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Medicare: Beneficiary Cost-Sharing Under Proposed Prescription Drug Benefits

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Summary

Medicare, the nationwide health insurance program for the aged and disabled, does not cover most outpatient prescription drugs. To address this gap in the Medicare benefit, proposals that have passed in House and Senate Committees in the 108th Congress would cover at least a portion of beneficiaries' prescription drug costs. In mid-June, both the House Ways and Means Committee and the House Energy and Commerce Committee approved the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 2473). Although differences exist between their versions of the bill, the prescription drug standard coverage and low-income provisions are similar. Their versions of the bill have been consolidated into H.R. 1. On June 12, the Senate Finance Committee approved the Prescription Drug and Medicare Improvement Act of 2003 (S. 1). This report provides background on how the cost-sharing and premium provisions under each bill would affect the amount that a beneficiary pays annually for prescription drugs.

Each of these proposals has a different form of cost-sharing (that is, the share of an enrollee's drug costs that are not paid by the Medicare prescription drug plan). Under S. 1, the plan would pay 50% of drug costs after the enrollee paid the $275 deductible (in 2006). After $4,500 in total drug spending (again, in 2006 dollars), the enrollee would pay for *all* prescription drug spending until reaching the $3,700 "true" out-of-pocket maximum (that is, cost-sharing amounts excluding those paid on behalf of the enrollee by private health insurance). After reaching that level of prescription drug spending, the plan would cover 90% of spending. The prescription drug cost-sharing and premiums are reduced or eliminated for certain low-income beneficiaries.

H.R. 1 includes a prescription drug proposal with a deductible of $250, after which the plan would cover 80% of spending. After $2,000 in total spending, the beneficiary would be responsible for *all* prescription drug costs until reaching the "true" out-of-pocket maximum. Like S. 1, the true out-of-pocket maximum in H.R. 1 is $3,500, and private health insurance payments do not apply toward it. However, under H.R. 1, once the true out-of-pocket maximum is reached, the plan would pay for all additional prescription drug spending.

Based on the premiums and cost-sharing in S. 1, the breakeven point — which is where the amount that an individual pays for in cost-sharing and premiums is equal to what he or she would have paid without any drug coverage — is at $1,155 in total annual drug spending for the typical beneficiary (that is, for those not receiving low-income assistance). Under H.R. 1, enrollees would receive more in benefits from the plan than if they lacked such coverage after spending $775 in prescription drugs.

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Providing a prescription drug benefit for Medicare beneficiaries is an important 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 in a plan 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).

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.

Out-of-pocket maximum, or 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 out-of-pocket maximum, all additional expenses for the year are paid by the third-party payer (e.g., Medicare, private insurance plan). S. 1, however, requires beneficiaries to pay a 10% coinsurance after the "maximum out-of-pocket" is reached. Under S. 1 and H.R. 1, cost-sharing amounts paid by private insurers on behalf of enrollees do not apply toward the out-of-pocket maximum.

In addition to the cost-sharing that exists under a plan, enrollees generally must pay a premium. A premium is 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

[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 RL31966, *Medicare Prescription Drug and Reform Legislation*, by Jennifer O'Sullivan et al.

monthly basis. While premiums technically are not considered part of cost-sharing, it is useful to take them into account when comparing plans with dissimilar cost-sharing requirements.

In mid-June, both the House Ways and Means Committee and the House Energy and Commerce Committee approved the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 2473). Although differences exist between their versions of the bill, the prescription drug standard coverage and low-income provisions are similar. Their versions of the bill have been consolidated into H.R. 1. On June 12, the Senate Finance Committee approved the Prescription Drug and Medicare Improvement Act of 2003 (S. 1). This report provides background on how the cost-sharing and premium provisions under each bill would affect the amount that a beneficiary pays annually for prescription drugs. In addition, this report gives examples of how annual cost-sharing would differ for beneficiaries with various levels of total prescription drug spending in 2006 under the plans.

