

The Effects of H.R. 2473 on Prescription Drug Costs for Medicare Beneficiaries

**Department of Health and Human Services
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In June 2003, H.R. 2473 was introduced in the House of Representatives to modernize Medicare and provide Medicare beneficiaries access to prescription drug benefits. For too long, many of the nation's seniors and citizens with disabilities who depend on Medicare have had to pay all outpatient prescription drug expenses out of their own pockets at full retail prices. This plan will give Medicare beneficiaries the buying power to reduce the prices they pay for drugs, in addition to prescription drug coverage under a new benefit. Further provisions of H.R. 2473 provide for comprehensive prescription drug coverage for the lowest income beneficiaries, and an immediate prescription drug discount card for all beneficiaries until the full plan is available nationwide. Additionally, the bill helps provide assistance for many state governments, and helps to modernize our nation's drug delivery infrastructure, among many other provisions.

Overview of H.R. 2473

- H.R. 2473 would provide real relief for seniors and disabled Americans: those who now pay full retail prices could see their total prescription drug spending reduced by an estimated 25 percent, and their overall out-of-pocket drug spending could fall by as much as 77 percent—in exchange for a premium of about \$35 per month.¹
- A substantial share of beneficiary savings from H.R. 2473 arises from drug price discounts, made possible by letting Medicare beneficiaries aggregate their purchasing power for the first time. It's common sense: the first step toward lower prescription drug costs for seniors is to give them the same means to get lower drug prices that are widely used for those under 65.
- H.R. 2473 includes important catastrophic protection for all seniors and those with disabilities who have high out-of-pocket prescription drug expenses—targeting this help to those who need it most.
- It would provide even greater relief for about 14 million Medicare beneficiaries with incomes below 150% of the federal poverty level. Those with incomes below 135% of poverty would pay no monthly premiums and only nominal cost sharing, while those with incomes between 135% and 150% of poverty would pay reduced premiums.²
- The bill offers immediate help with the high costs of prescription medicines by offering a prescription drug discount card program to begin soon after enactment.

¹ CMS Office of the Actuary has estimated 25% cost management savings for this bill.

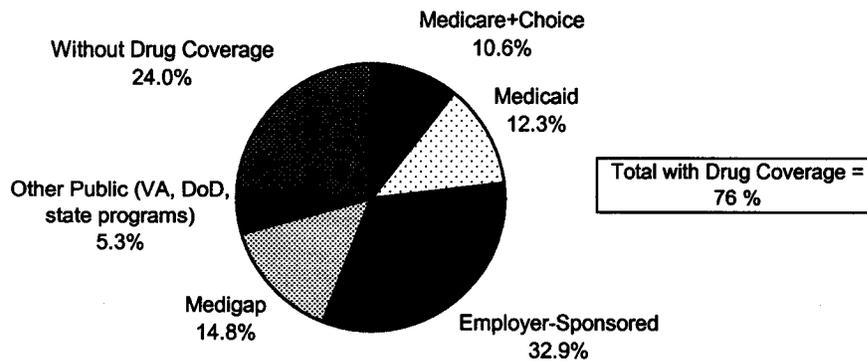
² In 2006, 150 percent of poverty would correspond to about \$14,000 in annual income for a single individual and about \$19,000 for a couple. 135 percent of poverty would be about \$13,000 for singles and \$17,000 for couples. ASPE projection of 2003 FPLs

- The bill will also provide billions of dollars in savings for states, helping to ease the serious budgetary problems they face due to rising drug costs in Medicaid.

Prescription Drug Coverage and Spending

- While some seniors have access to prescription drugs, nearly a quarter of Medicare beneficiaries have no drug coverage during the year, and many others have only partial coverage or have a drug plan—such as a Medigap policy—that does not negotiate price discounts on their behalf (see chart below). As a result, millions of seniors pay full retail price for their prescriptions. By contrast, the vast majority of Americans who have private insurance coverage pay prices that are as much less for their brand-name prescriptions.

