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Beneficiary Cost-Sharing Under the Medicare Prescription Drug Benefit

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Summary

On December 8, 2003, the "Medicare Prescription Drug and Modernization Act of 2003" was signed into law (H.R. 1, P.L. 108-173). The law adds Part D to Medicare, which establishes a new voluntary prescription drug benefit that begins in 2006. This report analyzes how the cost-sharing and premium provisions under Part D would affect the amount that a beneficiary would pay 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 plan's standard benefit.

Standard prescription drug coverage under the plan would pay 75% of drug costs after the enrollee paid the $250 deductible (in 2006). After $2,250 in total drug spending (the "coverage limit"), the enrollee would pay for *all* prescription drug spending until reaching the $3,600 out-of-pocket protection threshold. This threshold would be reached when total spending on prescription drugs exceeds $5,100, assuming none of the cost-sharing is paid for by group health insurance or other third-party arrangement. Medicare would then cover 95% of all additional drug expenses, as long as the beneficiary paid a minimum of $2 for each generic drug and preferred multiple-source drug, and a $5 copayment for all other drugs.

Thus, for most beneficiaries, Medicare would not contribute directly to the cost of drugs when annual drug expenses fall in a certain range, although Medicare would contribute directly toward beneficiary drug expenses at levels below and above this range. This aspect of the coverage is often referred to as the "doughnut hole." Under Medicare Part D standard coverage, the doughnut hole is between $2,250 and $5,100 in total prescription drug spending.

Low-income beneficiaries would not face a doughnut hole in their coverage. "Dual eligibles," Medicare beneficiaries enrolled in their state's full Medicaid benefits, who are also institutionalized would pay no premium and have no cost-sharing whatsoever. Noninstitutionalized dual eligibles with countable income below 100% of poverty would pay no premium or deductible but would face a $1 copayment for each generic and preferred multiple-source drug, and a $3 copayment for all other covered drugs until reaching the $3,600 out-of-pocket protection threshold.

All other dual eligibles would face a $2 copayment for each generic and preferred multiple-source drug, and a $5 copayment for all other covered drugs until reaching the $3,600 out-of-pocket protection threshold. This is also the level of cost sharing for Medicare beneficiaries with countable income under 135% of poverty and countable assets in 2006 of no more than $6,000 for an individual and $9,000 for a married couple. Those who do not qualify in any of the previous low-income categories but have countable income below 150% of poverty and countable assets of no more than $10,000 for an individual or $20,000 for a married couple in 2006 would be eligible for a partially subsidized premium and cost-sharing lower than the standard benefit.

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Beneficiary Cost-Sharing Under the Medicare Prescription Drug Benefit

Introduction

On December 8, 2003, the "Medicare Prescription Drug and Modernization Act of 2003" was signed into law (H.R. 1, P.L. 108-173). The law adds Part D to Medicare, which establishes a new voluntary prescription drug benefit that begins in 2006. This report analyzes how the cost-sharing and premium provisions under Part D would affect the amount that a beneficiary would pay annually for prescription drugs.[1] 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 plan's standard benefit.

Cost-Sharing and Insurance

Insurance acts to reduce uncertainty and individuals' exposure to high costs due to catastrophic events such as severe illness. In general, individuals pay a premium, and in exchange, insurers pay for their covered benefits. Premiums are paid regardless of whether covered expenses are actually incurred.

In addition to premiums, enrollees may also face cost-sharing, which is the portion of total expenses that enrollees must pay for covered benefits. Cost-sharing in a health plan generally includes some combination of deductibles, coinsurance, copayments, and limits on individuals' out-of-pocket expenses. Because these concepts are necessary to evaluate and compare the prescription drug coverage in the proposals, they are described in **Box 1**.

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[1] For a discussion of other issues associated with a prescription drug benefit, such as how much risk would be borne by private insurance, see CRS Report RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,* by Jennifer O'Sullivan et al.

Box 1. Terms Used to Describe Cost-Sharing

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

Coinsurance rate: The percentage of covered costs paid by the enrollee. The terms of coverage can specify various coinsurance rates for different aspects of coverage, for instance before and after a threshold of expenses.

Copayment: A fixed dollar amount that the enrollee must pay for each covered benefit — for instance, a filled prescription. A copayment differs from coinsurance in that the copayment amount does not vary with the cost of the service. However, copayments may differ based on the type of drug (for example, one copayment amount for brand-name drugs, another for generic drugs).

