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Report for Congress

Medicare: Beneficiary Cost-Sharing Under Proposed Prescription Drug Benefits

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Medicare: Beneficiary Cost-Sharing Under Proposed Prescription Drug Benefits

Summary

Providing a prescription drug benefit for Medicare beneficiaries is a policy issue facing the 108th Congress. In designing a prescription drug benefit, the 108th Congress may draw upon features of proposals put forth in the previous Congress.

One bill introduced in the 107th Congress, the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954, sponsored by House Republicans) was passed by the House on June 28, 2002. Other bills considered by the 107th Congress did not receive enough support to pass. These bills were the Medicare Outpatient Prescription Drug Act of 2002 (S.Amdt. 4309, sponsored by Senators Graham, Miller, Kennedy, and Corzine); the 21st Century Medicare Act (S. 2729, also referred to as the Tripartisan bill); and the Medicare Rx Drug Benefit and Discount Act of 2002 (H.R. 5019, sponsored by House Democrats).

Each proposal in the 107th Congress would have had a different form of cost-sharing (i.e., the share of an enrollee's drug costs that are paid by the enrollee out-of-pocket). The prescription drug benefit proposed by Senators Graham, et al. (S.Amdt. 4309) would have consisted of tiered copayments. Enrollees would have paid $10 for each generic prescription filled and $40 for each brand name prescription filled. The Tripartisan proposal (S. 2729) would have used coinsurance rates rather than flat copayments. Under this plan, enrollees would have paid 50% of drug costs after paying a $250 deductible. The House Republican proposal (H.R. 4954) was similar to the Tripartisan proposal, except that the House Republican proposal would have used tiered coinsurance rates. The enrollee would have been required to pay 20% of expenditures beyond the $250 deductible so long as cumulative expenditures for the year were less than $1,000. An enrollee would have had to pay 50% of expenditures between $1,000 and $2,000. The prescription drug benefit proposed by the House Democrats (H.R. 5019) would have also used coinsurance rates. Enrollees would have paid 20% of all drug expenses after the enrollee paid a $100 deductible.

The 108th Congress faces several decisions if it wants to enact a prescription drug benefit for the Medicare population. Several of these decisions pertain to the cost-sharing design of the benefit. One decision is whether to use flat copayments or coinsurance rates. Copayments might be simple for enrollees to understand. However, two individuals with equal levels of drug costs may consume different quantities and types of drugs. Because of different consumption patterns, these two individuals could pay different out-of-pocket amounts under a copayment plan. Another decision is the amount of cost-sharing enrollees should be required to pay. Low cost-sharing makes the drug benefit more affordable. Low cost-sharing also makes the benefit more expensive for the government, and raises the possibility of adverse selection.

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Providing a prescription drug benefit for Medicare beneficiaries is a policy issue facing the 108th Congress. One key aspect of any prescription drug proposal is how beneficiary cost-sharing would be structured.[1] Cost-sharing refers to the amount that an enrollee in an insurance plan must pay for medical goods and services. Cost-sharing generally entails some combination of deductibles, coinsurance rates or copayments, and limits on beneficiary expenses. **Box 1** describes some common insurance terms that relate to cost-sharing.

Box 1. Terms Used to Describe Cost-Sharing

Deductible: The amount an enrollee must pay out-of-pocket before the insurer begins paying for prescription drug costs. Generally, the enrollee must meet this amount each year. Plans with no deductible are usually said to provide "first-dollar" coverage.

Coinsurance rate: The percentage of prescription drug costs which are paid by the enrollee.

Copayment: A flat dollar amount that the enrollee must pay for each prescription filled. A copayment differs from coinsurance in that the copayment amount is fixed regardless of the price of the drug. However, copayments may vary based on the type of drug (e.g., one copayment amount for brand-name drugs, another for generic drugs).

Premium: The fixed amount an enrollee must pay to obtain an insurance policy. The enrollee pays this amount regardless of whether he or she incurs drug expenses. Premiums for health care policies are usually paid on a monthly basis. While premiums technically are not considered part of cost-sharing, it is necessary to take them into account when comparing plans with dissimilar cost-sharing requirements.

Coverage limit: An amount of drug expenses at which the third-party payer (federal government, insurance plan, etc.) stops covering an enrollee's costs. Once an enrollee's drug costs exceed the coverage limit, the enrollee must pay for all additional drug expenses. Some plans with a coverage limit provide additional coverage after out-of-pocket expenses exceed a certain threshold. Such plans are usually described as a "doughnut" plan because there is a range of expenditures (the "hole") where the enrollee pays 100% of expenditures.

Stop-loss amount: A limit on how much enrollees are required to pay each year out-of-pocket (excluding premiums). Once an enrollee meets the stop-loss amount, all additional drug expenses for the year are paid by the third-party payer (e.g., Medicare, private insurance plan). When applying the stop-loss amount, some proposals do not count payments made by third-party payers on behalf of enrollees.

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[1] There are other issues associated with a prescription drug benefit, such as how much risk would be borne by private insurance. See CRS Report RL31496, *Medicare: Major Prescription Drug Provisions of Selected Bills*, by Jennifer O'Sullivan.

