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From the Editor

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From the Editor

Drug Benefits in Medicare: Where Are We Headed?

In 1965, Congress modeled Medicare's original package of benefits after those offered by Blue Cross and Blue Shield plans at the time. "While few benefits have been added since then, the very nature of illnesses that afflict Medicare's 38 million beneficiaries has changed considerably."[1] What has also changed, of course, is our pharmaceutical armamentarium to cope with these illnesses.

Simply, Medicare does not pay for outpatient prescription drugs, and the availability of new drugs to treat the ills of old age has prompted President Clinton to propose adding a drug insurance plan to Medicare under which premiums would be waived for low-income people. What is the scope of this policy conundrum, and what might we anticipate in the near term?[1]

Thirty-five years ago, many of the drugs now used to treat cancer, heart disease, allergies, arthritis, depression, and other chronic disorders did not exist. "At that time, there was a greater emphasis placed on surgery and hospitalization, a fact that helps explain why drugs prescribed for hospitalized patients have been fully covered by Medicare since its inception."[2] Over time, however, private health carriers acknowledged the value of prescription drugs by including them in their coverage, leaving Medicare, according to the AARP, a "glaring exception."[2] Currently, people over 65 pay more for drugs than they do for doctors 'c a re. Sixteen cents of their healthcare dollar goes for drugs compared to about 15 cents for physicians. Added to the fact that the average Medicare beneficiary uses 18 prescriptions a year, that means 2.5 billion prescriptions we re filled in the United States in 1998, up a whopping 31% from 1993. In the same time period, studies show that the average price per prescription rose 40% from $26 and change to nearly $38. Finally, in 1998, the average price for a prescription for new drugs (those introduced in 1992 or later) was more than twice the average price for older drugs ($71 compared to $30).[2]

While for many people this increase in prescription drug cost is nearly invisible–their employer insurance plans typically cover most of the expense–for millions of Medicare beneficiaries, especially in the ranks of the "uncovered," the impact is far more severe. Nearly 19 million elderly people in the United States have little or no drug coverage at all nor do an estimated 43 million younger Americans–those who are unemployed, the working poor, immigrants, illegal aliens, and single mothers in part-time jobs.[3]

The pharmaceutical industry argues that new compounds are highly cost effective. They prevent prolonged hospitalizations. They improve the quality of life. These arguments are probably true. The question becomes: At what overall cost to society? I believe that policy makers have been moved by many factors including a series of front-page articles in the *New York Times*[4] and *USA Today*[5,6] outlining the inequities in prescription reimbursement. Stories abound of elderly Medicare beneficiaries having to choose between paying the rent and taking their physician-prescribed, life-saving medication for problems like hypertension and kidney disease. Still, other investigations point out the inequality in international drug pricing where every industrialized country, except the United States, imposes some form of price controls

on prescription drugs.[7] As a result, the United States literally pays the price with consumers subsidizing international research and development.[8]

What might a future Medicare prescription drug benefit look like, and how could we possibly afford it? Both Democrats and Republicans recognize the political capital to be gained from solving the problem of how to pay for prescription drugs for the elderly. I believe this will be a critical election issue come November 2000. The cost estimates from various Washington, D.C.-based economic think tanks vary wildly.[9] For example, a Congressional Budget Office (CBO) analysis predicted the 10-year cost of the drug benefit to the federal treasury at $111 billion, more than twice the White House estimate of $45 billion dollars. This is reminiscent of the early discussions on the overall Medicare budget circa 1965. Astute policy observers know that the original estimates were off by a factor of nearly 200. One billion here, one billion there–soon we're talking about real money!

The leadership of groups like the AARP and the Pharmaceutical Research and Manufacturers Association of America (PhRMA), both call for a prescription benefit under Medicare but with vastly different approaches. While the policy details are daunting, the AARP calls for a program recognizing that beneficiaries "are clearly willing to pay their fair share provided that the benefit itself is perceived as meaningful."[10] The PhRMA supports expanding prescription drug coverage as part of the Medicare overhaul that would rely on market competition and not government regulation or price controls to improve quality, integrate care, and manage costs.[11] The truth lies somewhere between these two models.

In my view, the work of Mr. Lynn Etheredge, and others, is a potential prototype! In short, Etheredge calls for a program where all Medicare-eligible elderly and disabled persons would be covered for outpatient prescription drugs through one of five mechanisms–a Medicare + Choice plan, employer-based retiree benefits, a redesigned Medigap plan, Medicaid, or fee-for-service Medicare. The pharmacy coverage would consist of basic benefits paid by individuals and catastrophic or stop-loss benefits paid by the government. The basic benefits would be standardized with a specified deductible. Medicare would use the best practices of private-sector purchasers rather than capitation. For example, Pharmacy Benefit Management firms or PBMs might be selected competitively, at least two in each region of the country. They would be paid through performance contracts or with risk sharing for both basic and catastrophic benefits.

Other experts, like Harry Cain[12], call for transforming Medicare into a Federal Employees Health Benefits-like program. The FEHBP, as it is known, is widely regarded as a very successful program, which has outperformed Medicare in every way including cost containment, benefit innovation, and customer satisfaction. While the intricacies of Cain's proposal are beyond the scope of this column, it is fair to say that there are many smart policy folks on Capitol Hill with an equal number of competing innovative proposals all deserving of our attention.

One thing remains, however, and that is any effort to change Medicare will require extensive education for beneficiaries. In the largest peacetime education campaign in history[13], the federal government mailed 40 million Medicare beneficiaries a guide to their benefits in September of 1999. This guide, supported by a toll-free telephone (800-633-4227) and an expanded website (www.medicare.gov), is part of a campaign to help the elderly understand the brave new world of healthcare choices envisioned by Congress. Any proposed new drug benefit would require a comparable

Herculean educational effort just to sort out the basic components. Regardless of what finally transpires, all informed citizens need to participate in the pending debate with regard to creating a Medicare drug benefit. As always, I am interested in your views. You can reach me at David.Nash@mail.tju.edu.

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