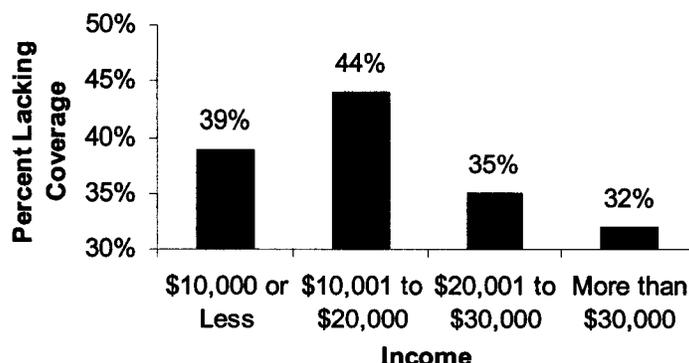
Percent of Medicare Beneficiaries with Drug Coverage, by Source of Coverage (2002 Projection)



SOURCE: Projection by Actuarial Research Corporation, based on 2000 Medicare Current Beneficiary Survey data and administrative sources.

- Paying full retail drug prices is most likely to result in financial hardship for those seniors with incomes between 100 and 150 percent of poverty, since they are more likely to go without drug coverage than other beneficiaries.

Percent of Medicare Beneficiaries Lacking Drug Coverage, By Income



Source: Laschober et al. Health Affairs, February 2002

- Those beneficiaries living in rural areas are also at a distinct disadvantage. In non-metropolitan areas, as many as 50 percent of beneficiaries lack drug coverage³—and these 3 million seniors and persons with disabilities account for more than one-third of all the Medicare beneficiaries who are uninsured for their drug spending.
- A full 87% of Medicare beneficiaries have a pharmacist fill at least one prescription per year, but the extent of their drug spending varies⁴. In 2006, when a full Medicare drug benefit would take effect, over 50% of Medicare beneficiaries are projected to use about \$2,000 or less worth of drugs. But about 17% are projected to have costs over \$5,000.⁵

H.R. 2473 Provides Savings for Medicare Beneficiaries

- Seniors paying full retail prices would save on average, an estimated 25 percent on their prescription drug spending as plans compete to serve them by offering price discounts and other help to lower their drug spending.⁶ Seniors would benefit from the efficiencies of private sector management tools and of pooling their purchasing power. In many cases, once seniors meet a modest deductible, they would pay only a portion of these reduced costs—giving them much-needed savings.

³ Kaiser Family Foundation. “Fact Sheet on Medicare and Prescription Drugs.” April 2003.

⁴ Testimony on Prescription Drug Coverage for Medicare Beneficiaries by Michael Hash, Deputy Administrator, Health Care Financing Administration U.S. Department of Health and Human Services Before the House Commerce Committee, Subcommittee on Health & Environment. September 28, 1999.

⁵ CMS Office of the Actuary.

⁶ CMS Office of the Actuary.

- Seniors receive prescriptions from their physicians for a variety of medicines to treat a wide range of conditions. With prescription drug plan coverage, they would receive significant savings on each of their medicines. As illustrated below, seniors save two ways—through discounts and prescription drug coverage.

Table 1. Comparison of Possible Cost-Sharing for Drugs Seniors Use Under H.R. 2473

Selected Popular Drugs for Seniors		H.R. 2473	
Drug Name	2002 Retail Price for 30 Tablets *	Discounted Price **	20% Coinsurance***
Lopressor 100mg	45.99	36.79	7.36
Imdur 30mg	48.89	39.11	7.82
Lipitor 20mg	108.65	86.92	17.38
Proscar 5mg	82.59	66.07	13.21
Celebrex 200mg	86.28	69.02	13.80
Zyrtec 10mg	69.52	55.62	11.12
Vanceril 42mcg	51.05	40.84	8.17
Norvasc 5mg	34.94	27.95	5.59
Fosamax 70 mg, 4 pills	80.45	64.36	12.87
Zoloft 100mg	78.96	63.17	12.63

NOTES: * Price data from "Shopping Smart for Prescription Drugs: A Guide to Discounts on Medication." Chicago Department of Public Health, Office of Managed Care. Prices are taken from telephone inquiries to a large chain pharmacy in September 2002. Future prices may be different. ** Calculations assume a 20% discount off retail prices. Actual discounts will vary from drug to drug and plan to plan. ***H.R. 2473 provides coverage for 80% of enrollees' prescription expenses after a \$250 deductible is met, up to \$2,000 of total annual spending. Most beneficiaries incur less than \$2,000 annually.