The 107th Congress considered several proposals for a prescription drug benefit. In designing a prescription drug benefit, the 108th Congress may draw upon features of proposals put forth in the previous Congress. One bill introduced in the 107th Congress, the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954, sponsored by House Republicans) was passed on June 28, 2002. The other bills did not receive enough support to pass. These bills were the Medicare Outpatient Prescription Drug Act of 2002 (S.Amdt. 4309, sponsored by Senators Graham, Miller, Kennedy, and Corzine); the 21st Century Medicare Act (S. 2729, also referred to as the Tripartisan bill); and the Medicare Rx Drug Benefit and Discount Act of 2002 (H.R. 5019, sponsored by House Democrats). This report provides background on how the cost-sharing provisions under each bill would have affected the amount that a beneficiary paid out-of-pocket.

Proposed Cost-Sharing Arrangements

The prescription drug benefit proposed by Senators Graham, Miller, Kennedy, and Corzine (S.Amdt. 4309, hereafter referred to as Graham, et al.) consisted of tiered copayments. This plan would not have required a deductible. Enrollees would have paid $10 for each prescription filled with a generic drug and $40 for each prescription filled with a brand name drug included in the formulary.[2] For prescriptions filled with a drug not included in the formulary, the enrollee would have paid for the entire cost of the drug. A stop-loss amount of $4,000 would have been in effect; in other words, once an enrollee's cumulative out-of-pocket payments reached $4,000 for the year, he or she would not have been liable for any additional drug costs for the year. Under this proposal, enrollees would have paid a $25 monthly premium.

The Tripartisan proposal (S. 2729) consisted of coinsurance rates rather than flat copayments. This plan would have required enrollees to meet an annual deductible of $250. That is, the enrollee would have been responsible for paying for the first $250 of his or her annual drug expenditures. Once the enrollee's cumulative drug expenses exceeded $250 within the year, insurance coverage would have begun. The enrollee would have paid 50% of drug costs above the $250 deductible but below $3,450. The enrollee would have been responsible for paying for all drug costs beyond the $3,450 coverage limit. Once the enrollee's total drug costs reached $5,300 (equivalent to $3,700 out-of-pocket, excluding premiums), the enrollee would have paid 10% of future drug costs for the year. Although no dollar amount for the premium was specified in the legislation, it was reported that enrollees would have paid a monthly premium of $24 under this plan.[3]

The House Republican proposal (H.R. 4954) was similar to the Tripartisan proposal. Both plans would have required a $250 deductible, a coverage limit, and

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[2] A formulary is a list of preferred drugs developed by a pharmacy benefit manager (PBM). PBMs often lower the costs of prescription drug benefit by encouraging enrollees to use drugs included in the formulary.

[3] Pear, Robert. Senate Begins Debate on Rival Medicare Prescription Plans, *New York Times*, July 16, 2002.

a $3,700 stop-loss provision. Unlike the Tripartisan bill, the House Republican proposal would have had two coinsurance rates. The enrollee would have been required to pay 20% of expenditures beyond the deductible so long as cumulative expenditures for the year were less than $1,000. Once an enrollee's cumulative expenses exceeded $1,000 for the year, the enrollee would have had to pay 50% of future expenditures. The 50% rate would have been in effect until the enrollee's cumulative expenditures reached $2,000 (the first coverage limit). Any additional expenditure beyond the $2,000 coverage limit would have had to be paid entirely by the enrollee. Once the enrollee's total drug costs reached $4,800 (equivalent to $3,700 out-of-pocket, excluding premiums), the enrollee would not have paid for any additional drug expenses for the year. Although no dollar amount for the premium was specified in the legislation, it was reported that enrollees would have paid a monthly premium of $33 under this plan.[4]

The prescription drug benefit proposed by the House Democrats (H.R. 5019) also would have used coinsurance rates. This proposal would have required an annual deductible of $100. Enrollees would have paid 20% of all drug expenses after this deductible was met. Once the enrollee's total drug costs reached $9,600 (equivalent to $2,000 out-of-pocket, excluding premiums), the enrollee would not have been liable for any additional expenses. Enrollees would have been charged a monthly premium of $25.

While all four proposals had a stop-loss amount, they differed on which payments would have applied towards the stop-loss. The proposals sponsored by Graham, et al., and by the House Democrats would have applied payments made by third-party payers (e.g., a retiree health plan, a state pharmaceutical assistance program) on behalf of the enrollee towards the stop-loss amount. The Tripartisan and House Republican proposals would have applied payments made by the enrollee, another individual (such as an enrollee's family member), or Medicaid, or payments on behalf of the enrollee under the bills' low-income subsidy provisions.

Table 1 summarizes the major cost-sharing provisions of the four prescription drug benefits proposed in the 107th Congress.

The next section discusses how cost-sharing would have been calculated under the proposals that would have used coinsurance. Following the section on coinsurance, the proposal that would have used copayments is discussed.

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[4] Pear, Robert. House Votes to Place Prescription Drugs Under Coverage by Medicare, *New York Times*, June 28, 2002.

