JOINT ECONOMIC COMMITTEE DEMOCRATS

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ECONOMIC POLICY BRIEF JANUARY 2004

THE NEW MEDICARE PRESCRIPTION DRUG ACT: INDEXING EFFECT ERODES BENEFIT

There is a little-noticed component of the new Medicare Prescription Drug, Improvement, and Modernization Act — the so called indexing effect — which seriously erodes the value of the prescription drug benefit over time.

The authors of this legislation have chosen to tie (index) annual changes to beneficiaries' cost-sharing to a growth factor. For all but the poorest beneficiaries, the growth factor that was chosen is high and substantially greater than other growth factors that could have been chosen. They chose to index cost-sharing to the annual growth in prescription drug costs for this new Medicare Part D program. Since drug costs have been growing at an annual rate that far surpasses general inflation, cost-sharing expenses under the new benefit will grow each year at a fast rate. Few people have yet taken notice of these scheduled increases in cost-sharing in this recently enacted law.

A Medicare drug benefit that many have already described as meager will become increasingly unaffordable.

As a direct result of this indexing effect, elderly and disabled citizens who elect to enroll in the new Medicare Part D drug plan can expect to see significant increases in required premiums, deductibles and coinsurance with each passing year; regardless of any increase in their own use of prescription medication. Thus, a Medicare drug benefit that many have already described as meager will become increasingly more unaffordable over time to beneficiaries on fixed incomes.

The Drug Benefit

The legislation establishes a voluntary prescription drug benefit program under a new Part D of the Medicare entitlement. In 2006, private prescription drug plans (PDPs) and Medicare Advantage (MA-PD) plans — the new name for current Medicare+Choice plans that provide a drug benefit — can offer either a "standard coverage" benefit or one that is actuarially equivalent to the standard benefit.

In 2006, the standard benefit will require an estimated $35 monthly premium that will cover 26 percent of the total prescription drug costs of Medicare beneficiaries, according to the Congressional Budget Office (CBO). The actual premium may be higher or lower than the $35 described in summary materials. Each private plan will calculate its own specific premium from a formula that uses the base premium calculated by the Secretary of Health and Human Services and the plan's own bid to provide the covered services.

In 2006, the standard benefit will also require a $250 deductible, and 25 percent cost-sharing up to the first $2,250 in prescription drug spending. After this initial coverage threshold is reached, the beneficiary is responsible for the next $2,850 in prescription drug costs (the "doughnut hole"), until coverage resumes at the out-of-pocket threshold.

For expenditures beyond the out-of-pocket threshold, a copayment per prescription equal to the greater of 5 percent or $2 for generics/$5 for brand names is required. This benefit structure is outlined in **Table 1**.

Drug Benefit Indexing

As each year passes, the deductible, cost-sharing components and benefit thresholds of the new drug benefit are indexed to rise at the rate of per capita increase in overall Part D drug spending. CBO expects per capita Part D drug spending to increase by an average of 8.57 percent annually from 2006 to 2013. This is a conservative estimate given that historic non-Medicare drug cost growth has been in excess of 10 percent annually.

The CBO estimates that while the deductible will begin at $250 under the standard benefit, it will reach $445 by 2013; a 78 percent increase. In addition, the amount of the "doughnut hole" will increase from $2,850 in 2006 to $5,066 in 2013. Total beneficiary drug spending before reaching the out-of-pocket threshold, which includes the deductible, coinsurance and expenses through the "doughnut hole," is expected to increase from $3,600 in 2006 to $6,400 in 2013, also a 78 percent increase. Finally, copayments for prescriptions above the out-of-pocket threshold are expected to reach the greater of 5 percent or $3.50/$8.85 per prescription by 2013. These increases are summarized in **Table 1**.

