Advocating for a Medicare Prescription Drug Benefit

John Rother, J.D.*

*Policy and Strategy Director, AARP

The health of a people is really the foundation upon which all their happiness and all their power as a state depend.

—Benjamin Disraeli, 1877

Efforts to enact a prescription drug benefit in Medicare date back more than forty years. Since then, drugs have continuously grown in importance; they have also grown in cost. Design and enactment of a Medicare drug benefit is therefore one of the most challenging health policy tasks before Congress. Many policy trade-offs have to be brokered, powerful interests acknowledged, budget limits respected, and public expectations rewarded. Ideology and partisan considerations also play a prominent role. As the benefit finally nears becoming law, as it inevitably must, the ongoing tension between adequacy and cost-containment has begun to play out in earnest. In all, the Medicare prescription drug debate serves as a microcosm of the competing forces that make the American health care system so challenging to reformers.

AARP (formerly the American Association of Retired Persons) made enactment of a voluntary, adequate, and affordable prescription drug benefit its top legislative priority for the past several years. This Commentary reviews the needs that have given urgency to this effort, the policy and political considerations surrounding the debate, and the advocacy strategy that AARP chose to achieve enactment of this benefit.

As this Commentary goes to press, the U.S. Senate and House of
Representatives have each passed Medicare prescription drug legislation. The conference committee, however, has just begun its work. The legislation's final form remains unknown.

NEED FOR COVERAGE: FINANCIAL BURDENS

Together, Medicare and Social Security were created to provide financial security to Americans in their later years. But there is no economic security for older Americans without comprehensive medical coverage, and there is no comprehensive medical coverage without prescription drug benefits.

Medicare beneficiaries make up approximately 15% of the population, yet account for about 40% of U.S. prescription drug spending. Almost a third of Medicare beneficiaries—roughly 13 million older and disabled Americans—have no prescription drug coverage at all. And about 40% of Medicare beneficiaries lack coverage at some point in the year. Millions of others have only partial or unstable coverage. This amounts to a staggering financial burden on millions of older Americans and persons with disabilities. An estimated 80% of Medicare beneficiaries use a prescription drug every day and, on average, fill or refill a prescription 24 times a year. According to the Congressional Budget Office (CBO), prescription drug spending for each Medicare beneficiary will exceed $3000, on average, by 2006. The average Medicare beneficiary spends more out-of-pocket on prescription medications than on physician visits, medical supplies and vision services combined.

5. This is an average based on Congressional Budget Office projections. Hearing, supra note 1, tbl.4.
6. DAVID GROSS & NORMANDY BRANGAN, OUT-OF-POCKET SPENDING ON HEALTH CARE BY
Elders with no drug coverage lack the comprehensive health benefits enjoyed by most insured Americans. They also are forced to pay top dollar for the prescriptions they buy because they are not eligible for the price discounts negotiated by insurers, managed care companies, and government health plans. In 1998, for example, Medicare beneficiaries who lacked drug coverage filled 31% fewer prescriptions than did beneficiaries with drug coverage, but spent an average of 40% more out-of-pocket on prescription drugs.7

**NEED FOR COVERAGE: HEALTH IMPLICATIONS**

According to recent studies, Medicare beneficiaries lacking drug coverage fill about 30 percent fewer prescriptions than do those with coverage.8 A recent eight-state survey reported that 22% of older Americans said they did not fill a prescription because it was too expensive, or skipped doses of their medications to make them last longer; this number rose to 35% for elders who lacked prescription drug coverage.9

Chronic health problems common to the elderly often require medications that can total hundreds of dollars a month. Absent Medicare prescription coverage, many who lack drug coverage or who have inadequate coverage must choose between the drugs they need to stay healthy and other life necessities. For example, nearly one-third of the Medicare-eligible with diabetes, but without drug coverage, skipped doses or did not fill a prescription. Similarly, about a third of those with heart disease and without drug coverage reported skipping doses and 25% did not fill a prescription because of cost.10

There are serious health consequences to this kind of behavior: Chronically ill lower-income Medicare beneficiaries who don’t take medications as prescribed are more frequently hospitalized, more likely to

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8. Id. at 80.
be admitted to nursing homes, and suffer more dire health outcomes.\textsuperscript{11}

