



CMA Weekly Alert – July 14, 2005

NEW STUDY LOOKS AT MEDICARE PRESCRIPTION DRUG COSTS FOR HIGH SPENDERS AFTER 2006

An article released this week on out-of-pocket costs beneficiaries will incur with Medicare's new drug coverage confirms the Center for Medicare Advocacy's concerns that the new law's cost-sharing requirements are too high to constitute a meaningful benefit for the nation's elderly and disabled.

Background

All Medicare beneficiaries who do not qualify for the low-income subsidy will have to pay a monthly premium for a prescription drug plan. Although the law allows premiums to vary with each drug plan, the average premium is estimated to be \$37/month in 2006. Under the standard benefit, beneficiaries will be responsible for a \$250 deductible, then 25% of the cost of their formulary prescriptions up to \$2250. Beneficiaries then enter the "donut hole" where they must pay for the full cost of their drugs (while still paying the monthly premium) until their total out-of-pocket costs for that year equal \$3600. Those who reach the catastrophic level in a given year will be responsible for 5% of the cost of their drugs.

Several points need to be emphasized about beneficiary cost sharing. First, drugs that are not on a plan's formulary do not count toward the deductible or the out-of-pocket limit. Second, the \$250 deductible and the \$3600 annual out-of-pocket limit increase each year by the increase in expenditures for Part D drugs. Third, Medigap policies cannot fill in the gaps of Part D coverage or pay beneficiary out-of-pocket expenses as they do for Part A and Part B expenses. Part D cost-sharing paid for by an employer plan or by other insurance does not count toward the out-of-pocket limit, making it more difficult for individuals to reach the catastrophic coverage.

Costs to Beneficiaries

"Riding the Rollercoaster: The Ups and Downs in Out-of-Pocket Spending Under the Standard Medicare Drug Benefit", published in this month's *Health Affairs*¹, found that less than half of drug costs for high spenders or catastrophic spenders will be covered by Part D during the period 2006-2008. In general, as annual drug spending goes up, the number of months that person will go without coverage increases, and total out-of-pocket costs vary based on total drug spending.

¹ Stuart, Bruce, Becky A. Briesacher, Dennis G. Shea, Barbara Cooper, Fatima S. Baysac, and M. Rhona Limcangco. "Riding the Rollercoaster: The Ups and Downs in Out-of-Pocket Spending Under the Standard Medicare Drug Benefit." *Health Affairs*. Vol. 24, No. 4. July/August 2005.

The study looked at estimated drug spending for the first three years of the program for beneficiaries who are likely to enroll and who are not eligible for the low-income subsidy. Likely enrollees were then placed in subgroups based on drug spending. Those who will likely reach the “donut hole” are dubbed high spenders, and those who will reach the catastrophic coverage benefit are called catastrophic spenders. The authors estimate that approximately 40 percent of beneficiaries will be high spenders, while 15 percent will reach catastrophic coverage. High spenders are expected to pay a staggering 67 percent of total drug costs with their own money, while catastrophic spenders will pay over half out of their own pocket (51%). In comparison, the study estimates that the *average* potential enrollee is expected to pay 44 percent of their costs with their own money.

The study also measures how many months a beneficiary might be without coverage based on drug spending. A beneficiary with \$1,000 in total prescription drug costs could be without coverage for 3 months in 2006, increasing to 3.6 months in 2008. Those who spend between \$3,000 and \$6,000 could have gaps from 4 to over 7 months in 2006, but will have fewer coverage gaps in 2008 because the donut hole threshold will increase. The group that may be the worst off are those who spend more than \$6,000. By the authors’ estimates, this group will generally have one more month of non-coverage in 2008 than they did in 2006, with some having as many as 7 months of non-coverage. Even those who are supposed to have the most generous benefits, for instance someone with \$10,000 in drug costs, will still have 3.7 months without coverage in 2006, increasing to 4.5 months in 2008.

The authors also remind us to view these costs against a typical beneficiary’s total income. The authors compare spending to a beneficiary who is the head of a household and is sixty-five or older, with a median income of \$23,118. If one person in the household is a high spender, total out-of-pocket costs could make up over 12 percent of that person’s income. For a catastrophic spender, it could comprise 14 percent of their income. A couple consisting of two beneficiaries over age sixty-five could potentially spend 20 percent of their income on drug costs.

The authors note that spending estimates do not include money spent on drugs not covered by a Part D plan (and therefore not included in total out-of-pocket spending by regulation). They also assume that prescription drug use is consistent over time, but note that studies show use decreases during periods of non-coverage, ironically lengthening the time a person would spend in the donut hole, without coverage.

Conclusion

The authors make two recommendations. They first suggest replacing the arbitrary catastrophic threshold with a number based on a beneficiary’s income. Though they do not recommend a specific figure, they do agree that it should be much lower than what beneficiaries are likely to spend (12%) under the current law. Their second recommendation is to repeal the portion of the law that prohibits plans from offering wrap around coverage. The authors do not address other recommendations to reduce beneficiary costs made by the Center and other advocates, including a recommendation to require the Secretary of the Department of Health and Human Services to negotiate the price of prescription drugs.

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