Medicare Prescription Drug Reform: Analysis in Light of Controlling Public Policy Goals

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When President Johnson signed legislation in 1965 enacting Medicare, the federal health insurance program that would aid seniors with healthcare costs, he declared “every citizen will be able … to insure himself against the ravages of illness in his old age.” While the Medicare program initially achieved its goals by covering hospital costs, the program requires immediate amendment to include prescription drugs if it is to fulfill this mission today. Medicare currently covers costs associated with hospitalization and inpatient drug costs as well as statutorily defined drugs for more than 40 million Americans over 65 years old.[i] Examples of drugs Medicare pays for include immunosuppressive drugs, erythropotiein, oral anti-cancer medicines, hemophilia clotting factors, and vaccines for influenza, pneumonia, and hepatitis B.[i]

Notably, since its inception, Medicare has undergone numerous incremental revisions, but with the exception of this narrowly defined group of drugs, medicines needed by persons not receiving care in a hospital have never been covered by the program. Considering that America's seniors use significantly more drugs per capita than other age groups, that many of them live on low fixed incomes, and that few receive substantial prescription drug benefits from insurers, prescription drugs would surely be covered if Medicare were designed today.[i]

First, an examination of the usage rates and costs associated with prescription drugs in the elderly reveals the urgent need to add a drug benefit to Medicare. Next,

consideration of the competing Congressional prescription drug proposals and analysis in light of important public policy goals render the Graham plan most appropriate in addressing Americans' needs.

With the growing elderly population expected to live longer than any generation before and prescription drug costs rising rapidly, America spends over twice as much per capita on healthcare than the average per capita expenditure of the other 29 industrialized nations.[ii, iii] The Congressional Budget Office (CBO) estimates that between 2002 and 2011 per capita drug spending on Medicare beneficiaries will grow at an annual rate of 10.3%, from $1989 to $4818.[iv]

The exorbitant costs associated with elderly drug spending become even more troublesome when the average incomes of Medicare beneficiaries come to light. The AARP reports that among Americans 65 and older over one-half live in households with an annual income under $25,000 while only 20% of households have annual incomes exceeding $50,000.[v] Although the average senior purchased 22 new and refill prescriptions in 1998, drug spending is disproportionately distributed within this group.[vi] In 2001, 46% of seniors spent $500 or less on prescription drugs, but this only accounted for 8% of total drug spending amongst the elderly.[i] Further, the CBO estimated that of the 88% of Medicare beneficiaries who would use prescription drugs in 2001, 53.8% of total drug spending would come from the 17% of beneficiaries who would spend $3,000 or more. Although only 6.3% of seniors would spend over $5,000 on drugs, they would account for 28.2% of total spending.[i] Thus, although many seniors have some prescription drug costs, the most devastating expenses fall on a small minority of patients. Elderly Americans deserve protection from these

catastrophic prescription costs through a Medicare drug benefit.

Seniors looking for assistance paying these high drug costs may turn to a variety of options. In 1998, 77% of seniors received some sort of insurance coverage for drugs in addition to Medicare.[i] Out of all Medicare beneficiaries, 13% received assistance through state-run Medicaid programs, 36% were covered under employer-based policies, 24% used individually purchased Medigap policies, and 4% received drug benefits in other ways. Despite these high insurance utilization rates, seniors still paid 44% of prescription drug costs out-of-pocket.[i]

Because they are most likely to have prescription coverage through employer-sponsored plans or Medicare, wealthier seniors and seniors below the poverty line are most likely to enjoy drug coverage.[i] Nonetheless, even these groups of Medicare beneficiaries have cause for concern because of discouraging trends and program rules. For instance, a 1999 Hewitt Associates survey of large employers regarding their expectations of retirees' prescription benefits found that 80% of responding firms would consider increasing cost sharing or premiums, 40% would think about lowering prescription coverage, and 30% would consider ending coverage completely.[vii]