Coverage limit: The total amount of incurred expenses at which the insurer (federal government, health care plan, etc.) reduces its contributions to the enrollee's expenses. For example, once an enrollee's drug costs exceed the coverage limit, the enrollee must pay for most or all the additional drug expenses.

Catastrophic coverage: To protect beneficiaries from exposure to extraordinarily large expenses, insurers may offer catastrophic coverage, wherein the insurer (for instance, Medicare or a private health plan) typically pays all or almost all additional expenses once an enrollee meets the annual out-of-pocket protection threshold, or catastrophic threshold (excluding premiums).

Cost-Sharing Arrangements

P.L. 108-173 establishes Medicare Part D, which includes a voluntary "standard" prescription drug benefit in Medicare that would take effect in 2006.[2] Variations in the beneficiary cost-sharing requirements of the plan will affect the level of potential out-of-pocket costs to individual beneficiaries. Since participation is voluntary, expected out-of-pocket expenses are likely to be a critical factor when beneficiaries consider whether to enroll.

Under Part D, a beneficiary with the standard coverage would pay 25% of drug costs after meeting the $250 deductible (in 2006). After $2,250 in total drug spending (the "coverage limit"), the enrollee would pay for *all* prescription drug spending until reaching the $3,600 out-of-pocket protection threshold. This amount is often referred to as the "true" out-of-pocket threshold because, according to the language in the conference agreement, cost-sharing paid on behalf of the enrollee by group health insurance or other third-party arrangement does not count toward the $3,600. This threshold is reached when total spending on prescription drugs exceeds $5,100, assuming none of the cost-sharing is paid by group health insurance or other third-party arrangement. After reaching this threshold, Medicare would cover 95% of all additional drug expenses, but the beneficiary must pay a minimum of $2 for

[2] Beneficiaries will be able to purchase either "standard coverage" or alternative coverage with actuarially equivalent benefits. Plans with different but actuarially equivalent benefits might have other cost-sharing requirements with slightly different deductibles and coinsurance rates.

each generic drug and multiple-source[3] preferred drug and $5 for all other drugs. The Congressional Budget Office estimates that the average monthly enrollee premium will be $35 in 2006.[4]

Table 1. Prescription Drug Standard Coverage in Medicare Part D, 2006

Annual premium	$420 ($35/month)[a]
Annual deductible	$250
Coinsurance on drug costs above deductible and up to coverage limit	25%
Coverage limit	$2,250 (beneficiary will have paid a $250 deductible and $500 of coinsurance costs)
Range of spending where enrollee pays 100% of drug costs	$2,250-$5,100[b]
Catastrophic threshold	$3,600 out-of-pocket ($5,100 total expenditures[b])
Cost-sharing payments that apply toward out-of-pocket threshold	Cost-sharing paid by the enrollee, another individual, a state pharmaceutical assistance program, or by Medicare under the low-income subsidy program.
Coinsurance beyond out-of-pocket threshold	5%, with a minimum copayment of $2 for each generic drug or preferred multiple-source drug and $5 for all other drugs

[a] Amount estimated by the Congressional Budget Office (CBO).
[b] Assumes none of the cost-sharing is paid by group health insurance or other third-party arrangement.

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[3] A "multiple-source drug" is a covered outpatient prescription drug for which there are 2 or more drug products rated as therapeutically and pharmaceutically equivalent by the Food and Drug Administration.

[4] Although the CBO estimate of the average monthly premium is $35 in 2006, many Medicare beneficiaries will face different monthly premium amounts for several reasons: (1) the drug premiums will be adjusted for geographic variation in the price of drugs; (2) beneficiaries' premiums will be adjusted up or down to reflect the difference between the approved bid of their prescription drug plan of choice and the national average bid amount (adjusted for geographic variation); and (3) a late enrollment penalty will increase the monthly premiums for beneficiaries who do not have any other "creditable prescription drug coverage" (including Medicaid, a group health plan, a state pharmaceutical assistance program, veterans' or military coverage, or Medigap) and fail to enroll within 63 days of becoming eligible for Part D.