- These examples show how discounted drug prices under H.R. 2473 can go a long way toward helping seniors get the drugs they need.
- These savings would add up for seniors. For instance, under H.R. 2473, a senior who buys \$2,000 worth of drugs today could see his total prices reduced to \$1,600, of which he would pay \$520 out of pocket and other tools could help further reduce his spending.⁷

⁷ ASPE analysis based on CMS Office of the Actuary estimate of 25% cost management savings for this bill.

Protection For Individuals with High Drug Costs

- The House proposal also includes important catastrophic protection for all seniors who have high out-of-pocket drug expenses – targeting help to those who need it most. It thus would help fulfill President Bush’s call to renew the commitment made when Medicare was enacted, so that illness will no longer sweep away the savings that older Americans have put away over a lifetime.
- Such catastrophic protection is the most difficult coverage to obtain today, and this protection is an appropriate target for government support. The approach contained in H.R. 2473, through providing appropriate incentives to plans and beneficiaries alike, helps limit the extent to which the costs for extremely high drug expenses are simply shifted to the Federal budget, and instead focuses government help on reducing the out-of-pocket costs that many seniors now pay.
- H.R. 2473 also establishes that beneficiaries will have a secure entitlement to the drug benefit, and that seniors will have a range of options so they can choose the drug plan that provides standard drug coverage or an improved benefit package in a way that best meets their own needs.
 - To ensure that the premium for this benefit remains attractive and affordable for all Medicare beneficiaries—regardless of age, health status, or income—the bill will provide a significant subsidy to purchase needed prescription drugs. This will assist beneficiaries in two ways—by lowering their costs and by preventing the kind of “adverse selection” problems that have made drug coverage difficult to obtain.
 - It also provides reinsurance subsidies for drug plan sponsors so that they are not penalized for attracting less healthy enrollees. In all cases, however, plans will face appropriate incentives to manage the benefit efficiently and to get the best value for their enrollees and the Medicare program.
 - H.R. 2473 also establishes a secure entitlement for beneficiaries and authorizes the program’s administrator to take the steps necessary to ensure that all beneficiaries have a choice of plans.

Special Assistance for Lower-Income Beneficiaries

- Seniors and Americans with disabilities having incomes below 150% of poverty would see even more savings under H.R. 2473. Those with incomes below 135% of the federal poverty level pay no monthly premium and only \$2 to \$5 for each prescription. Seniors with incomes between 135% and 150% of poverty would pay reduced monthly premiums.
- Overall, 38% of Medicare beneficiaries would face no deductible and substantially reduced cost-sharing requirements and would qualify for at least

some additional help with their premiums – and 33% of enrollees would not be liable for any premiums at all⁸.

- All this has been done in the context of a benefit that is fiscally responsible. The bill is estimated by CBO to cost about \$413 billion over 10 years⁹. H.R. 2473 targets the most assistance to those beneficiaries who need it most while seeking to ensure that all Medicare benefits remain secure in the future for all beneficiaries regardless of their income.