**EXISTING SOURCES OF DRUG COVERAGE**

Prescription drug expenditures are the fastest growing component of health care spending. According to the Centers for Medicare & Medicaid Services (CMS), total spending on prescription medications is projected to rise 13.4\% in the United States this year to $182.1\ billion, or 11.6\% of the nation’s $1.66 trillion in health spending.\textsuperscript{12}

These costs are forcing insurers and employers to reduce benefits. Many companies today are reducing or eliminating retiree health benefits—the primary source of comprehensive drug coverage for the Medicare-eligible. According to a recent study by the Kaiser Family Fund, only 21\% of companies with more than 200 employees provided health benefits to Medicare-age retirees in 2001, down from 31\% just five years ago.\textsuperscript{13}

Meanwhile, the private insurance market is proving dangerously volatile for Medicare beneficiaries. Faced with ballooning costs, many plans available through Medicare+Choice (the Medicare program that allows beneficiaries to opt into private plans) are increasing premiums and scaling back drug benefits. In 2003, 66.1\% of plans offer some type of drug coverage in a basic plan, down from 73.4\% in 1999.\textsuperscript{14} Moreover, the number of plans that do provide coverage, but limit that coverage to


\textsuperscript{14} It is important to note that these figures apply to any type of Medicare+Choice plan, not necessarily an HMO and, in 2003, 41.4\% of plans with some prescription drug coverage covered generic drugs only. Eighty-five percent of plans offering ‘generic coverage only’ had an unlimited generic benefit. \textit{Lori Achman & Marsha Gold, Mathematica Policy Res., Inc., Medicare+Choice Plans Continue To Shift More Costs To Enrollees} (2003).
"generic drugs only," almost tripled just between 2001 and 2002 (51% vs. 18%). As a result, those Medicare beneficiaries who need medications available only in brand-name forms have no coverage for those drugs.

Other Medicare+Choice plans are abandoning the Medicare market entirely, leaving tens of thousands of patients who relied on the plans for prescription coverage without recourse. Medicare+Choice plans serving 215,000 enrollees withdrew from the Medicare program or reduced their service areas effective January 2003, bringing to 2.4 million the number of beneficiaries who have been dropped by Medicare+Choice plans since 1999.

While some older Americans purchase additional insurance, known as Medigap policies, to cover prescription medications, these plans can be prohibitively expensive and offer only limited benefits.

The combined effect of these problems is that the need for a prescription drug benefit under Medicare is greater than ever.

**Benefit Design Issues**

AARP is committed to pursuing a Medicare prescription drug plan that is voluntary, reliable, affordable, provides adequate benefits, and is available to all beneficiaries. Political and financial constraints, however, pose significant challenges to achieving these goals.

Consumer acceptance of any prescription drug plan is critical. Consider the case of the Medicare Catastrophic Coverage Act of 1988, an effort by Congress in the late 1980s to protect beneficiaries from

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16. Id.

"catastrophic" medical bills not covered by Medicare. The goal was to provide a safety net for those with the highest out-of-pocket medical expenses. But the legislation drew fire from many of the very beneficiaries it was enacted to help—in part because lawmakers made premiums mandatory and added an income-related premium of up to $800 per year, even for those older Americans who already had drug coverage through employer health benefits or other privately-purchased insurance plans.

Rallying behind the slogan "Repeal the Seniors-Only Surtax," opponents waged a successful protest even as public opinion polls showed that most seniors with low-to-modest incomes supported the legislation. The catastrophic bill was repealed before it could be implemented.

That experience taught Congress an important lesson: Public support is essential. For Medicare beneficiaries, any new benefit must be both affordable and voluntary. But as lawmakers have discovered, it is difficult to provide a voluntary comprehensive prescription plan that includes the benefits older Americans expect at a price they can afford.

Older Americans will only buy into the program if they feel they are saving money, which is difficult to do if the program is covering the cost of insuring both low-income beneficiaries and the "high-cost" patients with expenses beyond four or five thousand dollars a year.