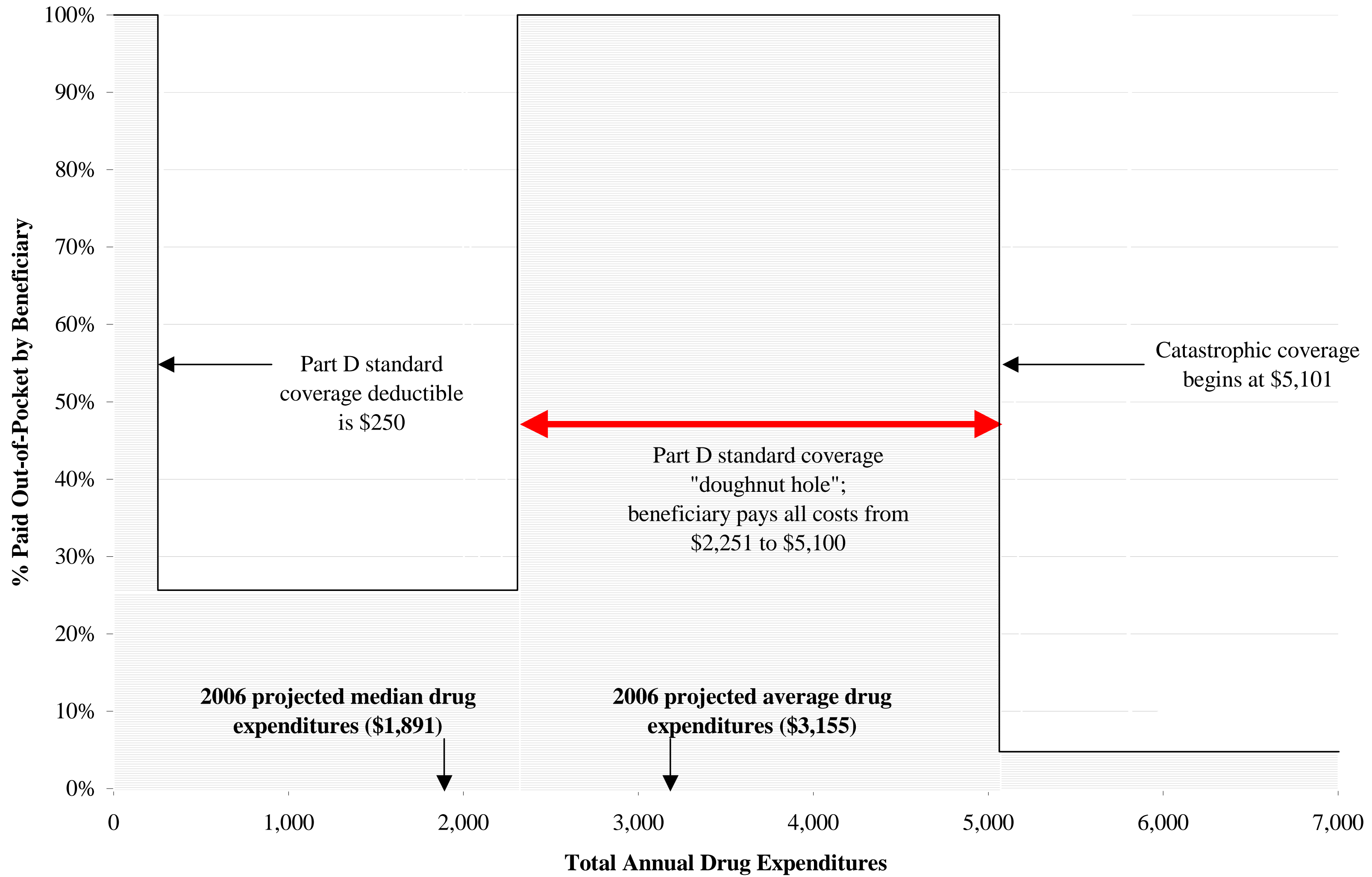
The "Doughnut Hole"

Under Part D, Medicare does not contribute toward the cost of drugs when an some individuals' annual drug expenses fall in a certain range — that is, when expenses are above the coverage limit but below the total amount necessary to reach the out-of-pocket threshold. This aspect of the coverage has been referred to as the "doughnut hole."[5]

Under Part D, beneficiaries receiving the standard benefit must pay the full cost of drugs once they reach the coverage limit of $2,250 and until their true out-of-pocket payments reach the catastrophic cap of $3,600. Because of the $250 deductible and the 25% coinsurance up to the initial coverage limit, beneficiaries with the standard benefit will have spent $750 out-of-pocket (excluding the premium) when a total of $2,250 in drug costs has been spent. Assuming none of the cost-sharing is paid for by group health insurance or other third-party arrangement, they will have to spend an additional $2,850 to reach the catastrophic threshold of $3,600. Since there is no Medicare contribution over this range, the beneficiary will bear the full cost of drugs from the coverage limit of $2,250 until accumulated drug expenses reach $5,100, as shown in **Figure 1**.