Table 1. Cost-Sharing Under Proposed Drug Benefits

	Graham, et al. (S. 2625)	Tripartisan (S. 2729)	House Republican (H.R. 4954)	House Democratic (H.R. 5019)
Monthly premium	$25	$24	$33	$25
Deductible	None	$250	$250	$100
Cost-sharing	Tiered copayments	Single coinsurance	Tiered coinsurance	Single coinsurance
Cost-sharing amounts	$10 for generic drugs; $40 for preferred brand name drugs; full-cost for non-preferred brand name drugs	50% of drug costs above deductible and up to coverage limit	20% of drug costs above deductible and up to $1,000; 50% of drug costs up to coverage limit	20% of drug costs above deductible
Coverage limit	None	$3,450	$2,000	None
Range of expenditures where enrollee pays for 100% of drug costs	None	$3,450-$5,300	$2,000-$4,800	None
Stop-loss amount	$4,000 out-of-pocket	$3,700 out-of-pocket ($5,300 total expenditures)	$3,700 out-of-pocket ($4,800 total expenditures)	$2,000 out-of-pocket ($9,600 total expenditures)
Out-of-pocket payments applied towards stop-loss amount.	Cost-sharing paid by enrollee or by third-party payer on enrollee's behalf	Cost-sharing paid by enrollee, another individual, Medicaid, low-income subsidy	Cost-sharing paid by enrollee, another individual, Medicaid, low-income subsidy	Cost-sharing paid by enrollee or by third-party payer on enrollee's behalf
Enrollee payments beyond stop-loss amount	None	10% of expenditures beyond stop-loss	None	None

Note: Premiums for the Tripartisan and House Republican proposals are estimates.

Coinsurance Proposals

The three proposals that would have used coinsurance rates (the Tripartisan plan and both House proposals) can be compared by examining how much a hypothetical enrollee with a given level of drug costs would have paid under each proposal. For a given level of prescription drug expenses, a beneficiary's out-of-pocket payments will vary depending on the combination of premium, deductible, coinsurance rates, coverage limit, and out-of-pocket limit. The cost to the government of providing coverage will also vary depending on these plan characteristics. More specifically, if a plan is designed to increase the beneficiary's share of the cost, the government's share of the cost will decrease.

The following examples illustrate how, for given levels of total drug expenditures, an enrollee's out-of-pocket payments would have varied under the Tripartisan proposal and the two House proposals. The examples assume that all cost-sharing is paid by the enrollee; they do not show the different effects that would have resulted when third-party payers make cost-sharing payments on behalf of enrollees. The following examples do not take into account reductions in expenditures that might have occurred because of the use of pharmacy benefit managers (PBMs) to control program costs.

Example 1: Enrollee has zero annual drug costs

Tripartisan (S. 2729)		**House Republican (H.R. 4954)**		**House Democratic (H.R. 5019)**	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Total payments	$288	Total payments	$396	Total payments	$300

Note: Premiums for the Tripartisan and House Republican proposals are estimates.

In Example 1, the enrollee does not have any drug expenditures. About 10% of Medicare Fee-for-Service enrollees fall into this category.[5] The enrollee participating in the drug benefit would have had to pay annual premiums based on the specific proposal.

[5] Congressional Budget Office, March 2002 baseline projections.

Example 2: Enrollee's annual drug costs equal $50

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Out-of-pocket	$50	Out-of-pocket	$50	Out-of-pocket	$50
Total payments	$338	Total payments	$446	Total payments	$350

Note: Premiums for the Tripartisan and House Republican proposals are estimates.

In the second example, the enrollee's annual drug expenditures equal $50. As with the first example, the enrollee must pay the annual premium amount. The $50 in drug costs fall below the $100 deductible proposed under the House Democratic plan and below the $250 deductible proposed under the House Republican and Tripartisan plans. Consequently, the enrollee would have been required to pay the entire $50 out-of-pocket under all three proposals.

Example 3: Enrollee's annual drug costs equal $750

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Deductible	$250	Deductible	$250	Deductible	$100
Coinsurance (= 50% of $500[a])	$250	Coinsurance (= 20% of $500[a])	$100	Coinsurance (= 20% of $650[b])	$130
Total payments	$788	Total payments	$746	Total payments	$530

Note: Premiums for the Tripartisan and House Republican proposals are estimates.
[a] Equal to total drug expenditures ($750) minus the deductible ($250).
[b] Equal to total drug expenditures ($750) minus the deductible ($100).

In Example 3, the enrollee has $750 in annual drug costs. This amount exceeds the deductibles proposed by each plan. In the case of the House Democratic plan, the enrollee's costs would have exceeded the deductible by $650. The enrollee would have paid the annual premiums, the full $100 deductible, and 20% of the $650 amount. In the case of the House Republican and the Tripartisan plans, the enrollee's costs would have exceeded the deductible by $500. Under the House Republican plan, the enrollee would have paid the annual premiums, the full $250 deductible, and 20% of the $500 amount. Under the Tripartisan plan, the enrollee would have paid the annual premiums, the full $250 deductible, and 50% of the $500 amount.