For seniors who wished to obtain prescription drug coverage through federally structured Medigap plans that pay for regular Medicare costs as well as prescriptions not normally paid for by Medicare, they paid up to a $3,000 premium, $250 deductible, and 50% co-payments in return for a maximum drug benefit of $3,000 in 2000.[i] Finally for Medicare beneficiaries lucky enough to live in areas where they could choose to receive benefits through health maintenance organizations, some prescription

coverage may be available. Under these arrangements, seniors choose to have their Medicare payment go to an HMO that might offer prescription benefits as part of a standard or more costly package. In 2000, 32% of these HMO organizations that offered prescription coverage capped drug benefits at $500 or less and 82% cut off drug coverage below $2,000.[i] Prescription drug coverage under Medicare-HMO arrangements has declined in recent years because managed care organizations complain that government payments are inadequate.

These discouraging predictions and low coverage levels associated with many forms of prescription drug insurance illustrate the failings of insurance plans in meeting the drug needs of elderly Americans and the urgency of instituting universal drug coverage for seniors.

Although these disturbing trends of decreased coverage cause many covered seniors to incur significant out-of-pocket costs, the most severe hardships fall on uncovered Medicare beneficiaries who have high prescription drug costs. Because wealthier seniors and those living below poverty are most likely to enjoy drug coverage, the lowest level of coverage occurs in the elderly between 100%-175% of poverty.[i] The CBO reports that 28% of seniors below the poverty line lack drug coverage, 41% of those between 100%-200% of poverty are uncovered, 31% of those between 200-300% do not have coverage, and 26% of those above 300% are without drug coverage.[iv] A 1999 survey found that the highest percentages of seniors lacking coverage reside in rural areas or are over 85 years old.[vi] Thus, acutely vulnerable seniors, those just above the poverty line and the oldest and rural seniors, are the most likely to have to make due without prescription drug coverage. A Medicare drug

benefit would address the pressing needs of these disadvantaged groups by ensuring that they can get medicines they currently lack.

The dramatic effects of living without drug coverage, illustrated in terms of access to medicines and amount paid out-of-pocket, further reveal the merits of a Medicare prescription drug plan. In 1998, the average Medicare beneficiary filled 22 prescriptions while seniors without coverage averaged 14.[vi] Beneficiaries in poor health who lacked coverage filled 15 fewer prescriptions than their similarly ill counterparts who enjoyed coverage.[vi] This inability to afford drugs results in greater incidents of serious illness and disability, sicknesses that prevent employment, and hospitalizations.[viii] A Medicare prescription benefit would prevent many of these unnecessary illnesses, disabilities, and hospitalizations.

In terms of spending, drug costs for Medicare beneficiaries with prescription drug coverage averaged $999 per person in 1998 and $546 per person for uncovered seniors.[i] Nonetheless, uncovered seniors incurred an average of almost twice as much in out-of-pocket expenses as did their insured counterparts in the same year.[i] Among the most ill who incurred drug costs in the highest 20% of average spending, uncovered seniors below 200% of poverty spent 20% of their total income. Moreover, those below the poverty line paid out over 25% of their yearly income in drug costs in 1998.[i] Thus, uncovered seniors must receive Medicare prescription coverage if they hope to enjoy the same health as their uncovered counterparts without spending even more out of their own pockets.

Mindful of increasing elderly prescription costs, the disproportionate distribution of expenses, the decline of prescription benefits for seniors, and the

hardships faced by the uninsured, legislators have developed several proposals to deliver a Medicare prescription drug benefit. In light of all these factors as well as budget pressures associated with total package cost, the Medicare prescription drug reform proposal sponsored by Senator Bob Graham would achieve the most compelling public policy goals.