[5] Some have referred to this as a "gap in coverage," which can be misleading. Coverage continues to be in effect even when Medicare is not contributing directly to the cost of drugs, and the beneficiaries' out-of-pocket expenditures accumulate toward the catastrophic threshold. While there may be a gap in Medicare payments, there continues to be coverage, and beneficiaries continue to have access to negotiated discounted prices.

Figure 1. Marginal Beneficiary Cost-Sharing by Total Drug Expenditures Under Medicare Part D Standard Coverage, 2006



Source: Congressional Research Service (CRS). The projected median and average prescription drug expenditures for 2006 are from the 2003 baseline of the Congressional Budget Office (CBO) and represent spending by or for Medicare enrollees, not including the impact of Part D.

Income-based Provisions

The Medicare Part D standard benefit's cost-sharing requirements are lowered for beneficiaries below certain income levels (with additional eligibility criteria); premiums, deductibles and coinsurance levels are reduced for qualifying low-income beneficiaries. In addition, low fixed-dollar copayments for each prescription are sometimes required rather than coinsurance. There is no coverage limit for these individuals, and thus no doughnut hole.

The provisions pertaining to low-income Medicare beneficiaries under Medicare Part D are summarized in **Table 2**. Eligibility is based not only on beneficiaries' countable income,[6] but also their countable assets, or "resources,"[7] whether they are enrolled in Medicaid with full benefits ("dual eligibles"), and whether they are institutionalized.[8]

Under Part D, dual eligibles who are institutionalized would have no cost-sharing and pay no premiums for their prescription drug coverage. Noninstitutionalized dual eligibles with countable income of no more than 100% of the poverty level would have no deductible but would have copayments of $1 for generic and preferred multiple-source drugs, and $3 copayments for all other drugs. They would face these copayments until reaching the out-of-pocket threshold, after which they would pay no more for additional prescription drug expenses for the year.[9]

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[6] "Countable income" means the amount of income counted for determining eligibility for Supplemental Security Income (SSI) and is defined in Section 1612 of the Social Security Act, as amended. "Poverty line," or "poverty," refers to the federal poverty guidelines published by the Department of Health and Human Services. The 2003 federal poverty guideline for an unmarried, aged Medicare beneficiary is $8,980 in countable income in the 48 contiguous states and the District of Columbia, $11,210 in Alaska, and $10,330 in Hawaii. The 2003 federal poverty guideline for a married, aged Medicare beneficiary is $12,120 in the 48 contiguous states and the District of Columbia, $15,140 in Alaska, and $13,940 in Hawaii. Because the guidelines apply to "countable income" (which excludes certain amounts and types of income), persons may qualify even though their *total* income is above these amounts. For further information, see CRS Report RS21675, *Medicare Prescription Drug Proposals, Estimates of Beneficiaries Who Fall Below Income Thresholds, by State*, by Chris L. Peterson.

[7] Throughout this report, "countable assets" refers to the amount of assets counted for determining eligibility for Supplemental Security Income (SSI), defined in Section 1613 of the Social Security Act, as amended.

[8] To be considered "institutionalized," dual eligibles must be an inpatient in a Medicaid-certified medical institution or nursing facility, according to 1902(q)(1)(B) of the Social Security Act, as amended.

[9] Under Part D, Medicare is the sole payer of dual eligibles' covered prescription drugs. Medicaid coverage is not permitted to pay for these drugs or the accompanying cost-sharing. However, this is not the windfall to states that it might appear to be. In 2006, states must pay the federal government approximately 90% of the costs they would otherwise have incurred if drug coverage for dual eligibles had continued under Medicaid. This percentage drops annually until reaching 75% in 2015.

All other dual eligibles would face no premiums or deductibles. Copayments would be required up to the out-of-pocket threshold: $2 per generic prescription and preferred multiple-source drug and $5 for all other prescription drugs. Once reaching the true out-of-pocket threshold, these beneficiaries would have no cost-sharing. This level of cost-sharing is also available to those who are not dual eligibles and have countable income below 135% of poverty and have countable assets of not more than $6,000 for an individual or $9,000 for a married couple.

Those who do not qualify in any of the previous low-income categories but have countable income below 150% of poverty and countable assets of no more than $10,000 for an individual or $20,000 for a married couple in 2006 would be eligible for a partially subsidized premium, determined on a linear sliding scale.[10] These beneficiaries would face a $50 annual deductible for their prescription drug coverage. Once the deductible was met, they would pay 15% of additional prescription drug expenses until reaching the out-of-pocket threshold of $3,600 (by incurring $23,717 in total drug expenditures, assuming none of the cost-sharing is paid for by group health insurance or other third-party arrangement). Once reaching that level of total prescription drug spending, copayments would be required for additional prescription drugs — $2 per generic and preferred multiple-source drug, and $5 for all other prescription drugs.