Table 1

Effects of Indexing on the Standard Coverage Drug Benefit

Indexed Value	2006	2010	2013	Percent increase 2006-2013
Monthly Premium	$35*	$47*	$58*	66%
Yearly Deductible[1]	$250	$350	$445	78%
Copayment of 25% at beginning of "doughnut hole"[1]	$500	$705	$889	78%
Beginning of "doughnut hole"[1]	$2,250	$3,170	$4,000	78%
Width of "doughnut hole" [1]	$2,850	$4,015	$5,066	78%
End of "doughnut hole"-- also out-of-pocket threshold[1]	$5,100	$7,165	$9,066	78%
Total beneficiary spending before out-of-pocket threshold is reached[1]	$3,600	$5,050	$6,400	78%
Copayment after reaching out-of-pocket threshold[1]	The greater of 5% or $2/$5 per prescription	The greater of 5% or $2.80/$7.05 per prescription	The greater of 5% or $3.55/$8.90 per prescription	78% or more

[1] Indexed by growth in per capita Part D drug spending as estimated by CBO.
* Average premium and growth based on a CBO estimate. Each plan will set its own premium.

The Part D premium is indexed differently. It is indexed to a formula based on the percentage per capita increase in Part D drug spending and bids by private plans to provide the benefit. Each plan will set its own premium. The CBO expects premiums will increase 7.4 percent annually, on average, from 2006 to 2013. As a result, the estimated $35 monthly premium would increase to $58 per month by 2013 (Table 1).

The Subsidized Low-Income Benefit

The federal government, under the new drug benefit, will subsidize cost-sharing for seniors and disabled Medicare beneficiaries with incomes below 150 percent of poverty who are either dual eligible for both Medicare and Medicaid or who have income levels below specified thresholds and meet specified asset tests. Currently, Medicare serves as the primary payor of the health care for this population. Medicaid serves as a secondary payor that provides wraparound services not covered by Medicare (such as prescription drug benefits) and covers Medicare premiums and cost sharing. Consistent with this historic policy, beginning in 2006, instead of receiving their drug coverage through state Medicaid programs, this population will receive private drug coverage through the new Medicare Part D program. However, unlike other Medicare benefits, states will still have to pay a percentage of the cost of the drug benefit for dual eligibles, beginning at 90 percent in 2006 and gradually decreasing to 75 percent in 2015 and beyond.[1] While states can choose to continue to use their Medicaid programs to provide wraparound drug benefits to this population (for example, for drugs not on a private plan formulary), they are prohibited from using any federal dollars to accomplish this. The effect of this new policy will be to reduce the drug benefits many low-income beneficiaries receive.

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Lowest Low-Income Group

Beneficiaries who are dual eligible and have incomes below 100 percent of poverty are subject to a copayment for each prescription of $1 for generic drugs and $3 for brand name drugs. Upon reaching the out-of-pocket threshold, there is no further copayment. This is summarized in **Table 2**.

Table 2

Out-of-pocket Drug Costs for the Lowest Low-Income Group

Indexed Value	2006	2010	2013	Percent increase 2006-2013
Copayment before out-of-pocket threshold[1]	$1.00/$3.00[2]	$1.10/$3.30[2]	$1.20/$3.55[2]	18-20%
Copayment after out-of-pocket threshold	0	0	0	0%

[1] Indexed by growth in CPI using recent historic average of 2.38%.
[2] No copayment for institutionalized dual eligibles with incomes below 135% of poverty.

The copayments for this beneficiary group are indexed for inflation annually using the Consumer Price Index (CPI). (Table 2) In approximately twelve states, under prior law, these beneficiaries paid no premiums or cost-sharing. Now they will be subjected to copayments.

