

# **Targeting Medicare Drug Benefits: Costs and Issues**

*Prepared by*

Marilyn Moon  
Matthew Storeygard  
The Urban Institute

*for*

The Henry J. Kaiser Family Foundation

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## Executive Summary

Medicare beneficiaries are among the highest users of prescription drugs, but they are also much less likely to have good insurance protections for those expenses. As the importance and costs of drugs continue to rise over time, the ability of Medicare beneficiaries with modest incomes to take advantage of these new drugs is compromised. In the last national election, presidential and congressional candidates in large numbers promised to develop a prescription drug benefit for Medicare. While much of the attention of Congress is currently focused on a universal benefit, failure to agree on such a plan may turn the debate to a benefit targeted on those with low incomes. Such a benefit can direct help to those most in need, but would add to the complexity of health coverage for this group and preclude many who would remain in need.

Our findings are that a low-income drug benefit could be quite expensive. About 44 percent of Medicare participants would have incomes low enough to qualify (under a cutoff level of 175 percent of poverty). And, even if persons with Medicaid and employer-sponsored insurance are excluded, 11.3 million low-income beneficiaries who either have no insurance or “unreliable” insurance would be eligible. Moreover, because these beneficiaries have low incomes, the drug benefit needs to be comprehensive. If everyone eligible participated, costs (including administration and some extra Medicaid costs) would total \$21.7 billion in 2002.

Based on the experiences of other low-income programs, however, not all eligibles would participate. In addition to assumptions about participation, the costs of such a benefit would vary widely depending upon the ability of the program to restrain growth in costs and use of drugs, how Medicaid would respond, and how comprehensive the benefit would be. A mid-range estimate, accounting for lower participation and other adjustments would be \$16.3 billion in 2002, reaching only a little more than half of eligibles. Over a ten-year period, costs could be as much as \$331 billion.

Costs would also be higher if, as in the case with the Administration’s Immediate Helping Hand proposal, catastrophic protections are added for beneficiaries not otherwise eligible. But the key to catastrophic costs is how high to set the level at which the government would assume the burden of drug spending for individuals, and how to change this threshold over time. At an out-of-pocket limit of \$6,000, only about 73,000 Medicare beneficiaries would likely participate. That number could rise to nearly a million over ten years, however, if the \$6,000 cap stays at that level with no inflation adjustments.

A combination of low-income and catastrophic benefits could cost as much as \$345 billion for the ten-year period, using up all of the dollars that have been allocated in the budget for both prescription drugs and other reforms. Moreover, it would help only about 6.1 million beneficiaries in 2002—about 15 percent of the Medicare population and less than one-fourth of those who lack reliable drug insurance protection. Finally, setting up a new low-income program would raise a number of equity and other issues, particularly if plans were run by the states.

Despite the realities of how much it might cost to do so, the current Congressional debate over a Medicare prescription drug benefit has largely been focused on achieving such coverage for the entire Medicare population. Although the dollars allocated to Medicare reform—including prescription drug coverage—are restricted to no more than \$300 billion over ten years, this approach recognizes the millions of Medicare beneficiaries across the income spectrum who currently lack access to prescription drug coverage.

While structuring a new drug benefit to include beneficiaries of all income levels would clearly increase overall program costs beyond \$345 billion, the resultant increase would not be proportional to the number of additional beneficiaries assisted. Those with higher incomes would have lower per capita costs and would also be less likely to participate in the first place. In addition, program dollars could be stretched further by reducing the comprehensiveness of the benefit and by phasing in the program over time. In sum, were modest subsidies to be offered to those with higher incomes under a universal approach, the program would reach many more people, while bringing down average per capita costs and potentially increasing participation among those with low incomes as well.

Prescription drug coverage for older and disabled Medicare beneficiaries has been identified as a high priority by most policymakers, but there is little agreement on the specifics. Unlike health insurance for working families, Medicare does not cover most prescription drugs. While attention is currently focused on establishing a universal drug benefit, failure to reach agreement on the specifics may lead to further consideration of a program that restricts benefits to lower income beneficiaries, either as an initial strategy or as permanent policy. The chief advantages of such an approach are its opportunity for limiting eligibility and hence program costs, and its potential for targeting aid to those who are most in need. But such an approach also has disadvantages, including disqualifying many in need of coverage unless the eligibility levels are set very high and creating administrative complications that come with an income-related benefit.

This report examines the potential costs of generating a benefit confined to Medicare beneficiaries with low incomes and discusses issues that arise from a targeted approach. The numbers generated here are not an attempt to provide formal cost estimates, but rather to examine the parameters that would likely affect program costs and the number of beneficiaries assisted. In general, we use specifications similar to those contained in President Bush's January 2001 Immediate Helping Hand Proposal. But we also consider a number of variations and specifications not contained in that proposal to explore the implications of various program design features.

Our findings are that a low-income drug benefit could be quite expensive. A large minority of Medicare participants would have incomes low enough to qualify under the cutoff levels that are often proposed. Moreover, because eligible beneficiaries would have low

incomes, the benefits offered need to be comprehensive or they will not achieve their goals of providing access to prescription drugs. Costs of such a benefit can vary widely depending upon income levels for eligibility, participation by eligibles, treatment of those now receiving Medicaid benefits, and the ability of the program to restrain growth in costs and use of drugs.

Participation by all eligible Medicare beneficiaries with incomes below 175 percent of the poverty guidelines (and excluding those with Medicaid and employer-sponsored insurance) could cost the federal government as much as \$21.7 billion in 2002. A mid-range estimate, accounting for less than full participation and other adjustments would be \$16.3 billion in 2002, substantially less than the full participation figure, but also reaching only about 6.1 million of the 11.3 million eligible. Over a ten-year period, we estimate that the cost of providing a drug benefit for those with incomes below 175 percent could be as much as \$331 billion even with less than full participation.

