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Mending the Medicare Prescription Drug Benefit:

Improving Consumer Choice and Restructuring Purchasing

PRESCRIPTION DRUGS play a central role in managing chronic illness and other health problems facing the elderly. Until recently, however, Medicare provided no insurance for most outpatient prescription drugs. Many elderly Americans, facing large out-of-pocket drug costs, failed to obtain the medicines needed to treat major chronic illnesses such as congestive heart failure and diabetes.

In 2006, Medicare Part D began to offer subsidized prescription drug insurance. In its first year, Part D provided insurance to about 22.5 million elderly Americans, including 2.7 million low-income seniors who previously had been without any coverage at all.

Although Medicare Part D provides welcome and important benefits, the program also suffers from significant limitations. In a new discussion paper released by The Hamilton Project, Richard Frank and Joseph Newhouse of Harvard University identify four broad problems with the program: 1) a daunting complexity that has likely discouraged enrollment; 2) incentives for insurance companies to avoid covering higher-cost individuals; 3) inefficient purchasing rules that increase the cost of the program; and 4) partial coverage (the so-called "donut hole") that leaves many seniors facing significant financial risks.

Frank and Newhouse propose a broad reform that would address each of these challenges, while preserving the basic principles on which Part D was founded: private provision of insurance, the use of market forces to determine drug prices, and enrollee choice. By better utilizing the forces of competition, these reforms could improve health outcomes and reduce the financial risks faced by the elderly.

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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. Traditional Medicare is simple: all participants are automatically enrolled into a single government plan. In contrast, enrollees in Part D must choose from a large number of private plans. The exact number of plans differs from state to state and currently ranges from forty-five in Alaska to sixty-six in Pennsylvania and West Virginia. These plans fall into one of three classes: a standardized plan that is defined in law, plans that are actuarially equivalent to the standardized plan, and enhanced plans that offer greater benefits in exchange for higher premiums. While these plans all must meet certain minimum standards, each plan has considerable leeway in designing both its formulary (the list of specific drugs covered) and its specific terms of coverage, such as copayments, prior authorization requirements, quantity limits, and requirements that patients try a lower-priced, but therapeutically similar, drug before resorting to a more expensive one.

Offering enrollees a wide variety of insurance plans is designed not only to help them find a plan that best suits their needs, but also to create effective competition that can restrain costs. But the downside of choice is complexity: in the case of Part D, choosing an appropriate plan requires Medicare enrollees to discriminate among dozens of insurance plans that differ in numerous important but often subtle ways.

Frank and Newhouse review a substantial body of evidence suggesting that the complexity of Part D makes it more likely that consumers will choose plans that are not in their best financial interest, even though a number of federal agencies offer assistance to beneficiaries in choosing drug coverage. In a survey of older Americans taken just prior to the launch of the Part D benefit, for example, only 36 percent of respondents were able to identify the plan that offered them the best financial protection (that is, the lowest out-of-pocket costs) when given a hypothetical choice among just five options—no drug coverage, the standardized plan offered under Part D, and three actuarially equivalent alternatives. The options available under Part D, of course, are far more numerous and complex and thus could lead to even fewer effective choices by enrollees.

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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.

Incentives that lead drug plans to avoid serving high-cost individuals. Prescription drug plans are required to provide coverage to everyone who applies; they cannot deny coverage or increase premiums for reasons such as preexisting conditions. They can, however, try to increase profits by adopting policies (such as benefit structures and formulary designs) that will encourage enrollment by low-cost individuals and discourage enrollment by high-cost individuals. To counter such behavior, Part D pays more to plans for enrolling individuals who are likely to have higher drug expenses. Frank and Newhouse cite evidence, however, that these higher payments fail to offset the strong incentives for plans to avoid serving high-cost individuals. Specifically, these adjustments account for less than half of the predictable variance in annual drug spending among the elderly.

Inefficient purchasing rules that lead to excessive drug and program costs. Frank and Newhouse point to three features of Part D that may lead to excessive drug costs. First, manufacturers of therapeutically unique drugs face little or no competition, and thus have substantial control over price. Second, Medicare patients who previously received drugs through Medicaid now may face substantially higher prices. Prior to Part D, individuals who were eligible for both Medicare and Medicaid (so-called dual eligibles) could purchase prescription drugs under a best-price rule: the price that a manufacturer offered Medicaid could not exceed the lowest price it received for the drug in the private market. Dual eligibles now are covered only under Part D, which has no such rule. Frank and Newhouse argue that this has led to significant price increases for drugs used by Medicare beneficiaries, and subsequent windfall profits for drug manufacturers. Finally, the fact that a minority of drugs are still covered under the Medicare Part B (which pays for outpatient services and has payment rules that are different from Part D's) creates the opportunity for manufacturers to game the system by formulating new drugs so that the manufacturer receives reimbursement from whichever part of Medicare will provide the most revenue.