For a viable program, premiums must be reasonably priced to attract middle class and relatively healthy beneficiaries. Otherwise, only high-risk beneficiaries—including patients with chronic conditions or higher-than-average drug costs—will buy in to the plan—a situation known as "adverse selection." If primarily high-cost beneficiaries bought in, an insurance "death spiral" could ensue, as premiums spiraled upward, and only those with the most expensive medical needs remained in the plan. If the cost of care exceeded the premiums collected and continuously forced increases in premiums, the plan would eventually fail.

Unfortunately, without federal support, the proposals under consideration could be priced far higher than most older Americans are willing or able to pay. Therefore, the only way to make a Medicare prescription benefit economically feasible is to factor in a significant federal contribution—a challenging prospect given current budgetary constraints.

CONGRESSIONAL DEBATE

In June of 2002, the United States House of Representatives passed a

$310 billion (over ten years) Medicare prescription drug bill that relied primarily on at-risk private insurers to administer the benefit. It also contained a significant gap in the benefit that critics dubbed the “doughnut hole.” In July of 2002, the Senate tried and failed four times with four separate bills to muster the sixty votes necessary to pass its own version of a Medicare drug plan. Ninety-nine Senators voted for competing versions of a benefit, but could not reach a bipartisan compromise to reach the sixty-vote threshold required in the Senate to overcome points of order.

Despite this failure, Senators implicitly reached agreement on several key points, most notably, a commitment to fund the program with at least $400 billion over ten years—still an amount less than many consider necessary for a meaningful benefit. In addition, there was bipartisan agreement to offer coverage to all Medicare beneficiaries, to subsidize costs for low-income beneficiaries and those with the highest drug costs, and to cap the amount beneficiaries would have to spend out-of-pocket at approximately $4,000 a year.

But partisan and policy disputes ultimately killed the chance for legislative compromise in the Senate in 2002. At issue were three primary points of contention:

1. **Benefit design:** The “doughnut hole” gap in benefit coverage would have affected almost one third of Medicare beneficiaries who have drug costs above $3,450 per year. Republicans were unwilling to allocate the funding necessary to close that gap, while Democrats generally saw it as a barrier to beneficiary acceptance and incompatible with the goal of financial protection that is the rationale for a benefit.

2. **Who bears risk:** Democrats generally believe that government should run the program and bear the risk of cost overruns, just as Medicare currently accepts cost overruns for other parts of the healthcare system. Republicans prefer to put delivery in the hands of private insurers, who would compete for the enrollment of beneficiaries. They believe that such entities could be more flexible in achieving cost savings and, because they would be at financial risk, would have a strong incentive to do so. Democrats counter that relying on private insurers would only add overhead costs and could leave beneficiaries vulnerable if profits suffer and companies pull out of the market.

3. **Asset test:** Republican proposals impose both an asset test and an income test on beneficiaries who want to qualify for more generous low-income assistance, primarily as a means of saving money. Democrats generally view this as stigmatizing and a barrier to enrollment, and, as a matter of principle, do not want to introduce asset tests into a social
insurance program.

Last fall, Medicare prescription coverage proved a potent political issue in congressional campaigns across the country. In fact, almost all successful candidates pledged to enact a benefit in 2003. As a result, Congress convened in January with the understanding that it had to produce a benefit.

In addition to the issues mentioned above, the 108th Congress faces a heightened need for even tougher cost containment mechanisms, as well as a push for broader Medicare reforms, to accompany a drug benefit. The election gave Republicans control of the Senate and a greater margin in the House. President Bush designated $400 billion in his annual budget proposal for Medicare reform and a prescription drug benefit. Bipartisan legislation in the Senate (S.1) passed in the early hours of June 28th. The House followed hours later, passing H.R.1 by a single vote. Both bills combined a modest and voluntary prescription drug benefit with various “structural reforms” that increased the role of the private sector in Medicare. Both bills made changes to current benefits in Part B, and increased rural provider payment rates. Finally both bills structured the prescription drug benefit to primarily assist lower-income beneficiaries and those with the highest level of drug expenses.

As this Commentary goes to press, AARP has commented extensively on both bills and has written a detailed letter to the conferees expressing substantive concerns and recommendations. AARP is withholding judgment on a conference report, pending resolution of these items. The issues addressed in this Commentary remain central to the final legislative debate, with AARP’s advocacy more intensive than ever in promoting an affordable, universal and workable benefit program.