Costs would also be higher if, as in the case with the new Administration's plan, catastrophic protections are added for beneficiaries with higher incomes. Although these costs would be relatively modest, they would boost total ten-year expenditures by another \$10 to \$15 billion, bringing total expenditures to about \$345 billion. The key to catastrophic costs is how high to set the level at which the government would assume the burden of drug spending for individuals and whether and how to raise that limit over time.

### **Numbers of Persons Eligible**

In 2002, nearly 42 million people will participate in the Medicare program, up from 41 million in 2001. Over 88 percent of these beneficiaries have prescription drug expenditures, but

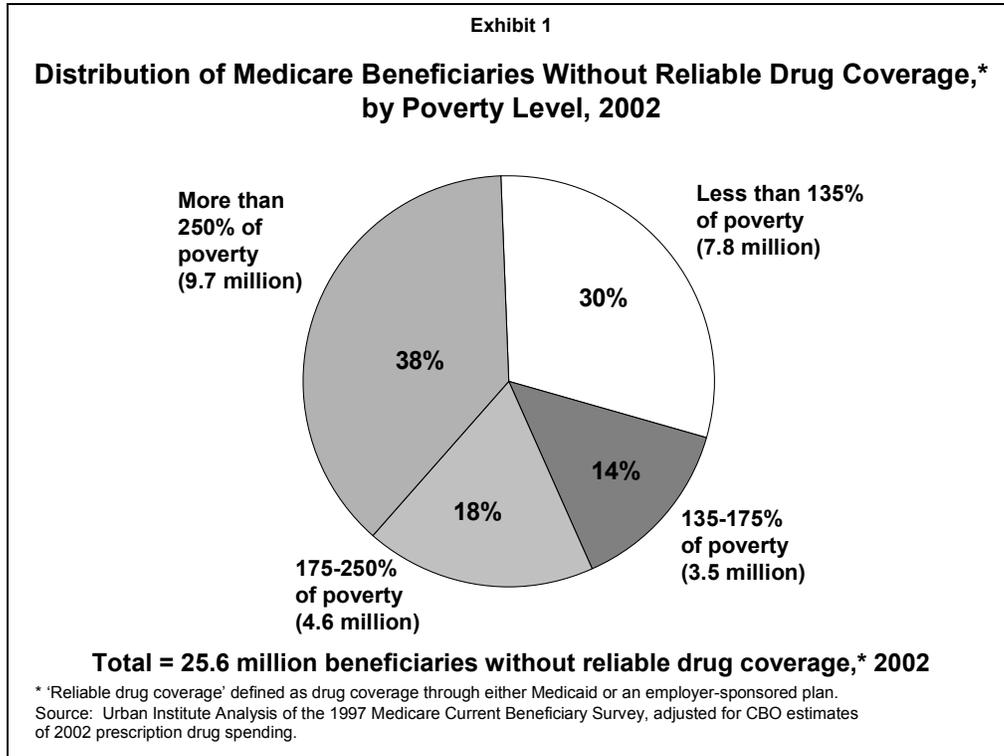
only 39 percent of all beneficiaries have relatively reliable drug coverage either through Medicaid (for those with low incomes) or employer-sponsored plans. Beneficiaries with employer-sponsored coverage or Medicaid would be ineligible for coverage under the Immediate Helping Hand proposal, presumably because their coverage is considered more stable. We recognize that 39 percent is considerably lower than the share of beneficiaries with drug coverage usually reported by others who have examined this issue (see, for example, Poisal and Murray, 2001; and Stuart, Shea, and Breisacher, 2001). Our number is different because we exclude other forms of supplemental insurance coverage that are not nearly as reliable or beneficial to Medicare enrollees.<sup>1</sup>

Prescription drug benefits through the Medicare+Choice program, for example, are now less available and, when offered, more likely to have an upper bound on payments of \$500 than just a few years ago (Cassidy and Gold, 2000). Medigap (private supplemental) plans are an even more unreliable source of coverage. They require beneficiaries to pay the full costs of coverage, the added costs of adverse selection, and high administrative expenses. These premium costs are increasingly unaffordable, even for modest-income beneficiaries (Stuart, Shea, and Briesacher, 2001). As a result, only a small share of those with standard Medigap have drug coverage (Chollet and Kirk, 2001). Thus, we consider people in HMOs or with Medigap to be without “reliable” insurance coverage and more likely to benefit from the addition of drug coverage under Medicare.

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<sup>1</sup>Employer-sponsored insurance might also be classified as unreliable for future retirees since it is being restricted or eliminated for many of those still in the labor force. But for those who currently have this coverage, it is an important and often generous source of support.

In 2002, 26.2 million of the 41.9 million beneficiaries are projected to lack reliable insurance coverage as we define it (see Exhibit 1).