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

Poorly designed cost sharing that exposes individuals to substantial risks. In order to limit costs, both the standardized and actuarially equivalent plans only insure annual drug expenses up to $2,400 and above $5,451 (current limits; these limits are adjusted each year). These plans provide no coverage, however, for annual drug expenses between $2,400 and $5,451 (the so-called donut hole). Frank and Newhouse note that about 25 percent of Part D enrollees are expected to have drug expenses above $2,400 this year. These enrollees will have to pay 100 percent of drug spending that falls in the donut hole—this after having already absorbed substantial out-of-pocket

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.

expenses for prescription drugs and premiums for the coverage on the first $2,400 spent on drugs. Although this cost-sharing design offers much-needed catastrophic coverage (it pays for 95 percent of any spending above $5,451), it still runs counter to fundamental insurance principles that emphasize protection against larger risks (in this case, the risk of incurring drug expenses between $2,400 and $5,451) over smaller ones (the risk of incurring expenses less than $2,400).

A NEW APPROACH

To address these challenges, Frank and Newhouse propose a set of policy changes designed to improve consumers' ability to choose among plans; prevent plans from adopting policies that discourage enrollment by high-cost seniors; lower the cost of important subsets of prescription drugs covered by Medicare; and improve the insurance features of the basic Part D coverage. By better utilizing the forces of competition, these changes could improve health outcomes and reduce the financial risks faced by the elderly. Moreover, some of these improvements could reduce the cost of Part D even as they improve the consumer choice and competition that are meant to be the hallmarks of Medicare Part D.

Reduce complexity by standardizing benefits and adopting automatic enrollment. Frank and Newhouse propose two steps to simplify the choices facing beneficiaries while increasing effective price competition and making the plan selection process more responsive to consumer needs. First, in order to make it easier for enrollees to determine the plan that best serves their needs, Frank and Newhouse propose limiting the number of plans to between seven and nine in each region. The choices would consist of the existing standard plan, three to four plans that are actuarially equivalent to the standard plan, and three to four enhanced plans that offer

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. Frank and Newhouse propose reorienting competition so that plan providers compete for a contract to serve an entire region instead of competing for individual enrollees. In each of the thirty-four regions, one contract would be awarded to a single insurer for a limited period of time on the basis of price, quality, and formulary design. The single insurer would provide all of the seven to nine approved plans. This would greatly reduce incentives for insurers to manipulate plan features to avoid particularly costly beneficiaries, as insurers would be guaranteed the business of an entire region and therefore could appropriately balance risks across the entire eligible population.

> 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.

Since contracts would be awarded separately in thirty-four regions, there is little chance that a single plan sponsor would become dominant nationally, thus competition would be preserved for future contract negotiations. Maintaining robust future competition for contracts could be further strengthened by limiting any one firm's market share to approximately 30 percent of the national market.

Frank and Newhouse note, however, that selecting the winner of a franchise-like competition in each of thirty-four regions would be administratively more demanding than the current practice of simply deciding whether a given plan meets the minimum standards specified in law. As a result, administrative costs for Part D could rise.

> 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. Frank and Newhouse propose three changes to the rules governing drug purchasing under Part D that could be adopted with or without the broader reforms they propose. Each of these changes is designed to strike a better balance between controlling budget costs and providing pharmaceutical companies with appropriate incentives to innovate and create effective new drugs.

Adopt Medicaid prices for drugs used by dual-eligibles. Frank and Newhouse propose that manufacturers be required to sell drugs to prescription drug plans for use by individuals eligible for both Medicare and Medicaid at prices that approximate the Medicaid prices that prevailed immediately before implementation of Part D. This would restore the balance between control of Medicare and Medicaid spending and protection of R&D incentives to its pre-January 2006 level, a balance that Frank and Newhouse note appeared to be acceptable to all parties. This rule change would significantly reduce Medicare drug spending, since the dual-eligible population accounts for more than 30 percent of Part D drug purchases. Frank and Newhouse argue that this change would entail little additional administrative costs, as it could mimic the rebate system that exists under Medicaid.

Monitor the prices of unique drugs and plan for temporarily administered prices. Manufacturers of therapeutically unique drugs have a monopoly that allows them to set very high prices. Frank and Newhouse conclude that the number of such unique drugs is not yet clearly sufficient to create a meaningful budget problem. Because of the potential for such drugs to increase budget outlays, however, Frank and Newhouse propose that the government carefully monitor the prices of such drugs and be prepared to intervene through temporary administered pricing if a budget problem arises. Frank and Newhouse note that an administered price—which could be determined either through binding arbitration or through some other process—would need to be crafted in a way that preserves R&D incentives, recognizes the health benefits produced by specific products, and limits unnecessarily high prices paid by the Medicare program.

Fold Part B drugs into Part D. To prevent manufacturers from gaming the differences in the reimbursement methods under Part B and Part D, Frank and Newhouse propose eliminating the distinction between Part B and Part D drugs and providing all prescription drug benefits under Part D. Prescription drug plans would negotiate prices for all drugs directly with manufacturers, just as they do now for Part D drugs.

Fill in the donut hole. The cost-sharing provisions that give rise to the donut hole were designed to control federal Medicare spending. Frank and Newhouse observe, however, that changes in cost sharing could extend coverage to expenses in the donut hole without increasing Medicare spending. They recommend that plans that are actuarially equivalent to the standardized plan be allowed to offer beneficiaries some coverage in the donut hole in exchange for greater deductibles, an offering that is currently explicitly prohibited under Part D. Doing so would allow these plans to offer a more

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:

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- **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.

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