[10] Based on CBO estimates, beneficiaries with income at 135% of poverty will have no premium, while those with incomes equal to 150% of poverty would be responsible for the full $35 monthly premium. In general, individuals with incomes equal to 142.5% of poverty (the midpoint of the range) would have a $17.50 monthly premium.

Table 2. Summary of Prescription Drug Coverage for Low-Income Individuals in Part D, 2006

	Institutionalized[a] dual eligibles[b]	Dual eligibles with countable income[c] at or below 100% of poverty	Noninstitutionalized dual eligibles with countable income above 100% of poverty; Medicare beneficiaries with countable income below 135% of poverty plus assets test[d]	All other Medicare beneficiaries with countable income below 150% of poverty plus assets test[d]
Monthly premium[e]	No cost-sharing or premium	$0	$0	$0-$35
Annual deductible		$0	$0	$50
Cost-sharing between deductible and out-of-pocket maximum		$1/generic or preferred multiple-source drug,[f] $3 for all others	$2/generic or preferred multiple-source drug,[f] $5 for all others	15%
Out-of-pocket maximum		$3,600	$3,600	$3,600
Beyond out-of-pocket maximum		0%	0%	$2/generic or preferred multiple-source drug,[f] $5 for all others

Source: Congressional Research Service.

[a] To be considered "institutionalized," dual eligibles must be an inpatient in a Medicaid-certified medical institution or nursing facility, according to 1902(q)(1)(B) of the Social Security Act, as amended.

[b] "Dual eligibles" are those Medicare beneficiaries who are also enrolled to receive the full benefits of their state's Medicaid program.

[c] "Countable income" means the amount of income counted for determining eligibility for Supplemental Security Income (SSI), defined in Section 1612 of the Social Security Act, as amended. "Poverty" refers to the federal poverty guidelines published by the Department of Health and Human Services.

[d] The assets test refers to the amount of assets counted for determining eligibility for SSI, defined in Section 1613 of the Social Security Act, as amended. To qualify in the below 135% of poverty category in 2006, countable assets (resources) are limited to $6,000 for an individual and $9,000 for a married couple. To qualify in the category below 150% of poverty, countable assets are limited to $10,000 for an individual and $20,000 for a couple.

[e] Additional amounts may be required for prescription drug plans with relatively high premiums. The full $35 premium is an estimate from the Congressional Budget Office (CBO).

[f] A "multiple-source drug" is a covered outpatient prescription drug for which there are 2 or more drug products rated as therapeutically and pharmaceutically equivalent by the Food and Drug Administration.

Cost-Sharing Examples

Examples follow of how much a hypothetical enrollee with a given level of drug costs would pay under the standard coverage in Medicare Part D in 2006. For a given level of prescription drug expenses, a beneficiary's out-of-pocket payments will vary depending on the plan's deductible, coinsurance, coverage limit, and out-of-pocket threshold. 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.

Each of the following examples assumes that none of the cost-sharing is paid by group health insurance or other third-party arrangement. The calculations do not consider reductions in expenditures due to negotiated discounts, the effects of formularies and pharmacy benefit managers (PBMs), or the consequences of incentives to use generic medications.

Example 1: Enrollee has zero annual drug costs

Medicare Part D standard coverage, 2006	
Premium	$420
Total payments	$420

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

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

Medicare Part D standard coverage, 2006	
Deductible	$50
Premium	$420
Total payments	$470

In the second example, the enrollee's annual drug expenditures equal $50. The $50 in drug costs falls below the plan's deductible. Consequently, the enrollee pays the entire $50 plus the premiums.

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

Medicare Part D standard coverage, 2006	
Deductible	$250
Coinsurance (= 25% of $500[a])	$125
Premium	$420
Total payments	$795

[a] 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 deductible in Part D standard coverage by $500. The enrollee would pay the premiums, the full $250 deductible and 25% of the $500 amount.

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

Medicare Part D standard coverage, 2006	
Deductible	$250
Coinsurance (= 25% of $1,250[a])	$313
Premium	$420
Total payments	$983

[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 enrollee would pay the premiums, the $250 deductible and 25% of expenses above the deductible.