Proposed Cost-Sharing Arrangements

Under S. 1 — in which the new prescription drug benefit would take effect in 2006, as in H.R. 1 — the plan would pay 50% of drug costs after the enrollee paid the $275 deductible. The coverage limit is $4,500. That is, after $4,500 in total drug spending (again, in 2006 dollars), the enrollee would pay for *all* prescription drug spending until reaching the out-of-pocket maximum. Under this plan the maximum out-of-pocket is $3,700 and is often referred to as the "true" out-of-pocket maximum because cost-sharing amounts paid on behalf of the enrollee by private health insurance do not count toward the $3,700. After reaching that level of prescription drug spending, the plan would cover 90% of spending. Under this proposal, enrollees would pay a $35 monthly premium in 2006.[2]

The prescription drug standard coverage in H.R. 1 has a deductible of $250, after which the plan would cover 80% of spending, until total prescription drug spending reaches the coverage limit of $2,000. The out-of-pocket maximum in H.R. 1 is $3,500. As in S. 1, private health insurance payments do not apply toward the out-of-pocket maximum. However, under H.R. 1, once the true out-of-pocket maximum is reached, the plan would pay for *all* additional prescription drug spending. Under this proposal, enrollees would also pay a $35 monthly premium in 2006.

Table 1 summarizes the major cost-sharing provisions of the prescription drug plans in S. 1 and H.R. 1.

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[2] The premium amount is an estimate from the Congressional Budget Office, which also provided the premium estimate for H.R. 1.

Table 1. Annual Premium and Cost-Sharing Under Drug Proposals

	S. 1	H.R. 1
Premium	$420	$420
Deductible	$275	$250
Cost-sharing	Single coinsurance up to coverage limit	Single coinsurance up to coverage limit
Cost-sharing amounts	50% of drug costs above deductible and up to coverage limit	20% of drug costs above deductible and up to coverage limit
Coverage limit	$4,500	$2,000
Range of expenditures where enrollee pays for 100% of drug costs	$4,500-$5,813[a]	$2,000-$4,900[a]
Out-of-pocket maximum	$3,700 out-of-pocket ($5,813 total expenditures[a])	$3,500 out-of-pocket ($4,900 total expenditures[a])
Out-of-pocket payments applied towards stop-loss amount	Cost-sharing paid by enrollee, another individual, Medicaid, low-income subsidy	Cost-sharing paid by enrollee, another individual, Medicaid, low-income subsidy
Enrollee payments beyond out-of-pocket maximum	10% of expenditures beyond out-of-pocket maximum	None

Note: The table does not include some of the plans' reduced cost-sharing for low-income beneficiaries or increased cost-sharing for high-income beneficiaries.

[a] Assumes all cost-sharing is paid by the enrollee.

Cost-Sharing Examples

Both proposals can be compared by examining how much a hypothetical enrollee with a given level of drug costs would pay under each proposal. For a given level of prescription drug expenses, a beneficiary's out-of-pocket payments will vary depending on each plan's deductible, coinsurance, coverage limit, and out-of-pocket maximum. The cost to the government of providing coverage will also vary depending on these plan characteristics as well as the premium charged to enrollees. 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 assume that all cost-sharing is paid by the enrollee; they do not show the different effects that would have resulted when private health insurance makes cost-sharing payments on behalf of enrollees. However, since the only impact of this provision is on the calculation of the maximum out-of-pocket, accounting for the provision would affect only those beneficiaries with high out-of-pocket prescription drug spending. Also, the following examples do not take into account reductions in expenditures that might result because of the use of the effects of formularies, pharmacy benefit managers (PBMs), and incentives regarding the use of generic medications.

Example 1: Enrollee has zero annual drug costs

S. 1		H.R. 1	
Premium	$420	Premium	$420
Total payments	$420	Total payments	$420

In Example 1, the enrollee does not have any drug expenditures, and therefore would only pay the premiums.

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

S. 1		H.R. 1	
Deductible	$50	Deductible	$50
Premium	$420	Premium	$420
Total payments	$470	Total payments	$470

In the second example, the enrollee's annual drug expenditures equal $50. The $50 in drug costs fall below both of the plans' deductibles. Consequently, the enrollee pays the entire $50 plus the premiums under both proposals.