In evaluating the following proposals, several factors must be considered to ensure equitable and meaningful access to medicines for enrollees, to ensure benefit utilization does not become burdensome to enrollees, and to ensure that program monies are spent wisely. Specifically, benefit package components including deductibles and co-payment rules should be assessed to ensure enrollees benefit equitably. Formulary policies, which determine the drugs plan members may use if they wish to receive coverage for specific drug purchases, must be evaluated to ensure beneficiaries can receive coverage if certain drugs are needed. The level of risk assumed by administering entities must also be scrutinized so that business practices designed to maintain low plan costs do not lead to exclusion of the most ill. Finally, a careful assessment of program costs and contextualization in light of other policy choices must be carried out to reveal the appropriateness of program spending.

First, an overview of some key features of the competing Medicare prescription drug bills allows comparison. The major proposals of the 107th Congress included the House-Passed plan (H.R. 4954, The Medicare Modernization and Prescription Drug Act of 2002), the Rangel bill (H.R. 5019, The Medicare Prescription Drug Benefit and Discount Act of 2002), the Graham bill and amendment (S. 2625, The Medicare

Outpatient Prescription Drug Act of 2002), the Tripartisan bill (S. 2729, The 21st Century Medicare Act), and the Hagel bill (S. 2736, The Medicare Prescription Drug Discount and Security Act of 2002). The House-Passed plan and the Tripartisan bill are generally favored by Republicans while the Rangel and Graham bills are preferred by most Democrats. Although the Senate did not vote on the House-Passed plan, it is the only bill passed by either chamber.[ix, x, xi, xii]

The Hagel bill relies the most on private insurers and is unique among the proposals in that seniors would participate in different privately administered drug discount programs that would operate under different co-payment rules rather than under federally determined benefit structures.[xiii] Additionally, the Hagel plan is distinctive because catastrophic coverage, or total insurer liability for additional drug expenses, would occur once beneficiaries reach total drug spending thresholds determined by their income levels instead of after some fixed level.[xiii] Since all other proposals call for uniform cost-sharing and catastrophic coverage levels and rely on fixed co-payment structures, the remainder of this analysis will focus on the House-Passed, Rangel, Graham, and Tripartisan bills.

All four packages would be available to all Medicare beneficiaries on a voluntary basis, would require seniors to pay monthly premiums and cost-sharing, and would impose a stop-loss limit on total out-of-pocket drug spending after which plans would pay for all drug costs.[xiii] Additionally, all plans would aid low-income beneficiaries by paying at least a portion of premiums and cost-sharing requirements for beneficiaries with incomes up to 150% of poverty.[xiii] The plans would avoid adverse selection by giving beneficiaries only one chance to enroll without financial

penalty. Adverse selection occurs when beneficiaries who expect to incur significant drug costs in the near future enroll in plans to avoid paying the expenses themselves. Adverse selection can severely increase overall program costs because plans become disproportionately burdened by the staggering costs associated with high-risk seniors. To discourage this sort of beneficiary behavior, the plans would impose actuarially fair penalties for beneficiaries who enroll outside of set election periods. Election periods would occur after turning 65 for seniors who do not have other prescription coverage and after termination of prescription coverage for Medicare beneficiaries who receive non-Medicare assistance with drug costs.

Rather than relying on the federal government to administer all the benefits, all plans would utilize competing contractors to deliver benefits in exchange for administrative fees.[xiii] These contractors, often pharmacy benefit managers (PBMs), handle the processing of drug claims and utilize mechanisms to limit drug costs.[i] Some of these cost-constraining mechanisms include financial incentives to use drugs on a formulary, utilization of mail-order pharmacies, and development of pharmacy network arrangements in which plan enrollees may use only certain pharmacies.