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

Medicare Part D standard coverage, 2006	
Deductible	$250
Coinsurance (= 25% of $2,000[a])	$500
Expenditures above $2,250 coverage limit	$750
Premium	$420
Total payments	$1,920

[a] Equal to the coverage limit ($2,250) minus the deductible ($250).

In Example 5, the enrollee's cumulative drug costs for the year equal $3,000.[11] Under Part D, for this level of total prescription drug spending, Medicare payments would occur only for the first $2,250 of expenses. Thus, the $3,000 in expenses generated by the enrollee would exceed the initial coverage limit by $750. 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) 25% of $2,000, where $2,000 equals the difference between the deductible and the coverage limit of $2,250; and (3) the $750 in expenditures exceeding the initial coverage limit.

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

Medicare Part D standard coverage, 2006	
Deductible	$250
Coinsurance (= 25% of $2,000[a])	$500
Expenditures above $2,250 coverage limit	$2,250
Premium	$420
Total payments	$3,420

[a] Equal to the coverage limit ($2,250) minus the deductible ($250).

In Example 6, the enrollee's cumulative drug costs for the year equal $4,500. The enrollee's payments would be calculated in a similar manner as in the previous example. Under Part D, the total out-of-pocket costs would be $3,420.

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

Medicare Part D standard coverage, 2006	
Deductible	$250
Coinsurance (= 25% of $2,000[a])	$500
Expenditures between $2,250 coverage limit and $5,100[b]	$2,850
Coinsurance (=5% of $900[c])	$45
Premium	$420
Total payments	$4,065

[a] Equal to the coverage limit ($2,250) minus the deductible ($250).
[b] The level of cumulative expenditures at which enrollee spends $3,600 out-of-pocket is $5,100.
[c] Equal to total drug expenditures ($6,000) minus $5,100.

[11] CBO projected that in 2006, Medicare beneficiaries will spend an average of $3,155 annually on drugs, not taking into account the prescription drug benefit in Part D.

Example 7 illustrates a situation in which an enrollee's payments exceed the bill's out-of-pocket protection threshold of $3,600 (excluding premiums). 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 $4,500, in cost-sharing (excluding premiums) without the plan's out-of-pocket protection.[12] However, because $4,500 exceeds the plan's out-of-pocket protection threshold, the enrollee would pay only 5% of the spending above the $3,600 out-of-pocket protection threshold. With a $250 deductible, a 25% coinsurance rate up to $2,250 in total spending, and 100% cost-sharing above the $2,250 coverage limit, an enrollee would reach the $3,600 limit on out-of-pocket payments once the enrollee's drug expenses exceeds $5,100 for the year. Of the additional $900 of spending above the out-of-pocket protection threshold in this example, the enrollee would be responsible for paying only $45.

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

Medicare Part D standard coverage, 2006	
Deductible	$250
Coinsurance (= 25% of $2,000[a])	$500
Expenditures between $2,250 coverage limit and $5,100[b]	$2,850
Coinsurance (=5% of $6,900[c])	$345
Premium	$420
Total payments	$4,365

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

[a] Equal to the coverage limit ($2,250) minus the deductible ($250).
[b] The level of cumulative expenditures at which enrollee spends $3,600 out-of-pocket is $5,100.
[c] Equal to total drug expenditures ($12,000) minus $5,100.

In Example 8, the enrollee's cumulative drug costs for the year equal $12,000. The enrollee's payments would be calculated in a similar manner as in the previous example. This enrollee would pay $4,365.

[12] Without the out-of-pocket protection, the beneficiary would have to pay a $250 deductible, $500 in coinsurance up to coverage limit of $2,250, and the full $3,750 between $2,250 and $6,000 for a total of $4,500.

Beneficiaries Receiving the Standard Benefit

Figure 2 and **Figure 3** illustrate beneficiaries' out-of-pocket payments plus premiums at different levels of total drug spending, based on the cost-sharing requirements listed in **Table 1**. **Figure 2** displays total prescription drug spending up to $2,000, while **Figure 3** shows spending up to $12,000.[13] The figures assume that all cost-sharing applies to each plan's out-of-pocket maximum and does not account for the reduced cost-sharing for low-income beneficiaries. The structure of the benefit and cost-sharing in Part D standard coverage produces many changes in coinsurance rates and out-of-pocket costs as total annual drug spending increases, as can be seen in the kinks and corners in the figures.