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

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $475[a])	$238	Coinsurance (= 20% of $500[b])	$100
Premium	$420	Premium	$420
Total payments	$933	Total payments	$770

[a] Equal to total drug expenditures ($750) minus the deductible ($275).
[b] Equal to total drug expenditures ($750) minus the deductible ($250).

In Example 3, the enrollee has $750 in total annual drug spending. This amount exceeds the deductibles proposed in both plans. Under S. 1, the enrollee's total prescription drug spending would exceed the deductible by $475. Thus, this enrollee would pay the premiums, the full $275 deductible and 50% of the $475 amount. In the case of H.R. 1, the enrollee's costs would exceed the deductible by $500. The enrollee would pay the premiums, the full $250 deductible and 20% of the $500 amount.

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

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $1,225[a])	$613	First coinsurance (= 20% of $1,250[a])	$250
Premium	$420	Premium	$420
Total payments	$1,308	Total payments	$920

[a] Equal to total drug expenditures ($1,500) minus the deductible.

The fourth example illustrates enrollee out-of-pocket spending when the enrollee's total drug costs equal $1,500. The proposals would work the same way in this example as in the previous example. Under S. 1, the enrollee would pay the premiums as well as the $275 deductible and 50% of expenses above the deductible. Under H.R. 1, the enrollee would pay the premiums, the $250 deductible and 20% of expenses above the deductible.

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

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $2,725[a])	$1,363	Coinsurance (= 20% of $1,750[b])	$350
		Expenditures above $2,000 coverage limit	$1,000
Premium	$420	Premium	$420
Total payments	$2,058	Total payments	$2,020

[a] Equal to total drug expenditures ($3,000) minus the deductible.
[b] Equal to the coverage limit ($2,000) minus the deductible ($250).

In Example 5, the enrollee's cumulative drug costs for the year equal $3,000. Under S. 1, the enrollee's payments would be calculated in the same manner as in the previous two examples.

Under H.R. 1, coverage would be limited to the first $2,000 of drug expenses. Thus, the $3,000 in expenses generated by the enrollee would exceed the initial coverage limit by $1,000. The enrollee would pay these excess expenses out-of-pocket. In total, the enrollee would pay the premiums as well as the following cost-sharing: (1) the $250 deductible; (2) 20% of $1,750, where $1,750 equals the difference between the deductible and the coverage limit of $2,000; and (3) those expenditures exceeding the initial coverage limit.

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

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $4,225[a])	$2,113	Coinsurance (= 20% of $1,750[b])	$350
		Expenditures above $2,000 coverage limit	$2,500
Premium	$420	Premium	$420
Total payments	$2,808	Total payments	$3,520

[a] Equal to total drug expenditures minus the deductible ($250). Total spending of $4,500 is the coverage limit for this plan. Thus, any additional prescription drug spending, up to the out-of-pocket maximum, would be paid for by the enrollee.
[b] Equal to the coverage limit ($2,000) minus the deductible ($250).

In Example 6, the enrollee's cumulative drug costs for the year equal $4,500. The enrollee's payments under these proposals would be calculated in the same manner as in the previous example.

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

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $4,225[a])	$2,113	Coinsurance (= 20% of $1,750[b])	$350
Expenditures between $4,500 coverage limit and $5,813[c]	$1,312	Expenditures between $2,000 coverage limit and $4,900[d]	$2,900
10% of $187[e]	$19		
Premium	$420	Premium	$420
Total payments	$4,139	Total payments	$3,920

Note: Assumes all cost-sharing applies to the out-of-pocket maximum.

[a] Equal to coverage limit ($4,500) minus the deductible ($275).
[b] Equal to the coverage limit ($2,000) minus the deductible ($250).
[c] The level of cumulative expenditures at which enrollee spends $3,700 out-of-pocket is $5,813.
[d] The level of cumulative expenditures at which enrollee spends $3,500 out-of-pocket is $4,900.
[e] Equal to total drug expenditures ($6,000) minus $5,813.