The proposals' most obvious differences for beneficiaries center on premium rates, deductibles, co-payments, and stop-loss thresholds. The two Republican proposals, the House-Passed plan and the Tripartisan bill, call for beneficiaries to choose between different benefit packages and then pay for the premium associated with the plan of their choice.[xiii] Congressional staff members estimate average 2005 premiums at approximately $33 for the House-Passed plan and at about $24 for the

Tripartisan plan. Conversely, the two Democratic plans each have uniform premiums of $25 that would change yearly based on changes in indices associated with drug spending amongst the Medicare population. Beneficiaries would still choose between plans competing in their geographical areas, but the premiums would be fixed in law. Different plans also envision different deductibles. The two Republican bills would have $250 deductibles, the Rangel plan would have a $100 deductible, and the Graham plan would carry no deductible.

Next, co-payment structures differ across plans. The House-Passed plan would have a sliding scale with spending limits, again indexed to changes in seniors' drug spending, that would call on the beneficiary to pay 20% of drug costs between $251-$1,000 of total spending, 50% from $1,001-$2,000, and 100% from $2,001-$4,800.[xiii] The stop-loss threshold would be set at $3,700 in total out-of-pocket spending by the beneficiary and indexed. After beneficiaries paid this much out-of-pocket in a year, plans would pay for all additional prescription costs. The Tripartisan plan also uses an indexed sliding scale and calls for beneficiaries to pay 50% of costs between $251 and $3,450 and 100% from $3,451-$5,300. Beneficiaries would still pay 10% of costs above the indexed stop-loss threshold of $3,700. Next, the Rangel plan includes an indexed cost-sharing provision where the beneficiary would pay 20% for preferred drugs and 20% plus the difference between the non-preferred drug and the lowest-priced preferred drug if the beneficiary must have or chooses a non-formulary medicine. The stop-loss provision would be indexed at $2,000. Finally, the Graham plan calls for indexed co-payments of $10 per generic medicine, $40 per preferred brand drug, and full beneficiary payment for non-formulary drugs. If the

above co-payments in the Graham plan exceed drug cost, the co-payment would become retail cost minus $5 for generic and preferred brand drugs. The stop-loss threshold would be indexed at $4,000. The two Democratic proposals would sum costs paid by enrollee and plan when determining stop-loss totals whereas the Republican bills would only consider costs paid by beneficiaries.

Some of the most ideologically centered differences distinguishing the competing bills deal with the government's relationship to private industry and with total program cost. The Republican and Democratic bills take differing approaches in encouraging private administering agencies to keep costs low and to provide high-quality customer service. The two Republican bills would have administering agencies bear full benefit risk except for very high-cost enrollees.[xiii] Although the government would assist plans in paying for the highest-cost enrollees, full benefit risk would render the administering entity liable for most expenditures associated with an individual even if expenses exceed deductible and premium payments for that person. Since PBMs bearing full benefit risk need maximum flexibility to ensure profit, the Republican proposals would also allow PBMs significant freedom to determine which pharmacies to include in their networks.

Conversely, the Democratic plans would tie administrative payments to performance criteria like prompt action regarding appeals, stable pharmacy networks, and high generic substitution rates. They would also require PBMs to include in their networks any pharmacy that meets specified federal standards and agrees to accept negotiated prices for medicines.

Next, the two Republican bills only regulate formularies by stating that

pharmaceutical and therapeutic (P&T) committees must develop formularies that cover drugs within each therapeutic class.[xiii] In contrast, the Rangel plan requires P&T committees to include a medicine from each therapeutic class, at least two medicines from each class if more than one is marketed, and two and at least one generic if possible. The Graham plan would require P&T committees to include all generics and at least one, and no more than two, brand-name drugs in each class. Finally, the proposals have starkly different CBO cost estimates over the years 2005-2012. According to the CBO, the House-Passed bill will cost approximately $309 billion, the Tripartisan plan will cost $370 billion, and the Graham proposal will cost $594 billion. Although no CBO cost estimate is available for the Rangel plan, the Kaiser Family Foundation, an independent philanthropy focused on health policy analysis, estimates total cost at $900 billion.[xiv]