Example 4: Enrollee's annual drug costs equal $1,500

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Deductible	$250	Deductible	$250	Deductible	$100
Coinsurance (= 50% of $1,250[a])	$625	First coinsurance (= 20% of $750[b])	$150	Coinsurance (= 20% of $1,400[a])	$280
		Second coinsurance (= 50% of $500[c])	$250		
Total payments	$1,163	Total payments	$1,046	Total payments	$680

Note: Premiums for the Tripartisan and House Republican proposals are estimates.
[a] Equal to total drug expenditures ($1,500) minus the deductible.
[b] Equal to $1,000 minus the deductible ($250).
[c] Equal to total drug expenditures ($1,500) minus $1,000.

The fourth example illustrates enrollee out-of-pocket spending when the enrollee's total drug costs equal $1,500. Under the House Republican plan, the coinsurance rate would have changed to 50% once the enrollee's cumulative expenses exceeded $1,000. Thus, the enrollee would have paid (1) the annual premiums; (2) the $250 deductible; (3) 20% of $750, where $750 equals the difference between $1,000 and the $250 deductible; and (4) 50% of $500, where $500 equals the difference between the total drug expenses and $1,000.

The Tripartisan and House Democratic proposals would have worked the same way in this example as they would have in the previous example. Under the Tripartisan plan, the enrollee would have paid the annual premiums, the $250 deductible, and 50% of expenses above the deductible. Under the House Democratic plan, the enrollee would have paid the annual premiums, the $100 deductible, and 20% of expenses above the deductible.

Example 5: Enrollee's annual drug costs equal $3,000

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Deductible	$250	Deductible	$250	Deductible	$100
Coinsurance (= 50% of $2,750[a])	$1,375	First coinsurance (= 20% of $750[b])	$150	Coinsurance (= 20% of $2,900[a])	$580
		Second coinsurance (= 50% of $1,000[c])	$500		
		Expenditures above $2,000 coverage limit	$1,000		
Total payments	$1,913	Total payments	$2,296	Total payments	$980

Note: Premiums for the Tripartisan and House Republican proposals are estimates.
[a] Equal to total drug expenditures ($3,000) minus the deductible.
[b] Equal to $1,000 minus the deductible ($250).
[c] Equal to the coverage limit ($2,000) minus $1,000.

In Example 5, the enrollee's cumulative drug costs for the year equal $3,000. Under the Tripartisan and House Democratic proposals, the enrollee's payments would have been calculated in the same manner as in the previous two examples.

Under the House Republican proposal, coverage would have been limited to the first $2,000 of drug expenses. Thus, the $3,000 in expenses generated by the enrollee would have exceeded the initial coverage limit by $1,000. The enrollee would have been required to pay these excess expenses out-of-pocket. In total, the enrollee would have paid (1) the annual premiums; (2) the $250 deductible; (3) 20% of $750, where $750 equals the difference between the deductible and $1,000; (4) 50% of $1,000, where $1,000 equals the difference between the initial coverage limit ($2,000) and $1,000; and (5) those expenditures exceeding the initial coverage limit, which equal $1,000 in this example.

Example 6: Enrollee's annual drug costs equal $4,500

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Deductible	$250	Deductible	$250	Deductible	$100
Coinsurance (= 50% of $3,200[a])	$1,600	First coinsurance (= 20% of $750[b])	$150	Coinsurance (= 20% of $4,400[c])	$880
		Second coinsurance (= 50% of $1,000[d])	$500		
Expenditures above $3,450 coverage limit	$1,050	Expenditures above $2,000 coverage limit	$2,500		
Total payments	$3,188	Total payments	$3,796	Total payments	$1,280

Note: Premiums for the Tripartisan and House Republican proposals are estimates.
[a] Equal to coverage limit ($3,450) minus the deductible ($250).
[b] Equal to $1,000 minus the deductible ($250).
[c] Equal to total drug expenditures ($4,500) minus the deductible ($100).
[d] Equal to the coverage limit ($2,000) minus $1,000.

In Example 6, the enrollee's cumulative drug costs for the year equal $4,500. The enrollee's payments under the House Republican and House Democratic proposals would have been calculated in the same manner as in the previous two examples.

Under the Tripartisan proposal, no coverage would have been provided after $3,450 worth of total expenses (including the $250 deductible). Thus, the $4,500 in expenses generated by the enrollee would have exceeded the coverage limit by $1,050. The enrollee would have been required to pay these excess expenses out-of-pocket. In total, the enrollee would have paid (1) the annual premiums; (2) the $250 deductible; (3) 50% of $3,200, where $3,200 equals the difference between the deductible and $3,450; (4) those expenditures exceeding the coverage limit, which equal $1,050 in this example.