State-by-State Analysis of Assistance for Lower-Income Seniors and Savings for State Governments

- Seniors and those with disabilities with the lowest incomes have the greatest difficulty affording prescription drugs. That is why H.R. 2473 offers additional premium subsidies to those beneficiaries with incomes below 150% of poverty, and only nominal co-payments to those with incomes below 135% of poverty.
- Table 2 (attached) shows that about 10.6 million elderly and disabled Americans with incomes below 135% of poverty would qualify for full assistance with their premiums and cost-sharing—or about one-third of all Medicare beneficiaries. In states with a disproportionate number of lower-income seniors, the portion of individuals who receive assistance is even greater.¹⁰
- Another 1.8 million seniors with incomes between 135% and 150% of poverty¹¹ would also get additional help with their drug benefit premiums and would get the same assistance with cost-sharing—so they will face no deductible and will generally have co-payments of \$2 to \$5. And the number of seniors and disabled helped by these provisions will only grow over time as the total number of beneficiaries enrolled in Medicare increases.
- About 4 million lower-income Medicare beneficiaries below 150% of poverty lack any drug coverage today, and thus will see the kind of reductions in their drug spending highlighted above in Table 1¹².
- In addition, states already operating drug assistance programs for seniors who do not qualify for Medicaid—including Pennsylvania, New York, New Jersey, Connecticut and Massachusetts—would see their costs reduced substantially. The same would be true for states like Florida, Illinois, Indiana, Maryland, South Carolina, and Wisconsin that have recently received waivers from HHS to use existing funds to expand drug coverage for Medicare beneficiaries with incomes up to 200 percent of poverty.

⁸ ASPE analysis.

⁹ American Health Line. June 18, 2003.

¹⁰ ASPE analysis of MCBS data.

¹¹ ASPE analysis of MCBS data.

¹² ASPE analysis of MCBS data

Beneficiary Scenarios

- The powerful combination of discounts through purchasing power and good prescription drug coverage will help millions of beneficiaries. Beneficiary savings under H.R. 2473 will really tally up for seniors who now lack drug coverage, as indicated in the following illustrations¹³:
 - Barbara M. currently spends approximately \$100 a month on medications to control her blood pressure and cholesterol. Because she has no drug coverage, she pays full retail prices for these drugs. Under H.R. 2473 her spending on drugs could fall by about two-thirds—from \$1,200 a year to \$380 per year. Even adding in her monthly premium costs, her total drug-related expenditures would be cut by almost a third, to \$800 per year.
 - Karen B. has the same health problems, but paying for her prescriptions is even more difficult because she and her husband live on a fixed income of \$16,500 per year. Under H.R. 2473 they qualify for full coverage of their monthly drug premiums and would generally have co-payments of only \$2 to \$5 per prescription—so her drug spending could fall to under \$100 per year.
 - Mark E. currently spends about \$200 a month on drugs to treat not only his cholesterol and diabetes, but also to treat an early form of prostate cancer and to avoid kidney problems from diabetes. Under the bill his out-of-pocket spending on drugs would drop from \$2,400 per year to around \$560—over a 75% reduction. Even with his premium payments factored in, his total costs for drugs could fall by about 60%.
 - Lou N. currently spends \$300 per month on prescriptions to treat multiple chronic conditions. Under the bill, his out-of-pocket spending on drugs would drop from \$3,600 per year to around \$1,300—about a 65% reduction. Even with his premium payments factored in, his total costs for drugs could fall by over 50%. These substantial savings come even though Lou has drug expenses that exceed the initial coverage limit.
- Because H.R. 2473 makes drugs more affordable, some beneficiaries may be able to use some of the savings to purchase additional drugs that they need but were previously unable to afford. Therefore, somewhat lower reductions in total drug spending may occur—because seniors are getting more and better drug coverage.

Other Key Provisions of H.R. 2473

- Beneficiaries will also see health gains under H.R. 2473. Not only will they gain more affordable access to the medicines they need, but the legislation also ensures the use of electronic prescribing—which should sharply reduce the substantial number of prescribing errors that occur each year. In addition, beneficiaries’

¹³ ASPE analysis based on CMS Office of the Actuary estimate of 25% cost management savings for this bill.

health will be protected—and unnecessary health costs avoided—through disease management programs and the use of automated systems to identify and thus prevent potentially adverse drug interactions.