First, the Graham proposal is superior because it is the most equitable option. Since it does not have a deductible that forces elderly Americans to pay out of their own pockets before they receive benefits, the Graham plan benefits every enrolled senior who needs medicine regardless of spending. Although no CBO data are available for such narrow spending ranges as would be needed to assess the number of seniors who would receive no benefit under the Republican or Ragel plans, in 2001 46% of all beneficiaries incurred drug expense of below $500.[i] Total spending on these seniors comprised only 8% of the $70.6 billion spent on drugs for the elderly. If the costs associated with those who spent up to $500 is so small, the costs associated with those who spend less than the Republican deductible of $250 and the Rangel deductible of $100 must be even less. Due to enrollee co-payment

obligations, the plans would not even incur the full prescription costs associated with this population.

Despite these minimal cost savings, these plans would deprive a significant portion the 46% of seniors who spent less than $500 on their drugs of any benefit at all from the program they pay premiums toward. Unlike co-payments, which encourage lessened unnecessary drug spending by requiring beneficiaries to use some of their own resources for medicines, deductibles are designed mainly to lower program costs.[viii] Thus, under all three proposals, the deductibles would do only a minor job of trimming costs while ensuring that millions of seniors who would spend their limited incomes on premiums see no benefit. Since the Graham plan has no deductible, it provides benefits even for seniors who spend little on drugs. This absence of a deductible allows the Graham plan to equitably assist all enrollees who incur drug costs.

The Graham plan is also the best choice because it requires plans to include any pharmacy that meets federal criteria in their pharmacy networks. Consequently, the Graham plan, like the Rangel bill, leads to greater consumer choice over which pharmacy to use. Since it encourages broader pharmacy networks, it also improves the likelihood that seniors will be able to get prescriptions filled at their regular pharmacy once they begin utilizing Medicare prescription drug benefits. The requirement including qualifying pharmacies in networks also ensures greater pharmacy network stability because the administering entity cannot exclude a pharmacy at will.

All of these issues associated with patients' continuity of pharmacy prove

critical in preventing adverse drug reactions and other undesirable events. For instance, a pharmacy that has served a patient for years would have a greater likelihood of personally knowing that person and understanding lifestyle or genetic factors that might influence his/her therapeutic outcomes. Specifically, a pharmacist who has served a patient over a long period of time might know that her patient spends time outdoors and thus recognize the heightened need to warn about severe reactions a drug has with sunlight. Instead of requiring network access for any pharmacy that meets requirements, the Republican plans only require administering entities to include enough pharmacies so that beneficiaries have "convenient access."[xv] They even authorize charging higher co-payments if patients use non-network pharmacies. Such conditions do nothing to ensure meaningful consumer choice and stability amongst pharmacy networks. At best, these regulations would prove burdensome for beneficiaries while at worst they would endanger seniors' health.

Next, the Graham proposal has the most appropriate formulary provisions. The two Republican proposals would set no federal regulations concerning what drugs plans must cover. Instead, they would leave such decisions up to the administering entities. If administering agencies behave like they do in the current market, the competitive nature of the plans, which encourages benefit administrators to keep costs low however possible, will lead to the development of restrictive formularies.[xvi] Although formularies that exist in the current market do cover drugs from each therapeutic class and many generics, some generic drugs and many brand drugs are excluded. Narrow formularies benefit administrating agencies because they ensure

that larger numbers of prescriptions are filled for one medicine over another. For this guarantee of increased demand, drug manufacturers may give administering agencies rebates.[xvii] For example, an administering agency could demand considerable manufacturer rebates in exchange for the inclusion of particular drugs on its formulary.