Example 7: Enrollee's annual drug costs equal $6,000

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Deductible	$250	Deductible	$250	Deductible	$100
Coinsurance (= 50% of $3,200[a])	$1,600	First coinsurance (= 20% of $750[b])	$150	Coinsurance (= 20% of $5900[c])	$1,180
		Second coinsurance (= 50% of $1,000[e])	$500		
Expenditures between $3,450 coverage limit and $5,300[d]	$1,850	Expenditures between $2,000 coverage limit and $4,800[d]	$2,800		
10% of $700[f]	$70				
Total payments	$4,058	Total payments[g]	$4,096	Total payments	$1,580

Note: Premiums for the Tripartisan and House Republican proposals are estimates.
[a] Equal to coverage limit ($3,450) minus the deductible ($250).
[b] Equal to $1,000 minus the deductible ($250).
[c] Equal to total drug expenditures ($6,000) minus the deductible ($100).
[d] Equal to the level of cumulative expenditures at which enrollee spends $3,700 out-of-pocket.
[e] Equal to the coverage limit ($2,000) minus $1,000.
[f] Equal to total drug expenditures ($6,000) minus $5,300.
[g] Equal to limit on out-of-pocket payments ($3,700) plus annual premiums.

Example 7, illustrates a situation in which an enrollee's payments exceed the $3,700 stop-loss amount that would have existed under the Tripartisan and House Republican proposals. Using the same methods as the previous example, the enrollee would have had potential out-of-pocket payments of $4,900, plus the annual premiums, under the House Republican proposal. But $4,900 is greater than the $3,700 limit. Thus, the enrollee's total payments for the year would have been $3,700 plus the annual premiums, a total of $4,096. This amount, $4,096, was the maximum that an enrollee would have paid in a year under the House Republican proposal. This maximum would have been paid by any enrollee with annual drug costs greater than $4,800.

Under the Tripartisan plan, an enrollee would have reached the $3,700 limit on out-of-pocket payments once cumulative drug costs reached $5,300. The enrollee would have then paid 10% of all expenditures above that amount. In total, the enrollee would have paid (1) the annual premiums; (2) the $250 deductible; (3) 50% of $3,200, where $3,200 equals the difference between the deductible and $3,450; (4) $1,850, which equals the amount of expenditures exceeding the $3,450 coverage limit but less than $5,300; and (5) $70, which equals 10% of expenditures above $5,300. Because the enrollee would have continued paying a portion of expenditures after the stop-loss amount is met, out-of-pocket payments would have continued to increase. Unlike the House Republican plan, there was no maximum out-of-pocket amount under the Tripartisan plan.

Example 8: Enrollee's annual drug costs equal $12,000

Tripartisan (S. 2729)		House Republican (H.R. 4954)		House Democratic (H.R. 5019)	
Annual premiums	$288	Annual premiums	$396	Annual premiums	$300
Deductible	$250	Deductible	$250	Deductible	$100
Coinsurance (= 50% of $3,200[a])	$1,600	First coinsurance (= 20% of $750[b])	$150	Coinsurance (= 20% of $9,500[c])	$1,900
		Second coinsurance (= 50% of $1,000[e])	$500		
Expenditures between $3,450 coverage limit and $5,300[d]	$1,850	Expenditures between $2,000 coverage limit $4,800[d]	$2,800		
10% of $6,700[f6]	$670				
Total payments	$4,658	Total payments[g]	$4,096	Total payments[g]	$2,300

Note: Premiums for the Tripartisan and House Republican proposals are estimates.
[a] Equal to coverage limit ($3,450) minus the deductible ($250).
[b] Equal to $1,000 minus the deductible ($250).
[c] Equal to the level of cumulative expenditures at which enrollee spends $2,000 out-of-pocket ($9,600) minus the deductible ($100).
[d] Equal to the level of cumulative expenditures at which enrollee spends $3,700 out-of-pocket.
[e] Equal to the coverage limit ($2,000) minus $1,000.
[f] Equal to total drug expenditures ($12,000) minus $5,300.
[g] Equal to limit on out-of-pocket payments plus annual premiums.

The House Democratic proposal would have limited enrollee out-of-pocket payments (excluding premiums) to $2,000. In Example 8, the enrollee's cost-sharing would have otherwise exceeded this limit. With total drug expenses of $12,000, the enrollee would have had to pay $2,480 under the 20% coinsurance rule. Because $2,480 would have exceeded the plan's limit, the enrollee only would have had to pay $2,000 for the year, plus $300 in premiums.