Breakeven. The breakeven point is the point where the amount that an individual pays for a plan's cost-sharing and premiums is equal to what would have been paid in drug costs in the absence of any drug coverage. The line in the **Figure 2** and **Figure 3** 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. The breakeven point is where this line is crossed by the line representing out-of-pocket spending under Part D standard coverage. In the figures, the line segment 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; the line segment 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 Part D standard coverage, the breakeven point is at $810 in total annual drug spending.

While the breakeven point is one factor in a beneficiary's decision whether to participate in this insurance plan, other factors, such as attitudes toward risk and uncertainty, are also important. Many beneficiaries will be making their decision about whether to purchase the insurance based on their expected annual prescription drug costs and their attitudes towards risk. All other things being equal, the higher the breakeven point, the less likely beneficiaries will be to join voluntarily.

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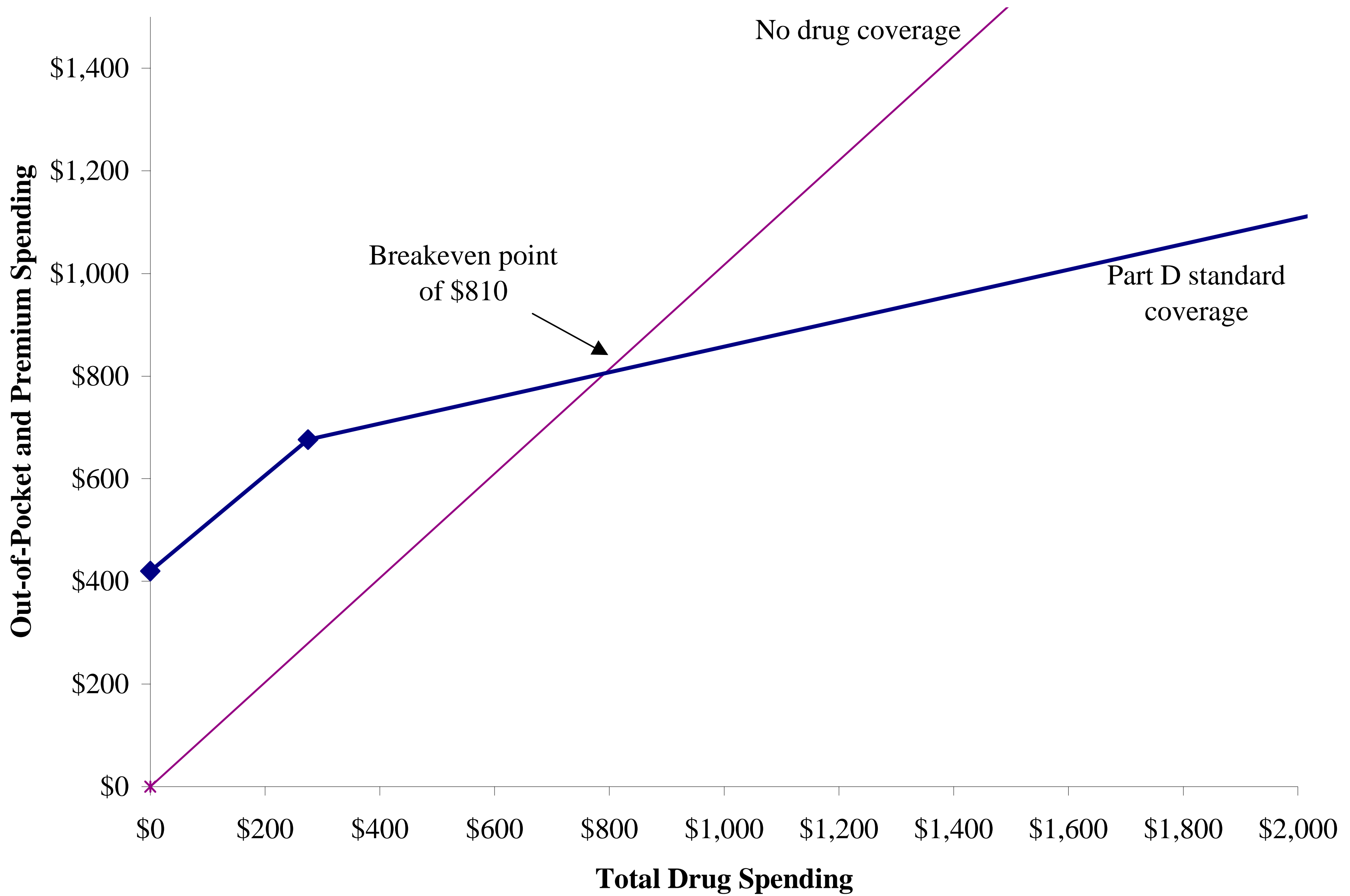
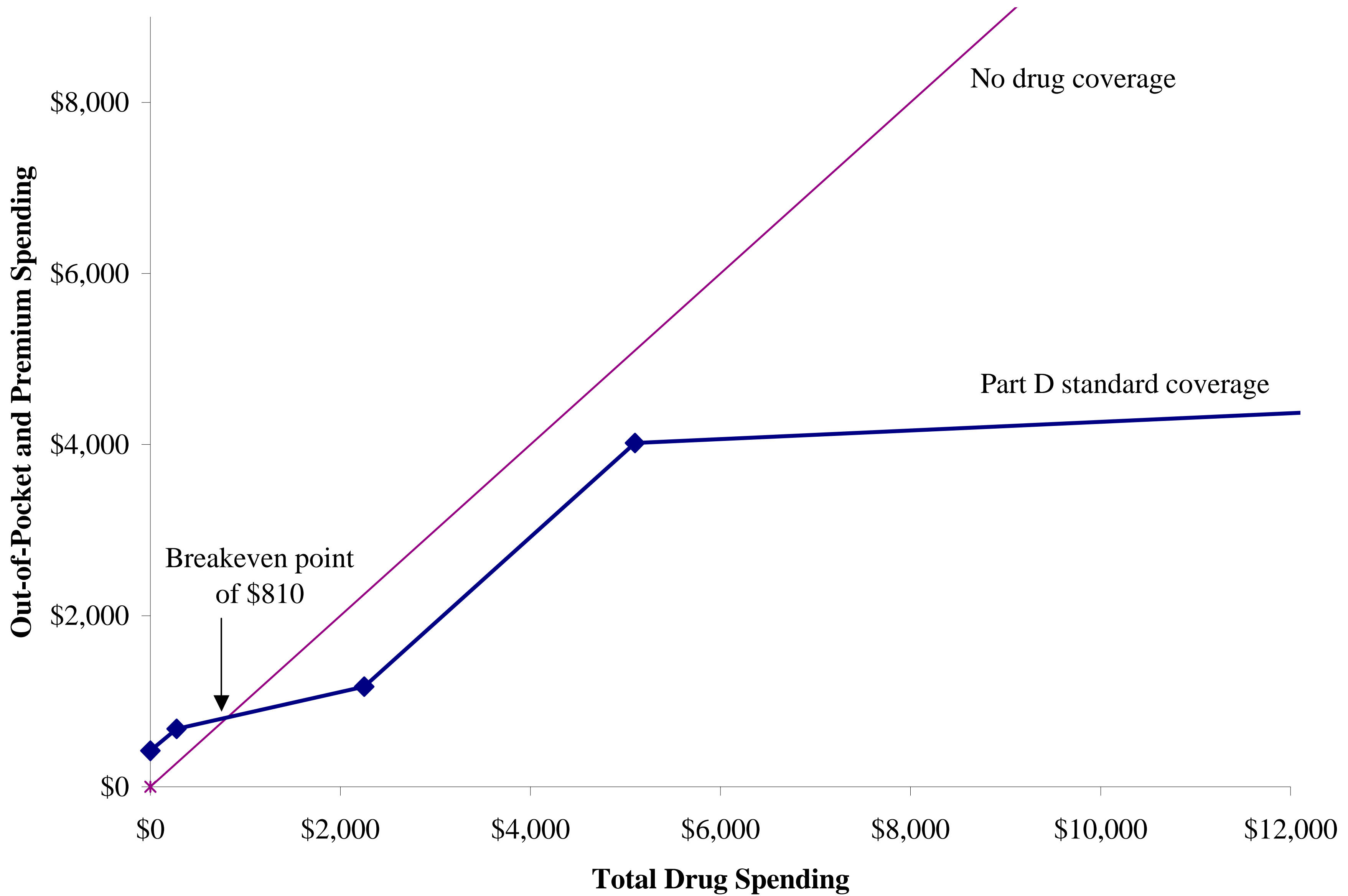
[13] CBO projects that 4.5% of beneficiaries will spend more than $12,000 on prescription drugs in 2006. See CBO, *March 2003 baseline projections*, not including the impact of Part D.

Figure 2. Annual Out-of-Pocket and Premium Spending, by Total Drug Spending, Up to $2,000, 2006



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

Figure 3. Annual Out-of-Pocket and Premium Spending, by Total Drug Spending, Up to $12,000, 2006



Source: Congressional Research Service (CRS).

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