Mid-Range Low-Income Group

There is no monthly premium or deductibles for low-income beneficiaries who have incomes below 135 percent of poverty, who are dual eligible, or have assets of less than $6,000 for an individual or $9,000 for a couple. There is a copayment for each monthly prescription of $2 (generic) and $5 (brand). Rather than indexing this dollar amount to the CPI rate that is used for the Lowest Low-Income Group, these copayments are indexed to average per capita Part D yearly drug spending increases. These beneficiaries are estimated to see their per prescription copayments increase from $2-$5 in 2006 to $3.50-$8.50 per prescription by 2013. **(Table 3)**

Highest Low-Income Group

Beneficiaries with incomes below 150 percent of poverty, who do not meet the requirements of the other low-income categories and have assets of less than $10,000 for an individual or $20,000 for a couple, face much higher out-of-pocket spending than the other low-income groups. This group pays a deductible of $50 and are responsible for 15 percent coinsurance for the cost of all drugs after the deductible until they reach the out-of-pocket threshold. Upon reaching this threshold, they will be responsible for the standard cost-sharing equal to the greater of $2.00 (generic)/$5.00 (brand) per prescription or 5 percent of the prescription cost. Additionally, these beneficiaries are required to pay a sliding scale monthly premium that is based on their income. This cost sharing is summarized in **Table 4**.

The deductible and copayments for this low-income group are also indexed to average per capita Part D yearly drug spending increases. Similarly, increases in required premiums are based on a formula of Part D drug spending per capita increases and bids from private plans. As a result, the required deductible is expected to increase to $89 by 2013. The amount of cost-sharing needed to reach the out-of-pocket threshold is expected to increase from $758 in 2006 to $1,347 by 2013. By 2013, copayments beyond the out-of-pocket threshold increase to the greater of $3.50/$8.85 or 5 percent per prescription. Premiums are estimated to be as high as $58 per month by 2013 for individuals with incomes near 150 percent of poverty. (Table 4)

Table 3

Out-of-pocket Drug Costs for the Mid-Range Low-Income Group

Indexed Value	2006	2010	2013	Percent increase 2006-2013
Copayment until out-of-pocket threshold[1]	$2.00/$5.00[2]	$2.80/$7.05[2]	$3.55/$8.90[2]	78%
Copayment after out-of-pocket threshold	0	0	0	0%

[1] Indexed by growth in per capita Part D drug spending as estimated by CBO.
[2] No copayment for institutionalized dual eligibles with incomes below 135% of poverty.

Table 4

Out-of-Pocket Drug Costs for the Highest Low-Income Group

Indexed Value	2006	2010	2013	Percent increase 2006-2013
Monthly Premium	$0 - $35*	$0 - $47*	$0 - $58*	0-66%
Yearly Deductible[1]	$50	$70	$89	78%
Copayment of 15% from deductible until out-of-pocket threshold is reached[1]	$758	$1,064	$1,347	78%
Copayment after reaching out-of-pocket threshold[1]	$2.00/$5.00	$2.80/$7.05	$3.55/$8.90	78%

[1] Indexed by growth in per capita Part D drug spending as estimated by CBO.
* Average premium and growth based on a CBO estimate. Individual premium based on beneficiary's income and premium rate set be each plan.

Low-Income Subsidy Asset Tests

Asset tests created in the new Medicare Prescription Drug Act are indexed annually to the CPI. The asset test to qualify for the Mid-Range Low-Income Group subsidy is estimated to increase from $6,000 (single)/$9,000 (couple) in 2006 to $7,070/$10,610 by 2013. Similarly, the asset test to qualify for the Highest Low-Income Group subsidy is expected to increase from $10,000/ $20,000 in 2006 to $11,790/$23,580 in 2013. These changes are summarized in **Table 5.**

If the assets of subsidy-eligible low-income beneficiaries only increase by inflation during a given year, they will still meet the criteria for a subsidy. Includable assets are defined by the same standards used to determine eligibility for federal Supplemental Security Income (SSI). While the same definition of assets is used, it is worth noting that the SSI asset test does not increase yearly based on indexing while the asset test for the new drug benefit does.