Although plans usually have some mechanism so that beneficiaries may gain coverage for medically necessary drugs, obtaining coverage can prove troublesome. Some current plans administered by entities similar to those that would deliver Medicare benefits are rigid and may make it difficult for patients to obtain coverage of medically needed non-formulary drugs.[xviii] A 1998 study found that among elderly beneficiaries such restrictive formularies lead to diminished access to drug therapy and increased health expenditures.[xix] Since many entities would compete geographically under the Republican proposals, not every administering agency would utilize exceptionally limited formularies that enrollees might find objectionable. Nonetheless, if enrollees' formularies prohibit the use of any generic medicines, as some are likely to do under Republican proposals, seniors would have less choice than if the Graham proposal prevailed. Thus, restrictive formularies similar to those some administering entities may impose under the Republican plans would endanger enrollee health by making it difficult for beneficiaries to obtain the drugs they need.

Conversely, the Graham Plan appropriately establishes rules for formularies by requiring that all generic drugs are included as well as at least one, and no more than two, brand-name drugs. Generic alternatives are only available for drugs that have

been in development and on the market long enough to exhaust their 17-year patent lives. Since physiologic differences cause patients to react more favorably to one drug over others in the same therapeutic class, beneficiaries must have the opportunity to use the drugs that are best for them.[xx] Additionally, since generics cost $19.33 on average in 2000 while brand-name drugs cost $65.29, Graham's proposal does not expose itself to extremely high drug costs through generic inclusion.[xxi] Instead, through its formulary and co-payment structure, the Graham plan provides incentives to utilize cheaper, generic equivalents when possible. Since the Rangel plan requires the formulary inclusion of only one generic drug, like the Republican bills, it fails to guarantee seniors easy access to generic medicines as the Graham plan does.

The Graham plan, like the Rangel plan, also does a better job of ensuring beneficiary satisfaction. To encourage compliance with performance criteria centered on customer service, administering agencies would put a portion of their administrative fees at risk based on how well they meet standards. If governmental reviewers found plans' performance unacceptable, portions of federal administrative payments would be withheld. Some examples of performance criteria include time taken to answer beneficiary and pharmacy questions and appeals, stability of pharmacy access networks, and timeliness and accuracy in processing claims.[xiv] Although benefit providers could lose up to 100% of their administrative fees for poor customer service, the Graham plan prohibits the loss of fees at a rate that "jeopardizes the ability of an eligible entity to administer and deliver the benefits."[xxii]

In contrast to the utilization of administrative fees as incentives, Republican

proposals call for administrating entities to bear full benefit risk. Consequently, plan administrators would feel enormous pressure to keep their expenses low by minimizing the costs associated with the most seriously ill seniors. If benefit administrators under the Republican plans act anything like they do in the private sector today, beneficiaries would soon have to deal with unstable pharmacy networks, enrollee selection practices designed to exclude the ill, and other unsavory actions.[xxiii] Instead of relying on an incentive structure that so strongly tempts benefit contractors to utilize practices that burden enrollees, the Graham plan's criteria centered on beneficiary satisfaction avoids these undesirable developments and ensures the consideration of seniors' needs.

Finally, the Graham plan is the most desirable option because it makes sound use of federal resources. As mentioned above, from 2005-2012, the House-Passed bill and the Tripartisan plan would cost $309 billion and $370 billion, respectively. The Graham proposal would total $594 billion, and the Rangel plan would cost about $900 billion. Although the stop-loss threshold in the Rangel bill would help many more seniors who would not receive catastrophic coverage under other proposals, $900 billion seems excessive considering that the total government revenues in 2001 totaled just under $2 trillion and that this amount would represent 24% of total Medicare spending over the period.[xxiv, xxv] With a staggering economy and the number of seniors likely to exceed $2,000 in future drug costs uncertain, it is imprudent to risk such high costs in a volatile environment. The projected growth of the Medicare population is from 40 million in 2002 to 47 million in 2011.[i] Thus, if estimates relying on multiple assumptions to project costs associated with catastrophic coverage even

slightly underestimate how many people will require catastrophic coverage, program costs would skyrocket. In light of these pressures, the federal government would be best served by the less costly Graham plan that does not put such a large amount of taxpayer money at risk based on uncertain predictions.