- The Institute of Medicine has estimated that as many as 98,000 Americans may die each year due to medical errors, with most of these deaths attributable to medication errors.¹⁴ A recent article estimated that the total the total cost of all preventable, drug-related mortality and morbidity range from \$30 to \$137 billion per year. The largest cost was for preventable hospitalizations.¹⁵
- Finally, under H.R. 2473, seniors and those with disabilities would also benefit immediately from discounts of 15%, 20%, 25%, or more on their drug spending through a Medicare-endorsed discount card program.¹⁶ The card program would begin soon after enactment.

¹⁴ Institute of Medicine. "To Err Is Human: Building a Safer Health System." Washington, D.C.: National Academy Press; 1999. Data in this report are from the American Hospital Association.

¹⁵ Johnson, J. A. and J. L. Bootman, "Drug-Related Morbidity and Mortality: A Cost-of-Illness Model," *Archives of Internal Medicine*, 1949-1956, 1995.

¹⁶ CMS estimated that total savings for beneficiaries for a similar drug discount card could be as high as 15 percent. Savings of 25 percent or more would be possible on some individual drugs. In January –April 2002, AARP calculated average savings of 19% and up to 47% using their MembeRx Choice card.

Table 2. Estimated Number of Beneficiaries in Each State Eligible for Reduced Premiums and Cost-Sharing Under H.R. 2473

State	Number of Medicare Beneficiaries (000s)	Number Below 135% of Poverty (000s)	Share Below 135% of Poverty	Number Below 150% of Poverty (000s)	Share Below 150% of Poverty
United States	38,286	10,608	28%	12,383	32%
Alabama	677	253	37%	281	42%
Alaska	40	9	23%	11	28%
Arizona	658	135	20%	163	25%
Arkansas	436	148	34%	176	40%
California	3,837	1,095	29%	1,285	33%
Colorado	458	92	20%	109	24%
Connecticut	512	119	23%	153	30%
Delaware	110	22	20%	26	24%
DC	76	26	34%	28	37%
Florida	2,771	722	26%	863	31%
Georgia	898	284	32%	313	35%
Hawaii	162	41	25%	47	29%
Idaho	161	33	20%	44	27%
Illinois	1,629	341	21%	389	24%
Indiana	845	211	25%	245	29%
Iowa	476	101	21%	127	27%
Kansas	389	90	23%	105	27%
Kentucky	615	206	33%	226	37%
Louisiana	597	214	36%	245	41%
Maine	213	53	25%	63	30%
Maryland	635	222	35%	236	37%
Massachusetts	954	219	23%	260	27%
Michigan	1,389	319	23%	391	28%
Minnesota	648	182	28%	214	33%
Mississippi	414	181	44%	194	47%
Missouri	854	209	24%	236	28%
Montana	135	32	23%	36	26%
Nebraska	252	61	24%	76	30%
Nevada	229	63	28%	76	33%
New Hampshire	167	44	26%	46	28%
New Jersey	1,195	314	26%	377	32%
New Mexico	229	104	45%	118	52%
New York	2,694	884	33%	1,029	38%

State	Number of Medicare Beneficiaries (000s)	Number Below 135% of Poverty (000s)	Share Below 135% of Poverty	Number Below 150% of Poverty (000s)	Share Below 150% of Poverty
North Carolina	1,111	400	36%	443	40%
North Dakota	103	37	36%	43	42%
Ohio	1,692	382	23%	461	27%
Oklahoma	504	141	28%	176	35%
Oregon	484	101	21%	121	25%
Pennsylvania	2,088	490	23%	566	27%
Rhode Island	170	56	33%	63	37%
South Carolina	555	187	34%	218	39%
South Dakota	119	27	23%	32	27%
Tennessee	815	238	29%	276	34%
Texas	2,223	775	35%	903	41%
Utah	201	33	17%	45	22%
Vermont	88	27	30%	32	36%
Virginia	876	225	26%	290	33%
Washington	725	189	26%	215	30%
West Virginia	336	111	33%	124	37%
Wisconsin	777	139	18%	164	21%
Wyoming	64	18	28%	21	32%

NOTES: Beneficiary counts based on 1999 data from the Medicare Current Beneficiary Survey, Current Population Survey, and administrative records.