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# Tough Questions for President Clinton's Prescription Drug Benefit

President Clinton has outlined a new prescription drug entitlement for people on Medicare, the federal health insurance program covering 39 million seniors and the disabled. The plan would:

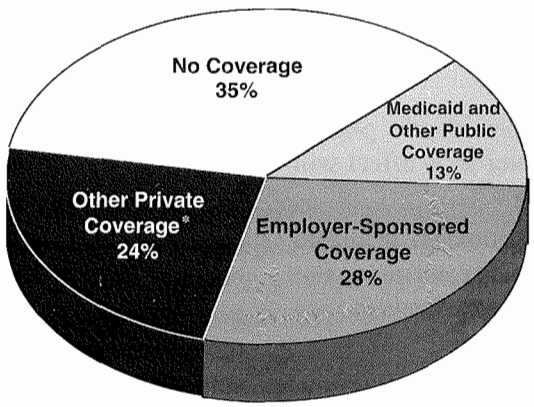
- Pay half of all prescription drug costs, with no deductible, up to a maximum of $2,000 in expenses (i.e., the government would pay as much as $1,000) beginning in 2002, growing to a maximum of $5,000 in expenses (or $2,500 for the government) by 2008.
- Charge participating seniors $24 per month, increasing incrementally to $44 per month by 2008.
- Allow any Medicare beneficiary to join, with the expectation that 31 million eventually would enroll.

According to the White House, beneficiaries would pay a total of $110 billion in premiums over 10 years, while the federal government would kick in $118 billion (or $168 billion according to the Congressional Budget Office).

Although Congress considered including a prescription drug benefit in 1965 when it created Medicare, concerns over additional costs and the paucity of advanced drugs undermined support for the benefit. So why do it now? Before Congress passes legislation extending such benefits, tough questions need to be answered.

**Is It Needed?** Today, seniors have access to a wide range of beneficial prescription drugs for both acute and chronic conditions. Many of the drugs are affordable for all but the poorest seniors, but some are very expensive. However, about 65 percent of Medicare beneficiaries have a prescription drug benefit to help them with those costs. [See the figure.]

## Medicare Drug Coverage




* Includes Medicare HMOs, individually purchased coverage and those who switched coverage during the year.

Source: Margaret Davis et al., "Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries," *Health Affairs*, January/February 1999.

Nevertheless, the White House expects the large majority of seniors — about 80 percent — to shift to the government plan because it will seem so cheap. Of course, the only reason it will seem cheap is that taxpayers will be subsidizing it.

**Who Will It Help?** Ironically, the plan gives little help to seniors with low or high drug costs. But it's ideal for someone in the middle. Since seniors initially will pay $24 per month, or $288 per year, in premiums to get the benefit, they won't gain unless they have more than $576 in drug costs. (At exactly $576, the benefit — $576 ÷ 2 = $288 — exactly equals the premiums.) And the total benefit is only $712 ($1,000 benefit minus $288 in premiums).

On the other hand, since the government will initially pay only $1,000 toward each senior's prescription drug costs, those with catastrophic costs — say, $12,000 a year or more — will get little help.

The president's plan also calls for paying the premiums and copayments for those below the poverty level. But is that necessary? Low-income seniors already qualify for Medicaid as well as Medicare — and Medicaid provides drug coverage for 88 percent of them. While the president talks about helping the poor, he really is creating a middle-class entitlement.

**Is It Fair?** The president's plan redistributes wealth from the "have-nots" to the "haves." Young, low-income families will be taxed to pay the $118 billion subsidy paid by the federal government. However, people age 65 and older have more assets and more aftertax income per capita than those under age 65.

**Will the Program Worsen Medicare's Financial Crisis?** Medicare is already facing a long-run funding crisis twice the size of Social Security's. Although recent changes in the program and a strong economy have postponed collapse of the Part A Medicare trust fund until 2015, the tax burden is expected to soar in

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future years. By the time today's college students reach retirement age, Medicare taxes will have grown from the current level of about 5.35 percent of payroll (the 2.9 percent payroll tax which funds Part A plus the general revenue subsidy to Part B) to almost 14 percent. In order for these students to collect their own benefits, future workers — most of whom are not yet born — will have to pay one out of every seven dollars they earn (almost as much as they will pay to support Social Security) just to cover medical bills for the elderly.

Adding an expensive benefit to Medicare will only increase the burden on future generations.

**What Will It Do to Drug Spending?** Whether, on balance, seniors spend more under the president's proposal is still an open question, at least in the short term. If seniors who already have comprehensive prescription drug coverage drop their plans for the president's less comprehensive but less costly program, they may spend less. And those with no coverage who join the president's plan may spend more.

But since coverage under the president's plan is scheduled to grow over time, the long-term effect will almost surely be increased spending.

One reason is utilization. When people are insulated from the cost of something, they tend to spend more. For example, according to a recent article in the health policy journal *Health Affairs*:

- Medicare beneficiaries without prescription drug coverage, on average, spend about $432 per year on drugs, all of it out-of-pocket.
- Seniors with coverage spend about $691 per year on prescription drugs, with $232 coming out of their own pockets.

**Can Managed Care Hold Down Costs?** President Clinton has proposed turning to large pharmacy benefit management firms (PBMs) as a way of achieving economies of scale to hold down costs. PBMs in each geographic region would bid on providing the service to all Medicare enrollees, and the federal government would grant monopoly status to the successful firm. PBMs would purchase the drugs in large quantities at discounted prices and supposedly pass the savings on to seniors.

Currently, about 170 million Americans are in some form of managed care and many of them acquire prescription drugs through PBMs. However, concerns are growing that some PBMs sacrifice quality for quantity. PBMs are under contract to the drug companies, which tie payments to sales volumes of particular drugs. According to the American Medical Association's drug policy director Joseph Cranston, "The motivation is to sell that product, possibly at the expense of the right clinical decision."

Thus the problem with PBMs appears similar to that with HMOs: the goal of controlling costs is sometimes achieved by sacrificing quality.

**Are Price Controls Next?** If the president has underestimated the program's cost or utilization or overestimated the budget surplus, Congress will be forced to raise premiums, raise taxes or impose price controls on drugs. The last option would be the most politically appealing — and the most devastating to research on and availability of new drugs.

**Is the President Making the Problem Worse?** Clinton administration policies have been reducing the number of seniors with a drug benefit by cutting reimbursement rates to Medicare HMOs. Some managed care plans got only a 2 percent increase in 1999, even though health care costs have been rising about 7 percent. As a result, many of the largest HMOs dropped out of some Medicare markets, leaving some 450,000 seniors, many of whom had drug coverage, scrambling to find new Medicare HMOs. Another 325,000 seniors may be dropped this year.

**Conclusion.** For the seniors who cannot afford the prescription drugs they need — and some cannot — it makes sense to consider a targeted solution rather than a broad-based new entitlement imposed on a financially strapped program.

To paraphrase P. J. O'Rourke from several years ago: You think drugs are expensive now, wait until the federal government decides to make them affordable.

*This Brief Analysis was prepared by NCPA Vice President of Domestic Policy Merrill Matthews Jr.*