The Consequences of Indexing on Medicare Beneficiaries

A large percentage of Medicare beneficiaries live on modest incomes funded through some combination of monthly Social Security and SSI. SSI is a federal program that provides income supplements to low-income individuals who meet specified financial requirements to help them meet their basic needs for food, clothing and shelter. All these federal payments are indexed to COLAs that have averaged approximately 2.4 percent over the past 10 years.

According to CBO, Medicare beneficiaries participating in the new Medicare drug program can expect required premiums, deductibles and copayments to increase at an average annual rate of 7.4 percent to 8.6 percent from 2006 to 2013. Since their drug costs will increase year-to-year at a much higher rate than their income will rise, paying for their drug costs will become increasingly difficult. **Chart 1** illustrates this effect. Whereas

Table 5

Effects of Indexing on Low Income Asset Tests

Indexed Value	2006	2010	2013	Percent increase 2006-2013
Mid-Range Low-Income Group Eligibility Asset Test	$6,000/$9,000	$6,590/$9,890	$7,070/$10,610	18%
Highest Low- Income Group Eligibility Asset Test	$10,000/$20,000	$10.990/$21,970	$11,790/$23,580	18%

the drug cost sharing for many beneficiaries is estimated to increase by almost 80 percent from 2006 to 2013, their incomes are expected to increase by less than 20 percent during that time period. Even what appear to be modest increases over the years in per prescription copayments can be a financial hardship on beneficiaries; particularly when one considers that the average senior is on three or more different prescriptions at any one time, according to a recent Kaiser Family Foundation/ Harvard School of Public Health survey.

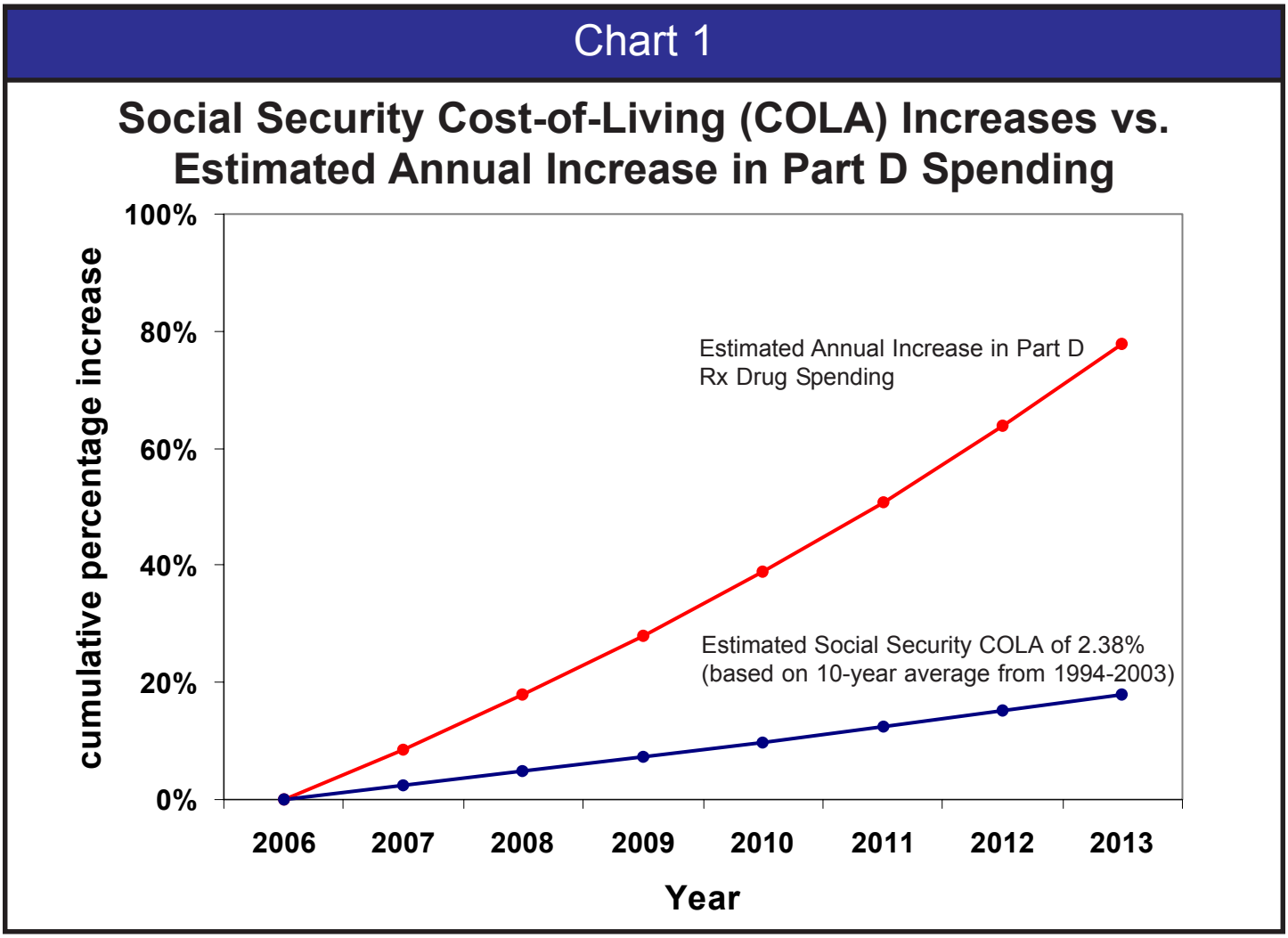
The fact that Medicare Part D premiums are expected to rise faster than the annual Social Security cost-of-living adjustment (COLA) suggests a related problem. Since Medicare Part D premiums are typically deducted from participants' Social Security checks, the dollar amount of the increase in the Medicare Part D premium will exceed the increase in their checks due to the Social Security COLA for some beneficiaries. In these cases, beneficiaries will actually experience a decrease in the amount of their Social Security check from one year to the next. Obviously, this would be a hardship for many individuals. Under current law there is a "hold harmless" provision with respect to the Medicare Part B (Physician and Out-patient services) premium. Beneficiaries are protected from a reduction in the amount of their checks if the Medicare Part B premium increase exceeds the amount of their Social Security COLA. They receive no less than the dollar amount of their previous year's Social Security check. No such protection is included under the new Medicare Part D drug benefit.