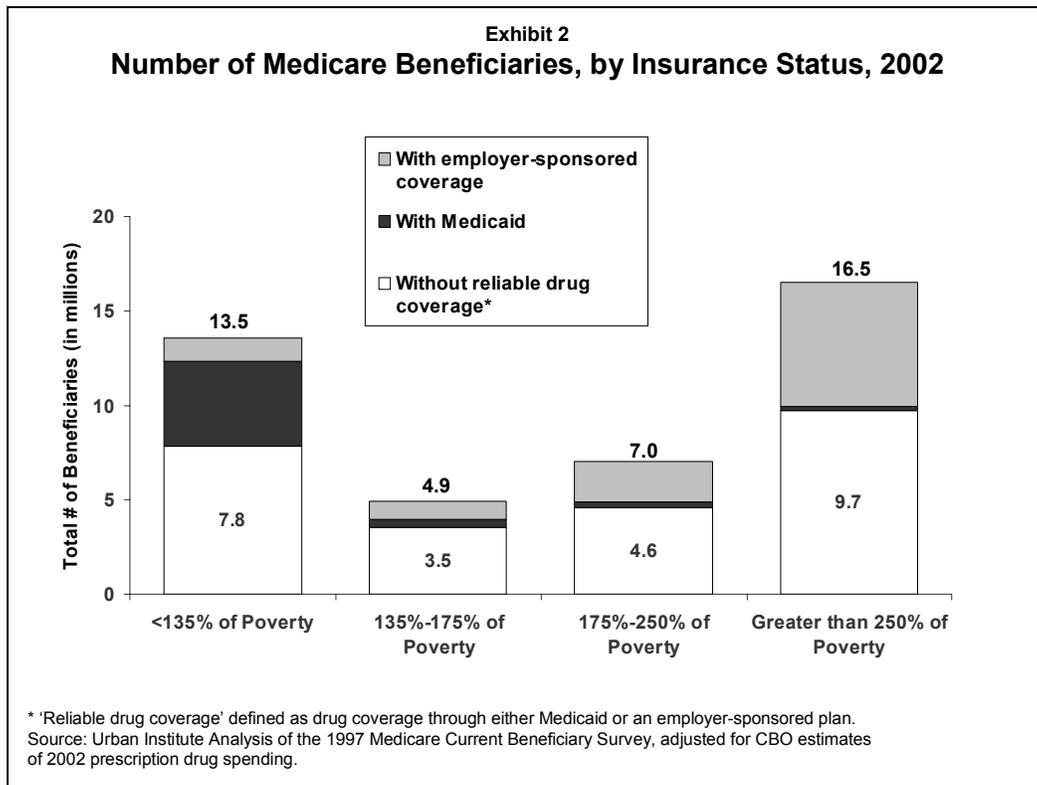


Surprisingly, of that number, less than half—11.3 million—have incomes below 175 percent of the poverty guidelines (set at about \$15,000 in income for single individuals and \$20,000 for couples). The 175 percent figure is a cutoff level used in several proposals that focus on the low-income population and hence is treated here as the upper bound on those eligible for a targeted benefit.<sup>2</sup> In addition, most proposals offer two tiers of coverage: comprehensive coverage to persons with the lowest incomes (for example, up to 135 percent of poverty) and less

<sup>2</sup>These numbers are higher than the ones normally reported in tables of poverty rates for Medicare beneficiaries for two reasons. First, we use the OMB poverty guidelines since they are used for purposes of eligibility. Second, income is limited to the individual and spouse (where applicable). When individuals and couples live in larger family units, the income of others is not counted. Again, this is the general way in which eligibility would likely be determined for a benefit.

generous protections for those with slightly higher incomes (those between 135 percent and 175 percent of poverty).

Another way to examine the numbers of beneficiaries in need of prescription drug coverage is shown in Exhibit 2.



About 7.8 million persons with incomes below 135 percent of poverty lack reliable drug coverage. Another 3.5 million of those between 135 and 175 percent of poverty also fall into this category. The 11.3 million without reliable coverage and with incomes below 175 percent of poverty account for about 61 percent of the 18.4 million beneficiaries with low incomes. The remaining 7.2 million with incomes below 175 percent of poverty are assumed to be ineligible for drug benefits because they participate in the Medicaid program (5 million) or have employer-sponsored drug benefits (2.2 million).

For those with higher incomes, the share without reliable coverage is about the same, but with employer-provided insurance accounting for much of the reliable drug coverage rather than Medicaid. The 4.6 million beneficiaries with incomes between 175 percent and 250 percent of poverty who lack reliable drug coverage look much like beneficiaries with incomes between 135 and 175 percent of poverty in terms of their health needs and levels of drug spending. Although they are better able to afford coverage, it would still be very expensive, if available at all.

Over time, Medicare+Choice and Medigap plans are likely to decline as sources of drug coverage. Since reliable insurance is not available to a majority of beneficiaries at all income levels, a case could be made for extending eligibility even further up the income scale.

### **Costs of Serving All Eligibles**

As shown in Exhibit 3, potentially eligible beneficiaries below 135 percent of poverty have average projected drug expenditures of \$1,683 in 2002, while those with incomes between 135 to 175 percent are estimated to spend \$1,842. These amounts are lower than the \$1,989 overall average spending on drugs, likely reflecting the difficulty these individuals have in affording prescription drugs.<sup>3</sup> The distribution of drug spending for potential eligibles is compared to that of all other Medicare beneficiaries in Exhibit 4. There are not large differences between the two groups, although potential eligibles are more concentrated in the under-\$1,000 spending categories. Potential eligibles, like all Medicare beneficiaries, include only a small number of very high spenders.

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<sup>3</sup>Our estimates use the 1997 Medicare Current Beneficiary Survey and have been calibrated to correspond to CBO's 2002 per capita estimate of \$1,989.

Exhibit 3

**Average Drug Expenditures and Total Program Costs, by Poverty Level, 2002**

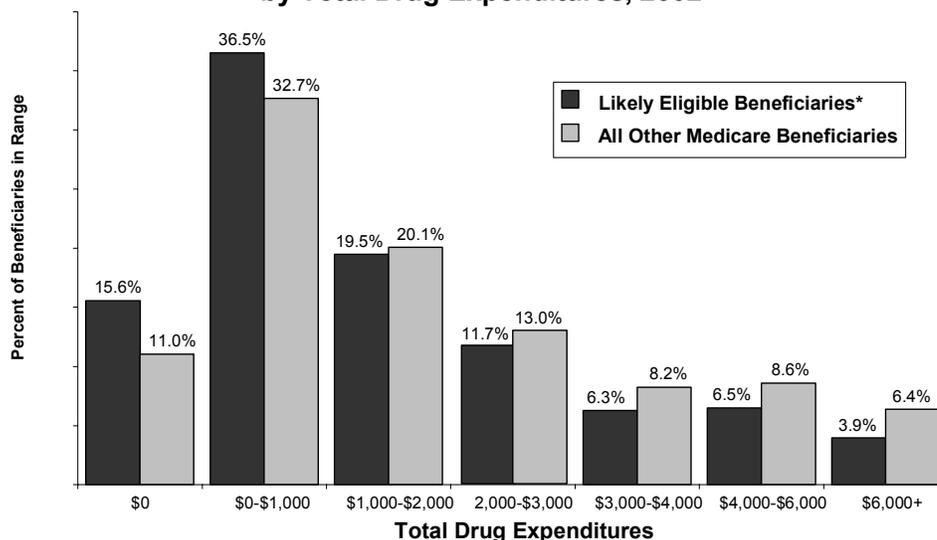
	Average Drug Expenditures	Average Benefit	Number of Potential Beneficiaries	Total Expenditures (in billions)	Medicaid Adjustment (in billions)	Total Program Costs* (in billions)
<b>Below 135% of Poverty</b>	\$1,683	\$1,683	7,831,000	\$13.2	\$2.8	\$17.6
<b>135-175% of Poverty</b>	\$1,842	\$921	3,508,000	\$3.2	\$0.5	\$4.1
<b>Total</b>	\$1,732	\$1,447	11,339,000	\$16.4	\$3.3	\$21.7

