THE HAMILTON PROJECT

Advancing Opportunity, Prosperity and Growth

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Mending the Medicare Prescription Drug Benefit:

Improving Consumer Choice and Restructuring Purchasing

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THE CHALLENGE

Unlike traditional Medicare, which provides services through a single, government-run program, Part D provides prescription drug benefits through private, competing insurance plans, with prices determined through negotiations between the plans and drug manufacturers. In designing Part D, Congress intended private competition both to control overall program costs and to provide a greater choice of plans. Frank and Newhouse argue that the benefits of competition have not been fully realized, however, because of four shortcomings in the design of Part D:

Excessive complexity that leads some consumers to choose the wrong insurance plan.

> In a survey of older Americans taken just prior to the launch of the Part D benefit, only 36 percent of respondents were able to identify the plan that offered them the best financial protection.

Frank and Newhouse also note that nearly 25 percent of those Medicare recipients who were thought to qualify for a low-income subsidy under Part D—and thus who could have received drug coverage at nearly no cost—did not enroll in any prescription drug plan. Frank and Newhouse speculate that the difficulty in choosing among so many plans may have discouraged enrollment among this group of Medicare recipients, who typically have less education than others and who frequently live alone.

> Annual drug expenses between $2,400 and $5,451 (the so-called donut hole) must be borne entirely by the individual.

Incentives that lead drug plans to avoid serving high-cost individuals.

Inefficient purchasing rules that lead to excessive drug and program costs.

Poorly designed cost sharing that exposes individuals to substantial risks.

Key Highlights

The Challenge

- **Complexity.** The need to choose from among dozens of insurance plans discourages enrollment, leads to some choices that are not in the best financial interest of consumers, and hinders effective competition.
- **Distorted incentives.** Insurance companies face incentives to avoid serving high-cost individuals.
- **Inefficient purchasing rules.** Part D pays excessive prices for important subsets of prescription drugs.
- **Inefficient cost sharing.** A gap in coverage for spending in the donut hole leaves many seniors without protection from thousands of dollars in prescription drug costs.

A New Approach

- **Reduce complexity.** Limit the number of prescription drug plans to between seven and nine and introduce automatic enrollment of seniors in a default drug plan, while preserving choice by allowing beneficiaries to change plans or to opt out entirely.
- **Reduce incentives to avoid serving high-cost seniors and increase competition.** Require plan sponsors to compete for regional contracts rather than for individual enrollees.
- **Adopt purchasing rules that are more cost effective.** Adopt Medicaid best-price rule for dual eligibles, monitor the prices of unique drugs, and remove the distinction between Part B and Part D drugs.
- **Change cost sharing.** Fill in the coverage gap by allowing plans that are actuarially equivalent to the standard plan to offer greater deductibles in exchange for greater coverage of drug expenses in the donut hole.

A NEW APPROACH

Reduce complexity by standardizing benefits and adopting automatic enrollment.

greater benefits in exchange for higher premiums. Each of these plans would be developed by a panel of interested stakeholders, which is similar to the process that was used to develop the standardized plans for Medigap (which allows Medicare recipients to purchase supplemental health care insurance). Citing experience with retirement security programs—employers that offer ten or fewer choices of 401(k)s tend to have significantly higher employee participation rates than those with more 401(k) choices—Frank and Newhouse argue that this smaller number of choices would increase participation in Part D. At the same time, this smaller number of plans would be sufficient to retain important variation with respect to features such as deductibles, cost sharing, and the formulary.

To further increase participation, Frank and Newhouse also propose automatically assigning Medicare beneficiaries to a standardized plan, although all beneficiaries would remain free to change their plan or to opt out of the program entirely. Citing evidence from the behavioral economics literature, Frank and Newhouse argue that automatic enrollments not only would result in expanded enrollment but also would help enrollees choose plans that better met their financial needs. This approach thereby would strike a better balance between preserving freedom of choice and reducing some of the negative outcomes that appear to accompany the combination of excessive and complicated choices and a lack of consumer knowledge. (The benefits of automatic enrollment in the context of retirement savings are discussed in *Improving Opportunities and Incentives for Saving by Middle- and Low-Income Households*, April 2006, The Hamilton Project.)

Reduce incentives for plans to avoid serving high-cost individuals by requiring plan providers to compete for regional contracts, not individual enrollees.

> Offering seven to nine choices of insurance plans, instead of forty to sixty, would make it much easier for consumers to choose the best plan, while retaining important variation in plan features.

> Allowing plans to offer beneficiaries some coverage in the donut hole in exchange for greater deductibles would provide a more valuable form of insurance.

Reduce drug prices by adopting more cost-effective purchasing rules.

Fill in the donut hole.

valuable form of insurance protection—using the savings from less protection against smaller losses to provide greater protection against larger losses.

Frank and Newhouse also recommend further consideration of a second option: mandating coverage of generic medications in the donut hole. Generic drugs account for about 50 percent of all prescriptions and an even higher percent of prescriptions filled by lower-income elderly people. Frank and Newhouse estimate that the incremental premium required for such coverage would be no more than $21 per month for existing plans. They note that this coverage also could lead to higher rates of adherence to treatment regimens for those with chronic disease, improving health outcomes and offsetting some of the costs of coverage through financial savings for Parts A and B of Medicare.

CONCLUSION

Millions of elderly Americans now benefit from the subsidized prescription drug coverage provided by Medicare Part D. In several important respects, however, the program falls short of its intended purpose. The reform recommendations made by Frank and Newhouse could be implemented as a package or, alternatively, many of the specific reforms could be adopted individually. All of them seek to improve the benefits offered by Part D without increasing Medicare spending or harming the incentives for pharmaceutical companies to develop new and better prescription drugs.

Learn More About This Proposal

This policy brief is based on The Hamilton Project discussion paper, *Mending the Medicare Prescription Drug Benefit: Improving Consumer Choice and Restructuring Purchasing*, which was authored by:

RICHARD G. FRANK
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Frank advises several state mental health and substance abuse agencies on issues related to financing of care, and his work on drug pricing and mental health services has earned him multiple prizes.

JOSEPH P. NEWHOUSE
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An elected member of the Institute of Medicine and the American Academy of Arts and Sciences, Newhouse has served as the vice-chair of MedPAC and founding editor of the *Journal of Health Economics.*

Additional Hamilton Project Proposals

Additional Hamilton Project discussion papers and policy briefs on health care can be found at www.hamiltonproject.org, including:

- **A Wellness Trust to Prioritize Disease Prevention**
  America's health infrastructure is ill-suited to deliver services that would reduce the largely preventable or manageable chronic diseases that now account for most of the health-care system's deaths and costs. The establishment of a Wellness Trust to prioritize, fund, and deliver preventive services could contribute to a healthier and more productive nation.

- **The Promise of Progressive Cost Consciousness in Health-care Reform**
  Health-care cost sharing implemented through health-savings accounts (HSAs) is unlikely to reduce total health care spending significantly, even as it increases the financial and medical risks faced by low- and moderate-income families. This paper shows that more effective forms of cost sharing, such as income-related cost sharing, could restrain health spending, improve the effectiveness of health spending, and insulate families from major financial risks.

The Hamilton Project

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