The effects of increased beneficiary cost-sharing created by indexing can be most detrimental to the low-income population.

The effects of increased beneficiary cost-sharing created by indexing can be most detrimental to the low-income population. A Center on Budget and Policy Priorities report summarizes the growing body of research demonstrating that even modest cost-sharing increases significantly reduce utilization of necessary medical services and drugs.[2] The effect is especially pronounced within the low-income population.

The negative effects of indexing on low-income beneficiaries are compounded by the fact that many dual eligibles will be worse off under the new legislation than they are today. Under current law, most dual-eligible beneficiaries pay no premium or deductible and may have a small drug copayment

Chart 1



that is not indexed at all. According to a recent Kaiser Foundation survey of state prescription drug programs, over 20 percent of the states currently require no drug copayment and the majority of the remaining states have a non-indexed copayment between $.50 and $2.00 per prescription.

Conclusions

Most Medicare beneficiaries are unaware of how the indexing features of the new Medicare Prescription Drug, Improvement, and Modernization Act will substantially increase their cost-sharing requirements each year. The costs for most beneficiaries of required premiums, deductibles and copayments are expected to increase by between 7.4 percent and 8.6 percent each year from 2006 through 2013. These anticipated cost-sharing increases are also significantly higher than the increases most beneficiaries can expect in COLA adjustments to their incomes. As a result, beneficiaries will find paying for their drug costs under this new benefit will become increasingly difficult over the years.

Endnotes

[1] This amount is determined by Medicaid spending in 2003 for Medicare beneficiaries adjusted for population and increases in prescription drug spending.

[2] Ku, Leighton, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 2003.