\* — including 10% Administrative Costs

Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey, adjusted for CBO estimates of 2002 prescription drug spending.

Exhibit 4

**Distribution of Medicare Beneficiaries, by Total Drug Expenditures, 2002**



\* Beneficiaries under 175% of poverty without drug coverage through either Medicaid or an employer-sponsored plan.

Note: Figures exclude institutionalized beneficiaries.

Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey, adjusted for CBO estimates of 2002 prescription drug spending.

The rest of Exhibit 3 examines potential costs of a low-income drug benefit. For those with the lowest incomes (below 135 percent of poverty), we assume a comprehensive drug benefit program, and that the higher-income group of potential eligibles (135 to 175 percent of poverty) would have to pay half of the costs of the premium for comprehensive insurance, effectively lowering their expected benefit to one-half of their spending level (see column 2 of Exhibit 3). When these numbers are combined, total expenditures in 2002 for potential eligibles could be as high as \$16.4 billion (see column 4 of Exhibit 3).

Even in this simple formulation, however, two additional sets of costs need to be added to come up with a full participation estimate. First, we adjust for the costs of filling in the gaps for Medicaid beneficiaries who do not have all of their drug expenditures covered by that program. Many of these individuals may be eligible for only part of the year, particularly if they qualify as medically needy. We also assume that the new program would fill some gaps for beneficiaries whose states restrict the type or amount of prescription drug benefits covered (Bruen, 2000). Although some proposals for low-income beneficiaries, such as that offered by the Bush Administration, prescribe that Medicaid beneficiaries are ineligible, strict adherence to that approach would result in a situation in which the lowest-income seniors and disabled persons would receive less generous benefits than those higher up the income scale. Thus, we assume that both of these types of Medicaid gaps would be filled by a new low-income benefit, either directly or indirectly. The fifth column of Exhibit 3 includes estimates for filling these Medicaid gaps.<sup>4</sup>

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<sup>4</sup>And, since drug coverage under Medicaid represents an optional benefit, we assume that at least some of these costs would be shifted to the federal government.

Second, we add likely administrative costs. We assume that 10 percent of program costs would need to be added to pay for administering this program. Taken together, these two added costs raise spending on the full eligible population to \$21.7 billion in 2002 (see the last column of Exhibit 3). This number assumes that all eligibles participate and that drug costs are fully covered by insurance.

### **Participation and Other Factors Affecting Costs**

In practice, a number of other adjustments need to be considered to come up with more realistic estimates of a low-income benefit. For example, no low-income program reaches all eligibles, with participation rates often affected by a number of policy decisions. For example, enrollment sites could range from welfare offices (likely reducing participation) to pharmacies (increasing participation). In addition, people may not learn about the program or they may find the requirements for participation to be too invasive or confusing. Consequently, we offer three sets of participation rates to establish bounds on potential program costs and to generate a mid-range estimate.<sup>5</sup>

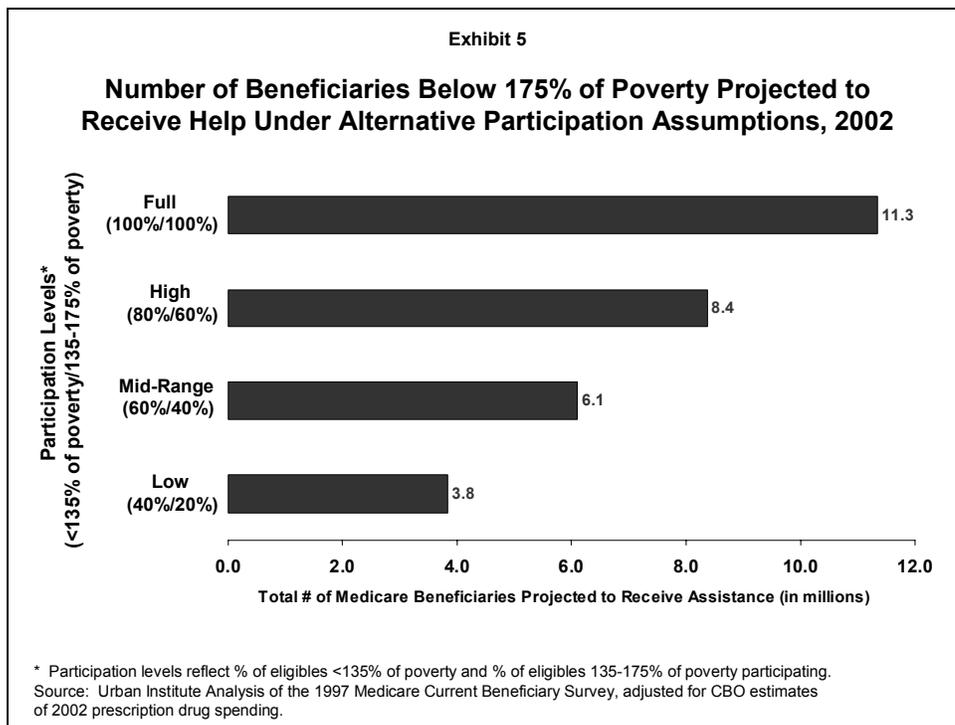
The high participation rate estimate assumes that 80 percent of eligibles below 135 percent of poverty and 60 percent of those with incomes between 135 and 175 percent of poverty would enroll. The drop in participation for higher-income persons reflects the fact that they may

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<sup>5</sup>Full participation is assumed for those already getting Medicaid whose benefits would be supplemented, but this affects only our estimates of dollars and not the number of people newly covered by a government program.

be reluctant to enroll, especially for only partial subsidies.<sup>6</sup> The low participation assumption is set at 40 and 20 percent rates, respectively. Our mid-range estimate assumes participation rates of 60 and 40 percent.