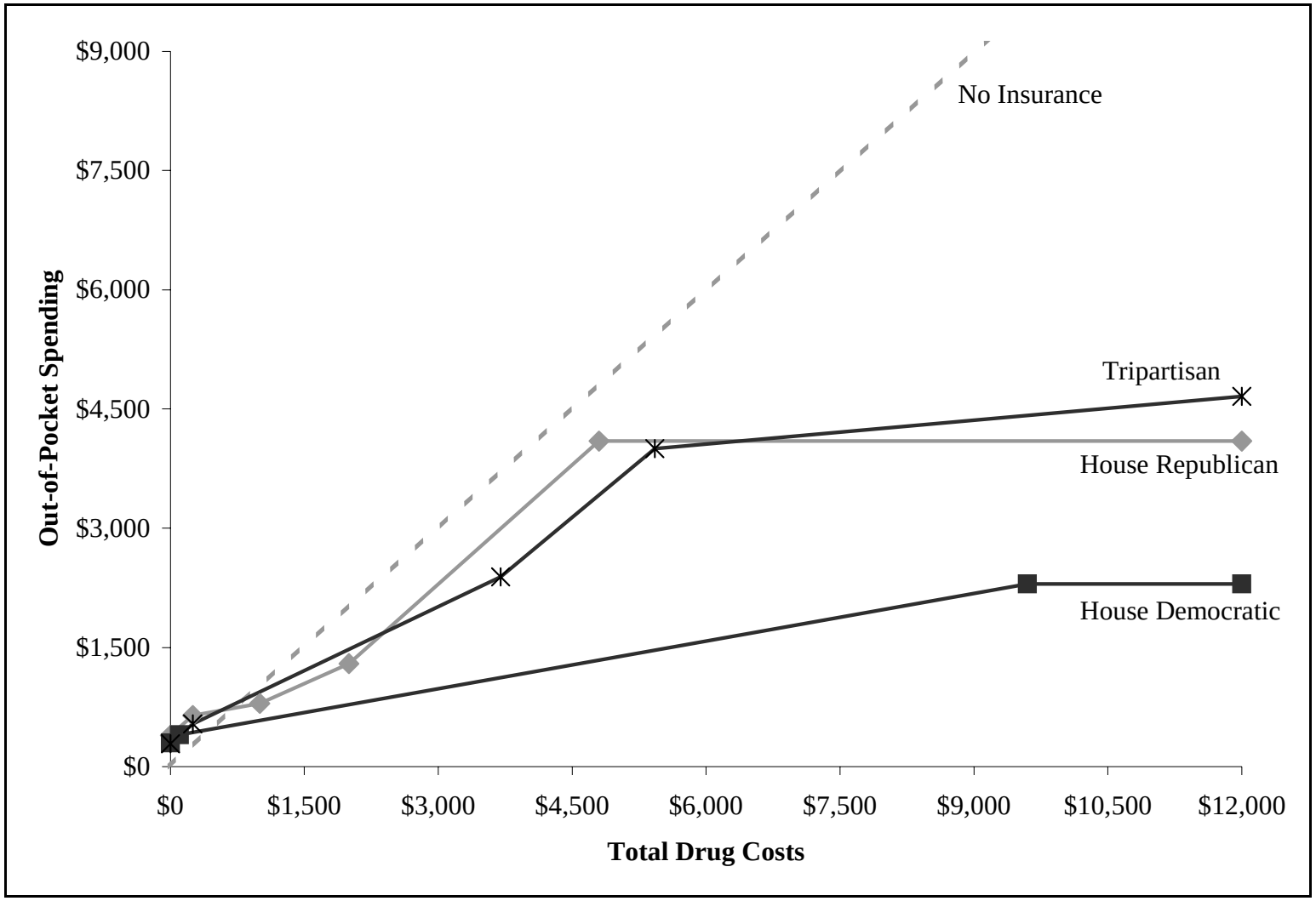
With a 20% coinsurance rate and a $100 deductible, an enrollee would have reached the $2,000 limit on out-of-pocket payments once the enrollee's drug expenses exceeded $9,600 for the year. Thus, any enrollee with drug expenses above $9,600 per year would have paid a total of $2,300 under the House Democratic proposal.

Figure 1 provides a graphical representation of the relationship between an enrollee's total drug costs and his or her total out-of-pocket expenditures (including annual premiums). The dashed line in **Figure 1** represents the amount that an individual would pay if he or she did not have any insurance coverage for prescription drugs. The dashed line also coincides with points where the amount that an individual pays out-of-pocket is exactly equal to his or her total drug costs. Points below this line represent levels of drug costs where the enrollee pays less in out-of-

pocket expenses than the amount of his or her drug costs. Points above the dashed line represent levels of drug costs where the enrollee must pay more in out-of-pocket expenses than his or her actual drug costs. In other words, the enrollee gets less out of the benefit in dollar terms than he or she pays in. This situation arises from the presence of fixed payments, such as premiums and deductibles.

A more detailed depiction of **Figure 1** that focuses on low values of total drug costs is shown in **Figure 2**. In **Figure 2**, the line representing the Tripartisan proposal crosses the dashed line (which represents no insurance) at $826. This means that an enrollee would have needed to have drug expenditures over $826 before he or she would have received more out of the benefit, in dollar terms, than what he or she paid. Thus, $826 represents a "break-even" point. To get a positive dollar benefit under the House Republican and House Democratic proposals, an enrollee would have needed to incur drug costs over $745 and $475, respectively.