Example 7 illustrates a situation in which an enrollee's payments exceed the bills' out-of-pocket maximums. H.R. 1 limits enrollee out-of-pocket payments (excluding premiums) to $3,500. In this example, the enrollee's cost-sharing would have otherwise exceeded this limit. With total drug expenses of $6,000, the enrollee would have paid $4,600, in cost-sharing (excluding premiums) without the plan's out-of-pocket maximum. However, because $4,600 exceeds the plan's out-of-pocket limit, the enrollee would pay only $3,500 in cost-sharing for the year. With a $250 deductible, a 20% coinsurance rate up to $2,000 in total spending, and no coverage above the $2,000 coverage limit, an enrollee would reach the $3,500 limit on out-of-pocket payments once the enrollee's drug expenses exceeds $4,900 for the year. Thus, any enrollee with drug expenses above $4,900 per year would pay a total of $3,500 plus premiums under H.R. 1 (assuming all cost-sharing applies to the out-of-pocket maximum).

Under S. 1, an enrollee reaches the $3,700 out-of-pocket maximum once cumulative drug costs exceed $5,813 (assuming all cost-sharing applies to the out-of-pocket maximum) plus premiums. The enrollee would then pay 10% of all expenditures above that amount. In total, this enrollee would pay premiums, the $3,700 amount plus $19, which equals 10% of prescription drug expenditures above $5,813.

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

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $4,225[a])	$2,113	Coinsurance (= 20% of $1,750[b])	$350
Expenditures between $4,500 coverage limit and $5,813[c]	$1,312	Expenditures between $2,000 coverage limit and $4,900[d]	$2,900
10% of $6,187[e]	$619		
Premium	$420	Premium	$420
Total payments	$4,739	Total payments	$3,920

Note: Assumes all cost-sharing applies to the out-of-pocket maximum.

[a] Equal to coverage limit ($4,500) minus the deductible ($275).
[b] Equal to coverage limit ($2,000) minus the deductible ($250).
[c] The level of cumulative expenditures at which enrollee spends $3,700 out-of-pocket is $5,813.
[d] The level of cumulative expenditures at which enrollee spends $3,500 out-of-pocket is $4,900.
[e] Equal to total drug expenditures ($12,000) minus $5,813.

In Example 8, the enrollee's cumulative drug costs for the year equal $12,000. The enrollee's payments would be calculated in the same manner as in the previous example.