Exhibit 5 indicates the numbers of persons assumed to enroll under the three sets of assumptions. From a potential maximum of 11.3 million beneficiaries, the three assumptions range from a low of 3.8 million to a high of 8.4 million. In 2002, 6.1 million individuals would receive benefits under the mid-range estimate. The potential variation in participation rates reflects differences in how well the eligible population would be served. For example, under the lower participation option, less than 10 percent of all Medicare beneficiaries and only a third of potential eligibles would be helped.



<sup>6</sup>Generally, the higher up the income scale, the lower the participation. For example, participation in the Specified Low-Income Medicare Beneficiary (SLMB) program is lower than that for the more generous and lower-income Qualified Medicare Beneficiary (QMB) Program.

Low participation rates translate into substantially lower costs, although the reductions are not likely to be proportional. With no other changes affecting per capita costs, the bounds on total spending would be \$17.4 and \$10.1 billion, depending upon participation in the program (see line 1 of Exhibit 6).

<b>Exhibit 6</b>			
<b>Estimated Costs After Adjusting for Additional Factors (in billions of 2002 dollars)</b>			
	<u>Participation Assumption</u>		
	High	Mid	Low
<b>Basic Spending Level</b>	<b>\$17.4</b>	<b>\$13.8</b>	<b>\$10.1</b>
<b>with Adjustment for Selection</b>	17.4	14.1	11.9
<b><u>Factors Potentially Lowering Costs</u></b>			
\$5 Copay for Beneficiaries <135%	\$1.0	\$0.7	\$0.5
\$10 Copay for Beneficiaries 135-175%			
15% Discount	2.6	2.1	1.8
25% Discount	4.3	3.5	3.0
<b>Lower Bound (Copay and 25% Discount)*</b>	11.8	9.6	<b>8.2</b>
<b><u>Factors Potentially Raising Costs</u></b>			
50% Increase in Use of Services	\$8.7	\$7.1	\$5.9
30% Increase in Use of Services	5.2	4.2	3.6
15% Shift of Medicaid Expenditures	1.5	1.5	1.5
30% Shift of Medicaid Expenditures	2.9	2.9	2.9
<b>Upper Bound (50% Increase in Use and 30% Shift)*</b>	<b>30.2</b>	25.1	21.7
<b>Mid-Range (30% Increase in Use, 15% Shift from Medicaid, Copay, and 15% Discount)*</b>	\$19.6	<b>\$16.3</b>	\$14.2
<small>* The estimates that combine several factors are not always additive due to interactive effects. Order also matters in calculating costs. Additionally, spending estimates include the adjustments for administrative expenses estimated in Exhibit 3.</small>			
<small>Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey, adjusted for CBO estimates of 2002 prescription drug spending.</small>			

The mid-range estimate would be \$13.8 billion. But low participation is not likely to result in an average group of eligibles enrolling. In particular, those in the 135 to 175 percent of poverty range who would have to pay a substantial premium would be more likely to participate if they anticipated having high drug costs. Consequently, we adjust the mid-range and lower-bound participation costs to reflect the enrollment of higher-cost beneficiaries. Selection among the mid-range group is assumed to occur only for the higher-income eligibles. Selection is assumed to occur for both eligible groups in the low participation estimate.<sup>7</sup> The range thus turns out to be \$17.4 billion down to \$11.9, and \$14.1 billion for the mid-range group (see line 2 of Exhibit 6). This adjustment thus narrows the range of spending estimates.

Other factors affecting per capita costs could further increase or decrease spending levels as well. Exhibit 6 illustrates the orders of magnitude of some of these potential influences for each of the three participation rate assumptions. How strong an influence they would have would depend upon the specific details of a proposal. For example, one way to lower projected costs would be to assess a co-payment. The numbers presented here reflect a \$5 co-pay per prescription for persons with incomes below 135 percent of poverty and \$10 for higher-income eligibles. Such a co-pay could save between \$0.5 billion for the low participation options and \$1.0 billion under the high participation assumption in a given year.<sup>8</sup>

If administrators of the low-income plan actively seek discounts and rebates from

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<sup>7</sup>We assume that no one with drug expenses in the bottom 20 percent of spending participates in the 135 to 175 percent category for the mid-range. In the case of the low participation estimates, we assume that the bottom 20 percent and 30 percent do not participate for the lower- and higher-income groups, respectively.

<sup>8</sup>No adjustment for use of services is incorporated into this estimate because we have not yet assumed any increase in use from expanded coverage.

pharmacies and drug manufacturers, further savings may be possible. To illustrate this impact, we present two levels of possible discounts: a 15 and 25 percent reduction in the costs for drugs paid for by the federal government. The lower discount might be achievable from volume purchasing of drugs alone. To reach 25 percent, states would likely need to have stringent requirements on beneficiaries to use generics and perhaps follow a formulary.<sup>9</sup> If a new program included both co-pays and relatively steep discounts, program costs would range between \$8.2 billion and \$11.8 billion in 2002.<sup>10</sup>

On the other hand, other factors could raise spending above the basic levels shown in line 2 of Exhibit 6. First, use of services is highly likely to rise as a result of providing coverage. There is evidence that those who have no drug coverage or only limited insurance benefits fill fewer prescriptions than do those with coverage (Poisal and Murray, 2001). A comprehensive benefit would thus likely encourage more use of services. We include two alternative assumptions in Exhibit 6 regarding increases in use: 30 percent and 50 percent. The lower increase assumes that some beneficiaries are now sacrificing other spending in order to afford drugs. If so, a new drug benefit would mean that their quality of life would rise, but drug use might not go up as much as some have feared. The 50 percent response would raise costs by

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<sup>9</sup>That is, the most generous rebates from manufacturers are provided not on the basis of volume of purchases but on whether users are steered toward a particular drug instead of another manufacturer's equivalent drug. A formulary specifies which of several patented drugs is the "preferred" drug.