**COST CONTAINMENT STRATEGIES**

Beyond the promise of an added benefit is the issue of how to keep it affordable over time, especially when drug costs are projected to increase at double-digit rates. A range of initiatives has been proposed. One such measure is a prescription discount card proposed by the Bush administration. Health and Human Services officials estimate that the card would save 10%-13% on eligible cardholders’ out-of-pocket prescription costs, or an average of $170 per year. Government funding would not provide these discounts. It is anticipated that decreases would largely be possible from discounts Pharmacy Benefit Managers (PBMs) will negotiate from pharmacies and, less likely, from drug manufacturers.

Additional cost savings will be necessary. The reality is that any
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comprehensive plan requires hard choices. The only way to have a sustainable drug benefit is to put in place mechanisms that contain costs and keep premiums affordable for beneficiaries.

Prescription prices in the United States are driven in part by the desire by drug manufacturers to recoup quickly their research, development, and capital costs—an investment now rewarded with twenty-year patents on new drugs that limit competition and delay the introduction of less-expensive generic alternatives. For this reason, among others, many in Congress have been reluctant to impose price controls, common in other countries, on pharmaceuticals. One way to control costs is through pharmacy benefit managers (PBMs), which negotiate discounts with drug manufacturers and pharmacies, and channel more prescription business through low-cost mail-order pharmacies.

A cost-sensitive prescription drug plan must also promote wider use of less expensive generic drugs where medically appropriate. Generics now account for 42% of all prescriptions filled, but potentially offer much greater savings: The Food and Drug Administration (FDA) estimates that nearly 60% of the most common brand name medications have cheaper generic equivalents, a figure expected to rise as patents on popular drugs expire over the next few years. In July of 2002, the United States Senate debated legislation (known as McCain/Schumer) that would have reformed federal patent law to promote price competitions and allow faster market access to generics. The bill would have closed loopholes in United States patent law that have allowed manufacturers to delay the introduction of generics to compete with name-brand drugs. According to an estimate by the CBO, the legislation would have reduced total spending on prescription drugs by $60 billion over the next ten years. The bill was approved by the Senate in 2002 but died in the House of Representatives. A modified version, with less savings, was approved in 2003 and included in the Medicare legislation by both the Senate and the House.

In addition, many states are implementing "preferred drug lists" (PDLs) and other measures to expand the use of generics and lower-cost brand-name drugs in their Medicaid programs. This could motivate manufacturers to reduce prices in order to remain competitive. This approach uses techniques applied by PBMs in the private sector to identify the most effective medication at the least cost. PDLs have substantially lowered state Medicaid drug expenditures and have prevented states from adopting more draconian cuts in their Medicaid programs, such as limiting eligibility.

But these approaches are not without controversy. Drug manufacturers are fighting many cost-control measures, and PhRMA, a
pharmaceutical trade group, has filed suit in federal court to block Medicaid PDLs.\textsuperscript{19} PhRMA contends that such programs illegally restrict access to drugs. Many retail pharmacies oppose PBMs, claiming that pharmacy benefit managers set reimbursement rates to pharmacies too low to cover the cost of services they provide, and rely on mail-order pharmacies that could drive traffic away from community drugstores.

Finally, any successful cost-containment initiative must address value. Some drugs produce little additional benefit for great additional cost. There is to date little research to determine the comparative efficacy of particular drugs. This is missing information that could direct cost control approaches to lower overall costs without lowering health benefits. Developing such studies is expensive, but needs to be a national priority. Funding for efficacy research could be repaid several times over in the long term by focusing coverage expenditures on appropriate and effective medications.

**MEDICARE STRUCTURAL REFORM**

A second issue before the 108th Congress is broader Medicare reform. Many insurance analysts believe that a voluntary, stand-alone prescription drug product is not viable because only the sickest beneficiaries would be certain to apply. An alternative is to place a drug benefit in the context of broader insurance benefit packages that would be associated with broader Medicare reforms. Under this approach, beneficiaries could choose to enroll in a “high option” set of Medicare plans that trade higher premiums for an improved benefit package. Republican health leaders have long favored a greater role for private plans in Medicare. They view a prescription drug benefit as the “carrot” that will permit broader restructuring than would otherwise be politically possible.