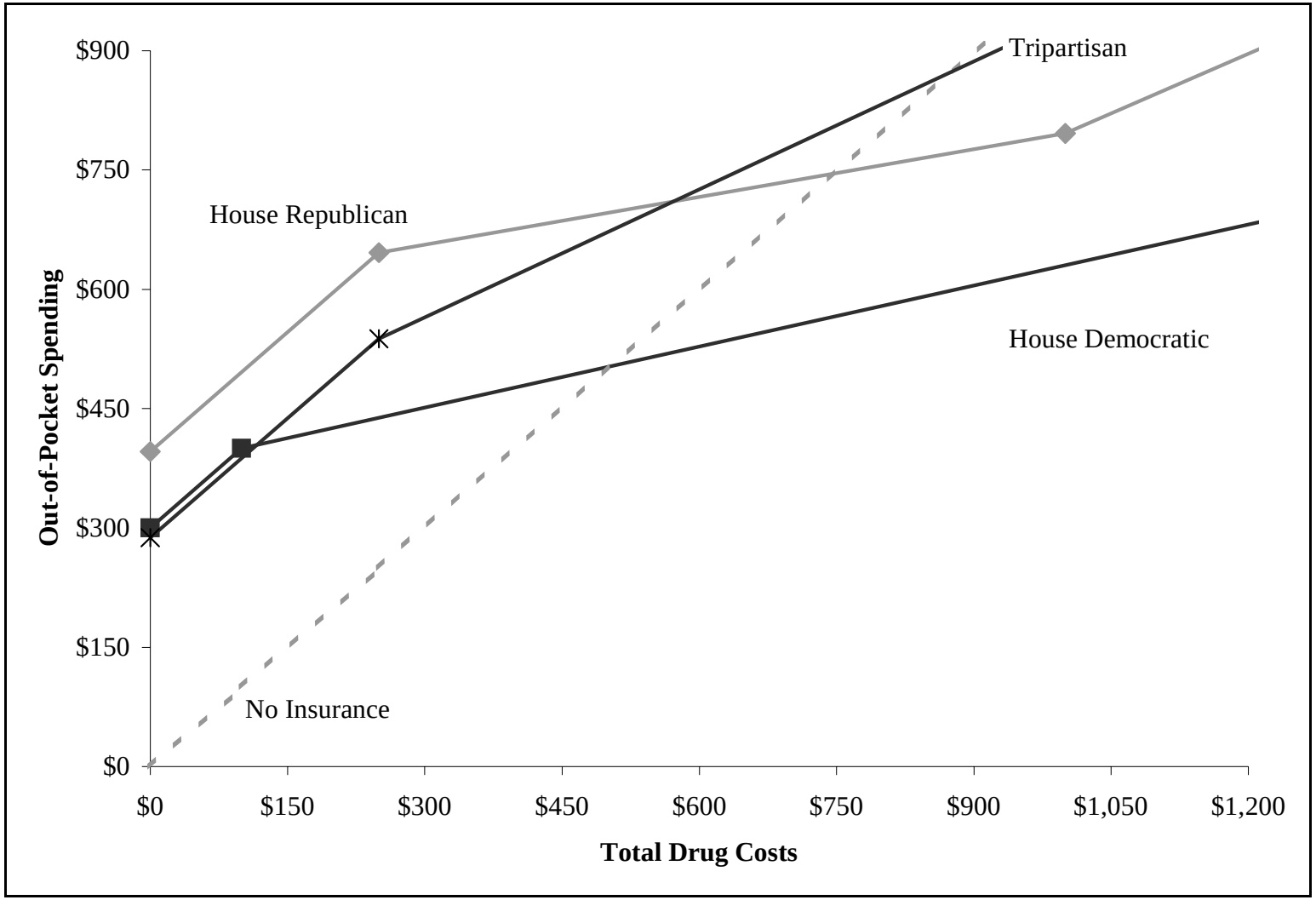
Figure 1. Out-of-Pocket Spending Under Proposed Prescription Drug Benefits



Source: Congressional Research Service (CRS).

Note: Out-of-pocket spending includes annual premiums.

Figure 2. Out-of-Pocket Spending Under Proposed Prescription Drug Benefits (When Total Drug Costs Are Less Than $1,200)



Source: Congressional Research Service (CRS).

Note: Out-of-pocket spending includes annual premiums.

Copayment Proposal

The proposal sponsored by Graham, et al., would have required enrollees to pay flat payments per prescription rather than a percentage of their drug costs. Enrollees would have paid $10 for each prescription filled with a generic drug, $40 for each prescription filled with a brand-name drug included in the formulary, and the full cost for each prescription filled with a brand-name drug not included in the formulary.

The amount that an enrollee would have paid in cost-sharing, relative to that enrollee's total drug costs, would have likely varied depending on the enrollee's drug utilization patterns. Under coinsurance plans, similar to those described above, individuals with identical levels of annual drug costs pay the same amount in cost-sharing (ignoring special provisions for low-income beneficiaries). This is not necessarily true under a drug benefit that uses copayments. For individuals with identical annual drug costs, the number of prescriptions filled in a year can vary significantly. For example, Medicare beneficiaries with annual drug costs around $500 fill between 2 and 83 prescriptions per year.[6] Some of this variation is due to different amounts of pills per prescription (e.g., 30-day supply versus a 90-day supply); the proposal sponsored by Graham, et. al., could have reduced some of this variation because the bill provided a definition of what constitutes a prescription. Even so, the exact amount that an individual with $500 in annual drug costs would have paid under a copayment system still would have varied depending on the number of prescriptions and the share of those prescriptions filled with generic drugs. Because of this variation, it is not possible to link cost-sharing payments under a copayment plan to an enrollee's total drug costs or calculate a break-even point, as was done for the proposals that would use coinsurance rates.