<sup>10</sup>Another factor—whether states would get their programs up and running in a timely fashion—could lower costs substantially. That is not included here, but is discussed later.

between \$5.9 billion and \$8.7 billion.

Finally, costs could be affected by how Medicaid interacts with a new, targeted drug benefit. Low-income Medicare beneficiaries who qualify might get enough relief from drug costs to reduce their likelihood of qualifying for Medicaid as medically needy—resulting in a shifting of costs from Medicaid to this new program. Further, a drug benefit that would exclude Medicaid patients but provide federal dollars for others with no required matching funds generates a strong incentive for states to find ways to move Medicaid beneficiaries onto the new program. States have shown a considerable amount of ingenuity in shifting costs to the federal government under Medicaid and they are likely to seek to do so in this type of program as well.

If, for example, states responded to a new program by effectively freezing their Medicaid drug spending at the 2001 rate, they could realize savings of about 15 percent in 2002 by shifting those costs to the federal government. If they were even more aggressive, they might be able to shift as much as 30 percent of their drug costs to this new program.<sup>11</sup> This would add about \$3 billion to the costs of the benefit regardless of participation level. The combination of a significant shift of Medicaid liabilities to the new program and higher use among new beneficiaries results in an upper bound estimate of \$30.2 billion for 2002. States and beneficiaries would be well served under these assumptions, but the costs to the federal government are substantially more than many anticipate from a targeted program.

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<sup>11</sup> Another possibility is to consider a plan that works through Medicaid to expand coverage for prescription drugs for low-income Medicare beneficiaries. While some of the issues raised here would remain the same, this would likely change the nature of the program substantially. It would likely work best if the income cutoffs were relatively low (since participation would likely be a problem for those with higher incomes), but the perverse incentives for Medicaid to shift costs would likely be lower and administrative costs might be more reasonable as well.

In sum, the question of what it will cost to provide a drug benefit to low-income Medicare beneficiaries will thus be driven by the specifics of the proposal and the responses of both states and beneficiaries. The range we come up with of \$8.2 billion to \$30.2 billion is very broad and a case could be made for either extreme.

For purposes of further discussion, we use the mid-range estimate based on the middle participation assumption, combined with the more moderate potential impacts that could *both* increase and decrease spending. That net figure, shown at the bottom of Exhibit 6 would be \$16.3 billion in 2002. This estimate first takes the mid-range participation assumption of 6.1 million people newly covered by a public program. We then assume (in order) a 30 percent rise in use of drugs, a 15 percent discount in prices charged for these drugs, a co-payment for each prescription, and a 15 percent shift of costs now incurred by Medicaid to this new program.<sup>12</sup> This illustrates how various assumptions about the responses of beneficiaries, states, and drug manufacturers to a new benefit can strongly affect the projections of net additional costs to the federal government.

### **Catastrophic Protection**

Proposals from the new Bush Administration and others often include a catastrophic benefit for persons with very high out-of-pocket drug costs in addition to coverage targeted at the low-income population. Adding such a benefit for all Medicare beneficiaries would provide some relief for those with very large expenditures. However, the level above which that

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<sup>12</sup>The various pieces cannot simply be added together since there are interactive effects. Moreover, the order in which the various factors are applied matters in this combined estimate. For example, we first assume that drug use will increase in response to coverage and then apply the discount to the resultant higher figures.

protection is offered matters substantially. To keep costs low, one threshold often proposed is \$6,000. That is, once individuals have paid more than \$6,000 out of pocket for their drug costs, their *remaining* drug expenses would be paid by the government. In other words, they would still have to pay \$6,000 out of pocket. For those who are just above the eligibility level for a low-income benefit—for example, about \$17,000 for a single Medicare beneficiary—protections above \$6,000 may offer little consolation. These persons are unlikely to hit the cap and, even if they do, they will likely make considerable sacrifices long before they would be eligible for help. Others have suggested lower cutoffs, such as \$4,000. Each downward shift of the catastrophic limit would add more beneficiaries to the number of potential eligibles and result in higher per capita protections for those with very high expenses.

Our estimates for 2002 indicate that 1.7 percent of all Medicare beneficiaries will have out-of-pocket drugs costs above \$6,000. For this analysis, we assume that all beneficiaries below 175 percent of poverty would either be served by the low-income program (which would be comprehensive and hence eliminate the need for such a benefit) or would decline to participate in this part as well. Anyone above 175 percent of poverty would be eligible, although we assume that individuals would keep any drug coverage they currently have. This limitation reduces the number of Medicare beneficiaries who *could* be eligible to 23.5 million. Of that group, just 365,000 people (or 1.6 percent of the potential eligibles) would go over the \$6,000 out-of-pocket limit in 2002. The full costs of such coverage would be \$1.1 billion.

The issue of participation also arises for this coverage. How many people will keep sufficient records to establish their eligibility? And, among that group, how many will seek to obtain what are likely to be modest benefits in most cases, especially if they believe that this

classifies them as a “welfare” case, a stigma that is likely stronger for persons at higher levels of income. Thus, for the catastrophic benefit, we assume only a 20 percent participation rate, bringing the costs down to \$226 million and the number of persons helped to 73,000.<sup>13</sup>

It might be possible to attract greater participation if eligibility were determined electronically through participating pharmacies. In that case, a Medicare beneficiary who knows that she has multiple, ongoing prescription needs could register with a participating pharmacy. Once the \$6,000 cap was reached, the pharmacy could automatically send the bills to the government program. This coordination might be cumbersome at first, but could increase participation and serve as a good model for the streamlining of other benefits.