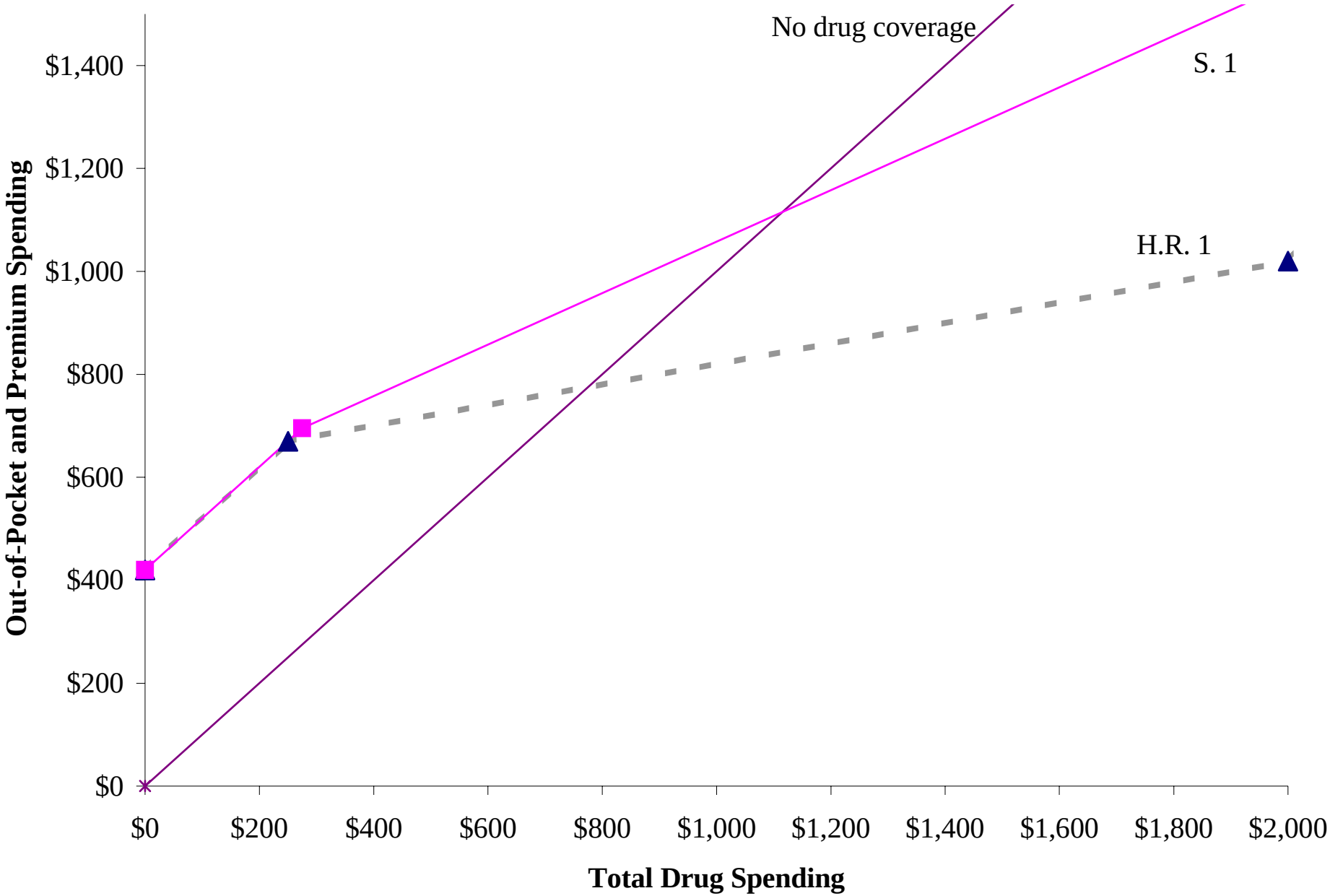
An individual enrollee with a certain amount of total prescription drug spending may have very different experiences in each of these plans because of the structure of the plans' benefits and resulting cost-sharing. **Figure 1** and **Figure 2** illustrate beneficiaries' out-of-pocket payments at different levels of total drug spending, based on the cost-sharing listed in **Table 1**. **Figure 1** displays total prescription drug spending up to $2,000. **Figure 2** shows spending up to $12,000, although some enrollees may have spending exceeding that amount. The figures assume that all cost-sharing applies to each plan's out-of-pocket maximum and does not account for some of the plans' reduced cost-sharing for low-income beneficiaries or increased cost-sharing for high-income beneficiaries.

The line in the figures labeled "No drug coverage" represents the amount that an individual would pay if he or she did not have any insurance coverage for prescription drugs not presently covered by Medicare. The lines of the other plans cross this line at the "breakeven point" of their respective plans — that is, the point where the amount that an individual pays for a plan's cost-sharing and premiums is equal to his or her total drug costs. The breakeven point could also be described as the point where the amount that an individual pays for a plan's cost-sharing and premiums is equal to what he or she would have paid without any drug coverage. In the figures, line segments to the right of the "No drug coverage" line represent levels of drug spending where the enrollee pays *less* in out-of-pocket expenses and premiums than if they had no drug coverage. In the figures, line segments to the left

of this line represent levels of drug spending where the enrollee pays *more* in out-of-pocket expenses and premiums than if he or she had no drug coverage.