Table 2 illustrates how much an individual could have paid under the proposal sponsored by Graham, et al. The number of prescriptions specified are hypothetical; the table includes payments when an enrollee fills 22 prescriptions per year, the average number of prescriptions filled by noninstitutionalized Medicare beneficiaries in 1998.[7] Ranges of payments are provided to reflect three different scenarios: all prescriptions are filled with generic drugs, 50% of prescriptions is filled with generic drugs and the other 50% is filled with brand name drugs, and all prescriptions are filled with brand name drugs. **Table 2** does not illustrate the situation where an enrollee receives a prescription for a drug not included in the formulary; in this situation, the enrollee would have to pay for the entire cost of the drug.

Table 2 depicts how the stop-loss amount would have worked under the proposal sponsored by Graham, et. al. When total copayments reach $4,000, the enrollee would not have paid for any additional prescriptions filled. The number of prescriptions it would have taken to reach the stop-loss amount would have depended on the mix of prescriptions an enrollee uses. In the examples provided in **Table 2**, an enrollee who used all brand name drugs would have reached the stop-loss amount once he or she filled 100 prescriptions for the year. An enrollee whose prescriptions

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[6] Centers for Medicare and Medicaid Services, 1998 Medicare Current Beneficiary Survey.

[7] Ibid.

were one-half generic and one-half brand name would have reached the stop-loss amount at 160 prescriptions. An enrollee who used only generic prescriptions would have reached the stop-loss amount at 400 prescriptions. An enrollee who used drugs off the formulary would have reached the limit with even fewer prescriptions.

Policy Options

The cost-sharing design is one of the many issues that the 108th Congress would need to consider in developing a prescription drug benefit for the Medicare population. Several options are available, each with particular trade-offs in terms of cost for beneficiaries and program costs for the government.

One key decision is whether to design cost-sharing around coinsurance rates or flat copayments. The advantage of coinsurance rates is that, aside from any special provisions for low-income beneficiaries, individuals with identical levels of annual drug costs would pay the same amount. On the other hand, copayments could be easier for Medicare beneficiaries to understand; the enrollee pays the same amount for all brand name drugs or for all generic drugs, regardless of the drugs' cost, and does not have to be concerned about deductibles, differing coinsurance rates, or coverage limits.

Another policy issue concerns the amount of cost-sharing an enrollee should be required to pay. Low levels of cost-sharing reduce the financial burden that enrollees would have to bear. However, these reduced burdens must be borne by some entity. If enrollees face low cost-sharing, the costs of providing a benefit must be picked up by the government, third-party payers contracted by the government, or providers of pharmaceutical goods and services.

In addition, the level of cost-sharing affects the break-even point, discussed earlier in the report. Low cost-sharing results in a low break-even point, and a relatively low break-even point could encourage more beneficiaries to choose to participate in the prescription drug benefit. On the other hand, a relatively high break-even point means that a larger share of beneficiaries are paying more for coverage than they are receiving for benefits. Consequently, a relatively high break-even point could result in lower program costs than if there were a low break-even point. However, a break-even point that is too high might discourage many beneficiaries from enrolling; this phenomena is referred to as "adverse selection." Under adverse selection, individuals with low expected drug costs choose to pay for their drugs entirely out-of-pocket instead of purchasing insurance coverage. Adverse selection can result in higher program costs because there are fewer low-cost enrollees participating in the program. The proposals of the 107th Congress required enrollees to pay late-enrollment penalties if they did not elect coverage when first becoming eligible; such penalties could reduce the possibility of adverse selection.

Table 2. Hypothetical Copayments Under the Amendment Sponsored by Graham, et al.

	Annual copayments				Total payments (equal to copayments + annual premium)		
No. of prescriptions	**All generic**	**50% generic/ 50% brand**	**All brand**	**Annual premium**	**All generic**	**50% generic/ 50% brand**	**All brand**
0	$0	$0	$0	$300	$300	$300	$300
2	$20	$50	$80	$300	$320	$350	$380
6	$60	$150	$240	$300	$360	$450	$540
10	$100	$250	$400	$300	$400	$550	$700
22[a]	**$220**	**$550**	**$880**	**$300**	**$520**	**$850**	**$1,180**
50	$500	$1,250	$2,000	$300	$800	$1,550	$2,300
100	$1,000	$2,500	$4,000[b]	$300	$1,300	$2,800	$4,300
160	$1,600	$4,000[b]	$4,000[b]	$300	$1,900	$4,300	$4,300
200	$2,000	$4,000[b]	$4,000[b]	$300	$2,300	$4,300	$4,300
400	$4,000[b]	$4,000[b]	$4,000[b]	$300	$4,300	$4,300	$4,300

[a] Represents the average number of prescriptions filled by Medicare beneficiaries in 1998.
[b] Equal to the stop-loss amount.