Finally, lowering the threshold for catastrophic drug coverage would result in substantial increases in both the number of persons protected and in government costs. Many more beneficiaries would be served if the limit were set at \$4,000 rather than \$6,000. The number of potential eligibles (with incomes over 175 percent of poverty) would rise nearly threefold to 892,000, and the potential costs would more than double.

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<sup>13</sup>The other factors of induced demand or discounts on payments are less likely to apply to this benefit. Moreover, the small size of the benefit also suggests that other adjustments would have little impact on overall estimates.

## **Growth in Total Costs Over Time**

The very high expected growth rates in the costs of prescription drugs would mean that costs to the federal government of a Medicare drug benefit of any kind would rise substantially over time. For example, the combined effect of a 15 percent rate of growth in per capita costs of a drug benefit and the projected rise in the number of Medicare enrollees would result in the mid-range estimate of \$16.3 billion in 2002 rising to \$24.8 billion in 2005 and to \$57.4 billion in 2011. The ten-year total would be \$331 billion for coverage of the low-income population.<sup>14</sup>

It is more complicated to estimate the costs over time of a catastrophic benefit. An important policy detail is whether the catastrophic cap would be increased each year and, if so, by how much. Although the costs of a catastrophic cap shown above are not particularly high, they could rise rapidly depending upon the type of inflator used to adjust the cap upward over time. For example, if the cap remains at \$6,000, more and more people would exceed it each year as their spending goes up but the limit does not (see Exhibit 7). By 2011, the number of participating eligibles would rise from 73,000 to nearly 1,000,000 beneficiaries. On the other hand, a fully indexed cap (that rose with drug spending) would retain approximately the same share of eligible persons over time. Participating eligibles would go up by 13,000 to 86,000.<sup>15</sup> Exhibit 7 also shows the impact of using an intermediate inflator that attempts to capture price differences only. In that case, the number of participating eligibles would rise to 174,000.

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<sup>14</sup>We use a higher growth rate than the 10.3 percent CBO baseline growth rate, assuming that expanded coverage will also increase the growth rate at least for a period of time. If the rate were only 10.3 percent, the mid-range costs over 10 years would be \$234 billion.

<sup>15</sup>Growth in the number of persons covered by Medicare would be a factor and we have included that in these estimates.

**Exhibit 7**  
**Cost Estimates of Catastrophic Drug Benefit, 2002-2011**

**Alternative Growth Rates for Catastrophic Cap**

Year	Constant \$6,000		Inflated for Drug Prices		Inflated for Drug Costs	
	Participating Eligibles (in thousands)	Total \$ (in billions)	Participating Eligibles (in thousands)	Total \$ (in billions)	Participating Eligibles (in thousands)	Total \$ (in billions)
<b>2002</b>	73	\$0.2	73	\$0.2	73	\$0.2
<b>2003</b>	95	0.3	79	0.3	74	0.3
<b>2004</b>	141	0.5	85	0.4	75	0.3
<b>2005</b>	191	0.7	94	0.4	76	0.4
<b>2006</b>	256	1.1	101	0.5	77	0.4
<b>2007</b>	351	1.5	112	0.7	79	0.5
<b>2008</b>	460	2.1	127	0.8	81	0.6
<b>2009</b>	600	3.0	145	1.1	82	0.7
<b>2010</b>	775	4.1	158	1.3	84	0.8
<b>2011</b>	955	5.6	174	1.6	86	0.9
<b>Total</b>		19.2		7.4		5.1

Note: Drug price inflator assumed to be 11%; drug cost growth assumed to be 15%; participation rate set at 20%.

Source: Urban Institute Analysis of the 1997 Medicare Current Beneficiary Survey, adjusted for CBO estimates of 2002 prescription drug spending.

With an inflator that rose with drug spending, costs would quadruple over ten years. If the cap were to stay at \$6,000, there would be a 25-fold increase in potential costs. The ten-year costs of the catastrophic program would range from \$5.1 billion to \$19.2 billion, depending upon the rules for inflating catastrophic limits and the rate of growth of drug spending. It is unlikely that the catastrophic cap would remain at \$6,000 over the ten-year period, but if the full inflator were used, beneficiaries who qualified for catastrophic protection would still find their drug expenses increasing as a share of their incomes due to relatively rapid increases in drug prices. (For this reason, some suggest a lower inflator that takes income growth into consideration.) An intermediate inflator might be most appropriate and would put the ten-year costs of the catastrophic benefit in the \$10 to \$15 billion range.

## **Financing and Other Issues Facing Enactment of a Drug Benefit**

The Bush Administration's budget proposed \$153 billion in new spending over ten years to serve the needs of Medicare beneficiaries in terms of both prescription drug coverage and other Medicare reforms.<sup>16</sup> The recently passed Senate Budget Resolution increased the amount dedicated to these purposes to \$300 billion. Our estimate of a fully functioning program for the low-income population and a small catastrophic benefit over that same period would be nearly \$345 billion.<sup>17</sup> Our estimate assumes that, in 2002, more than half of all eligible beneficiaries would be newly covered by a government program. Even assuming that all additional spending was to be allocated to prescription drugs, the Bush administration's proposed contribution would be sufficient to cover only slightly more than half of those 6.1 million beneficiaries, or would require that each beneficiary receive a substantially less comprehensive benefit than has been assumed here. And, although the amount in the Senate Budget Resolution would be nearly enough for the benefit described in this report, it would not be sufficient to provide a universal drug benefit to all Medicare beneficiaries without further limits on eligibility or generosity of coverage.

