous than the proposed Medicare benefits, even in the president’s plan, this would amount to a substantial reduction in retirees’ compensation. If the firm fully compensates retirees for the benefit reduction (if it did not, the firm would be cutting its wages), then the firm’s total compensation costs would be unchanged. However, the retirees would have to pay taxes on at least some of the additional income, whereas the generous drug benefit they had been receiving was nontaxable. The median retiree in most firms that provide generous drug coverage faces a marginal tax rate (federal and state) of 25 percent or higher, so this response seems unlikely.

Second, the firm could drop its coverage and “wrap around” the new Medicare benefit. In this case, the firm would need to pay the beneficiary premium—again at the partial subsidy rate of 33 percent—which, with a corporate tax rate of 35 percent, would amount to an after-tax rate of $0.433 per $1 of benefits ($0.67 payment times [1–.35], the firm’s tax rate, since the premium payment could be expensed). Alternatively, the firm could compensate the retiree directly for the cost of the premium, at the full subsidy rate. Because such compensation would be taxed as personal income, the after-tax cost to the firm would be $0.433 per $1 of benefits ($0.50/[1–.25] times [1–.35] equals
$0.433, where the division by 1–.25 reflects the fact that the retiree faces a tax rate of 25 percent on the additional income).

Third, the firm could continue to offer coverage, and take the (partial) direct subsidy. In this case, each $1 of drug benefit spending again costs the firm $0.435 (equal to $1 times 0.67 times [1–.35], reflecting both the 33 percent subsidy and the fact that the spending is deductible as a business expense). Thus, the net costs to the firm of buying in and wrapping around, or of continuing to provide coverage, are virtually identical. The firm’s choice between these two options will reflect the firm’s judgment about whether it is less burdensome to buy in to the new Medicare coverage and wrap around, or to avoid the administrative costs of coordinating coverage by continuing to provide drug coverage. Either way, the crowding out of private financing is reduced by one-third. Note that if many firms opt to wrap around, the proposal would reduce the crowding out of private financing but not of the actual provision of benefits.

14. About half of current drug expenditures, or about $500 per beneficiary, is financed by insurance. Gluck, A Medicare Prescription Drug Benefit. Because comprehensive coverage probably would induce some greater utilization, a conservative estimate of the total premium for a comprehensive plan today is $1,000. If Medicare subsidized half of this premium, the cost would be around $19 billion per year (and rising rapidly).

15. This is a fundamental point in the economics of insurance. See K. Arrow, “Uncertainty and the Welfare Economics of Medical Care,” American Economic Review 53, no. 5 (1963): 941–973.

16. For this purpose, actuarial value equals the average expected plan payment to beneficiaries given the benefit design and their expected drug use.


18. Breaux–Frist does require a proposed new Medicare board to study the enrollment issue and make recommendations to Congress in advance of the benefit’s implementation.

19. Even with this limited enrollment opportunity, there are difficult transition issues in creating a new program. For example, older beneficiaries would, presumably, have a clearer idea about their lifetime drug use than younger ones would; thus, the program may initially experience more selection bias than it would if only younger beneficiaries were eligible for the program.

20. See H.A. Huskamp et al., “The Medicare Prescription Drug Benefit: How Will the Game Be Played?” Health Affairs (Mar/Apr 2000): 8–23, which also reviews some additional concerns about PBM administration that we do not address here, such as the formulary determination process.

21. Although the chronicity of most drug use means that good risk adjustment is important for the success of a drug benefit, it is even more important under proposals in which drug benefits are chosen separately in traditional Medicare. In this case, competing drug plans could select beneficiaries based only on drug coverage; if beneficiaries choose entire plans, incentives to select on drug benefits alone are blunted.


23. In this case, the assignment of full risk is analogous to capitation. PBMs would keep all premium payments in excess of plan payments plus administrative costs. Conversely, they would lose money to the extent that premiums were not sufficient.