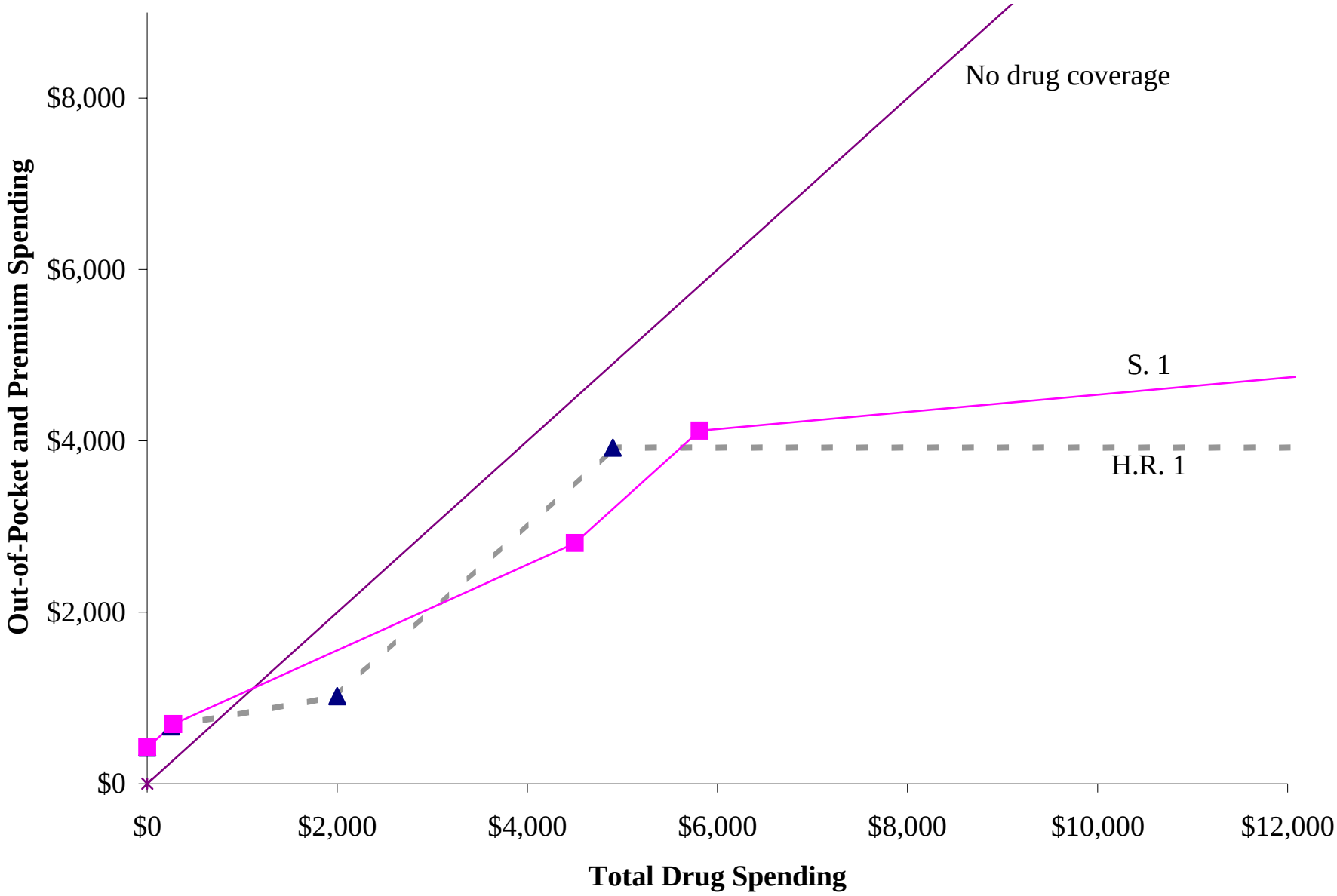
Based on the premium and cost-sharing outlined in H.R. 1, the breakeven point is at $775 in total annual drug spending. Under S. 1, enrollees would receive more in benefits from the plan than if they lacked such coverage after spending $1,155 in prescription drugs.

Figure 1. Annual Out-of-Pocket and Premium Spending, by Total Drug Spending, Up to $2,000



Source: Congressional Research Service (CRS).
Note: The figure assumes that all cost-sharing applies to each plan's out-of-pocket maximum. The figure does not reflect some of the plans' reduced cost-sharing for low-income beneficiaries or increased cost-sharing for high-income beneficiaries.

Figure 2. Annual Out-of-Pocket and Premium Spending, by Total Drug Spending, Up to $12,000



Source: Congressional Research Service (CRS).

Note: The figure assumes that all cost-sharing applies to each plan's out-of-pocket maximum. The figure does not reflect some of the plans' reduced cost-sharing for low-income beneficiaries or increased cost-sharing for high-income beneficiaries.

Conclusion

The cost-sharing design and premium amounts are some of the issues that the 108th Congress is considering 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 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, low cost-sharing makes the benefit more expensive for the government and raises the possibility of adverse selection and overutilization. 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.