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<sup>16</sup>Technically, this is a "net" figure that includes savings from other parts of Medicare that could be used to increase funding for the drug benefit.

<sup>17</sup>This amount combines the mid-range low-income program estimate of \$294 billion and \$10 to \$15 billion for a catastrophic benefit with a partial inflator.

Financing is not the only issue that arises from this approach to providing a new drug benefit. Another key issue is who would manage such a program. Targeted programs funded by the federal government are often administered at the state level. Otherwise, the federal government would have to develop a new mechanism for determining eligibility. Further, many of the proponents of a low-income drug benefit suggest that it be operated as a block grant program to be run by the states. Indeed, a number of states have relatively successful prescription drug programs of their own (GAO, 2000), and thus could more rapidly implement a targeted program. Other states could use the Medicaid program for establishing eligibility. But if that eligibility is extended higher up the income scale to meet the needs of beneficiaries, Medicaid will likely constitute a less effective administrative structure. As mentioned above, at higher-income levels, participation rates tend to drop as people are more reluctant to go to “welfare offices” to sign up for public programs.<sup>18</sup>

Further, a state-level program raises equity issues. First, it is always difficult to develop formulas for allocating federal dollars to the states. If the goal is to fill in the gaps for those who are most needy, more money would go to states with restrictive Medicaid programs and no separate prescription drug plan. These states have the largest shares of persons with unmet need. On the other hand, such an approach penalizes states that are currently doing the most to help their seniors and persons with disability afford prescription drugs, establishing perverse incentives for states to do less on their own. To encourage states to continue their existing

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<sup>18</sup>Of course, even a universal program would face some of the same issues if it contained extra benefits for persons with low incomes.

commitments, an allocation based on the total number of persons below the eligibility cutoffs would seem to be a more equitable approach.

In addition, states that already have working drug assistance programs could come up to speed much faster than others, creating substantial disparities in access to prescription drug coverage, at least initially. Some states would not be able to use their full allocations, while others that gear up quickly might exceed the allocations and end up having to place limits on the drug benefits they could offer.

Would there be flexibility in these programs in terms of allowing different levels of eligibility, different levels of effort in certifying that eligibility, and/or different levels of benefits offered? One of the rationales for state programs is to allow for innovation and creativity, but such flexibility may also contribute to differential access.

Finally, how well will a low-income drug program—at either the federal or state level—interact with Medicare? One of the important issues already facing beneficiaries is the complexity of insurance plans and programs for older and disabled persons. Low-income individuals would potentially have to apply separately for the QMB/SLMB programs and a new drug benefit, perhaps enduring two sets of application and verification procedures. Although it might make sense to combine them, the new drug benefit would then look more like a welfare program and hence face problems of stigma and low participation. Further, it is not clear how a new drug program for low-income persons would be coordinated with Medicare+Choice plans, which tend to offer limited drug benefits. Who would be the primary payer? Would beneficiaries have to apply or would HMOs apply for them? In the latter case, would the HMO have any say over what drugs are covered, what co-pays are charged, or other details that may

differ between the HMO and the low-income drug plan? These and related questions point to the potential for complexity and confusion that could result from such a program.

## **Conclusion**

The current Congressional debate over a prescription drug benefit for older Americans has been largely restricted to discussions about universal coverage and defining the dollars that should be committed to such an effort. At present, it appears that the dollars are restricted to no more than \$300 billion over ten years. As this is clearly not enough to provide a reasonably generous, universal benefit, the limits that Congress has imposed on itself for such a benefit may shift the discussion towards a more targeted approach.

A low-income approach to covering prescription drugs for Medicare beneficiaries could help hold down costs and target benefits to those most in need. However, because of the large numbers of Medicare beneficiaries at the lower end of the income scale and the widespread need for meaningful, relatively comprehensive benefits for this population, the costs of such an approach would be quite high despite its limited nature. Some of the factors that could potentially reduce program costs, such as lower participation rates or discrepancies across states, could moreover be considered failures of the program. And finally, even with relatively generous income eligibility criteria, millions of Medicare beneficiaries across the income spectrum would remain without access to prescription drug coverage.

While structuring a new drug benefit to include beneficiaries of all income levels would clearly increase overall program costs beyond the \$345 billion discussed above, the resultant increase would not be proportional to the number of additional beneficiaries assisted. Those with

higher incomes would have lower per capita costs and would also be less likely to participate in the first place. In addition, program dollars could be stretched further by reducing the comprehensiveness of the benefit and by phasing in the program over time. In sum, were modest subsidies to be offered to those with higher incomes under a universal approach, the program would reach many more people, while bringing down average per capita costs and potentially increasing participation among those with low incomes as well.

## **Bibliography**

Bruen, B. *Medicaid and Prescription Drugs: An Overview*. Prepared for The Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., October 2000.

Cassidy, A, and M Gold, “Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?” Report prepared for the Commonwealth Fund, 2000.

Chollet, D, and A Kirk, “Medigap Insurance: Industry Structure, Change, and Implications for Medicare.” Report to ASPE and HCFA, January 2001.

Congressional Budget Office. “Laying the Groundwork for a Medicare Prescription Drug Benefit.” Testimony of Dan Crippen before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 27, 2001.

General Accounting Office. *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets*. Report #: HEHS-00-162, September 2000.

Poissal, JA, and L Murray. “Growing Differences between Medicare Beneficiaries With and Without Coverage.” *Health Affairs* (March/April 2001), pp. 74–85.

Stuart, B, D Shea, and B Briesacher. “Dynamics in Drug Coverage of Medicare Beneficiaries: Finders, Losers, Switchers.” *Health Affairs* (March/April 2001), pp. 86–99.

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The Henry J. Kaiser Family Foundation  
2400 Sand Hill Road  
Menlo Park, CA 94025  
(650) 854-9400 Fax: (650) 854-4800

Washington Office:  
1450 G Street NW, Suite 250  
Washington, DC 20005  
(202) 347-5270 Fax: (202) 347-5274

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