Medicare structural reform, however, complicates both the design issues and the politics of achieving a drug benefit. Design issues take into account the need to reform the entire Medicare benefit structure, complicating the risk of pooling relationships between the original Medicare program and any new alternatives. Established ways of reimbursing providers for care may be affected, and reforms are likely to add to the total costs of a legislative proposal, at least for the near future. These issues had the potential to make or break the prescription drug drive to enactment in 2003. Like most other aspects of healthcare, the interrelationships among all aspects of financing, delivery, cost-

\textsuperscript{19} See, e.g., Pharm. Research & Mfrs. of Am. v. Walsh, 123 S. Ct. 1855 (2003).

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containment and consumer acceptance make Medicare policy-making especially difficult.

AARP'S ADVOCACY STRATEGY

AARP is the voice of the beneficiary, so we adopted a consumer-driven strategy. We have used all of the advocacy tools available to us to keep the concerns and views of beneficiaries before policy-makers, to present preferred solutions to the design and political challenges involved, and to keep the legislative momentum moving forward. We see ourselves as the key bridge between the political parties. We also act as a principal "validator" to the public for the worthiness of various proposals.

Our fundamental strategy has been to apply enough pressure on the Congress and the industry to break the legislative and political logjam. Given the budget constraints set by the White House, the proposed program was unlikely to be seen as adequate. Out of a projected total nationwide expenditure for prescription drugs of 1.8 trillion over the next ten years, the program would cover less than one-quarter of costs. Nevertheless, if a solid foundation was established, it could be built upon in future years. If assistance was targeted to lower-income beneficiaries and those with high expenses, the most pressing immediate needs would be met. Waiting for a more favorable budget allowance in future years seemed hazardous at best.

AARP played a crucial role in this campaign, mainly due to the clout of our thirty-five million members. We also developed a unique set of advocacy tools to employ in this effort. The challenges inherent in this effort required that all of these tools be used effectively in order to mount a successful campaign.

To support our ongoing advocacy strategy, we:

- Sponsor an active program of consumer polling and focus groups;
- Employ sophisticated economic policy analysis and modeling, including actuarial models and budgetary forecasting tools;
- Call upon our grassroots base and thousands of dedicated community-based volunteer advocates;
- Host candidate debates and town meetings during elections, although we do not fundraise for candidates or endorse them;
- Compile voters' guides based on candidate responses to our questions and distribute them to our members;
- Publish a monthly newspaper that features regular reporting on the progress of the campaign and on the urgency of the
problems. This newspaper goes to all AARP members, making it the largest circulation newspaper in the country;

- Sponsor radio interviews and television news spots that are broadly distributed to stations;
- Litigate to keep pressure on the industry to limit anti-consumer practices, and to make sure that laws are interpreted and enforced consistent with their intent;
- Advocate for state-based pharmaceutical assistance while the congressional debate continues. We believe that the state experience can contribute to the development of good policy, whether on cost-containment or the administrative arrangements involved in administering the benefit. To support this effort, AARP has staffed offices in every state;
- Join coalitions with other interested parties, such as business leaders, insurers, and governors. These coalitions are especially helpful in formulating consistent advocacy messages from a range of perspectives, and in building a broader base of support for particular aspects of legislation; and
- Engage in face-to-face lobbying in both the Congress and the Executive Branch to communicate about all of this work, to exchange ideas, and to respond to the ideas of others. Although our small handful of lobbyists who work on this issue are greatly outnumbered by the paid lobbying efforts of the pharmaceutical industry and other interests, it is the grassroots, analytical, and communications structure that supports those lobbyists that gives their work the impact that it has.

This advocacy strategy in 2003 was grounded in a sense of urgency. While design, political, and budgetary challenges are always serious, it is crucial to remember that delay also has a price. For many disabled and older Americans, this is not just a matter of dollars, it is also a matter of access to the drugs they need to stay healthy and stay alive. Nearly forty years ago, President Lyndon Johnson signed Medicare into law, promising that "no longer will older Americans be denied the healing miracle of modern medicine." Today, prescription medications are a crucial component to that healing miracle. Without prescription benefits, the promise of elders' access to the miracles of modern medicine is not fulfilled.