Although the Republican plans are much less expensive than the Democratic plans, and more in line with the $300 billion allotted in Bush's budget for 2003-2012, program costs deserve contextualization before judgments are made.[xxv] For instance, if the Graham plan were implemented, it would account for about 16% of total Medicare spending through 2012.[xxv] This seems like a moderate amount of spending considering that total senior drug costs will sum almost $1.5 trillion over the same period.[xxv] Next, consider that the recently passed tax cut will cost the federal government $1.35 trillion from 2001-2011 and .[xxvi] In comparison to such staggering costs, the $594 billion cost associated with the Graham proposal seems less monumental. Indeed, legislators cannot tell needy seniors that the federal government cannot afford the more generous Medicare drug proposal; they must admit that other policy choices like a tax cut that saved the wealthiest 1% of Americans about $53,000 each in 2001 won out in Washington.[xxvii] Thus, although some may argue that the Graham plan is too costly in comparison to the Republican proposals and too demanding toward beneficiaries who incur excessive drug costs versus the Rangel bill, it provides a meaningful prescription drug benefit at a cost that falls in line with other policy decisions and does not foolishly risk significant unanticipated costs resulting from dubious assumptions.

In sum, America's seniors have had to worry for too long that excessive drug

costs will drain their savings and leave them in financial ruin. Prescriptions are becoming more expensive, seniors are requiring more and more drugs as they age, and many are losing or seeing reductions in the prescription drug coverage they have. This lack of coverage simply perpetuates an unnecessary cycle of illness and poverty that prohibits seniors from accessing the therapy they need to recover from debilitating illnesses and enjoy their lives. To combat these factors that are converging to make prescription drugs so worrisome for America's seniors, legislators should enact a Medicare prescription drug benefit. Such legislation should benefit all seniors who pay premiums, ensure customer satisfaction and access to drugs, appropriately balance risk between the government and administering entities, and use tax dollars responsibly.

The Graham proposal is the only option that addresses all of these concerns in a meaningful way. It benefits all enrollees who use drugs by starting assistance with the first dollar spent instead of after beneficiaries meet deductibles. It maximizes beneficiary choice in which pharmacy to use, and it utilizes a formulary that would control costs while allowing easy access to needed medicines. Instead of tempting administering entities to utilize cost-control techniques that would frustrate seniors, it employs administrative payments designed to increase customer satisfaction. The costs associated with the Graham proposal make it a viable policy alternative as compared to other choices made by legislators. All of these factors combine to make the Graham proposal the optimal choice for bringing a Medicare prescription drug benefit to America's 40 million needy seniors.

Appendix A

Definitions

Adverse Selection: Selection techniques practiced by benefit administering entities to generate a less costly membership by attracting healthier enrollees and discouraging more ill seniors from joining.

Benefit Risk: The financial risk administering entities bear when they must pay for enrollee benefits even when drug benefits to an enrollee exceed payments by that enrollee.

Cost-Sharing/Co-Payment: Arrangements that call for beneficiaries to pay a portion of drug costs as part of their benefit package.

Catastrophic Coverage: Prescription coverage where the administering agency pays all costs associated with covered drugs after a beneficiary's total drug expenditures exceed a fixed amount in a year.

Deductible: The amount of drug costs enrollees must incur out-or-pocket before they can receive financial assistance from plans.

Formulary: A list of drugs developed by a pharmacy and therapeutics committee that defines which medicines enrollees may use in order to receive financial assistance from administering agencies.

Generic Drug: A chemical that is bioequivalent to another drug. May only be marketed after a brand-name drug's patent has expired.

Indexing: The process of adjusting benefit package components in response to changes in healthcare indices that track such trends as per capita elderly prescription drug spending.

Poverty Level: In 2001: Average income of $8,590 for an individual and $11,610 for a couple.

Pharmacy Benefit Managers (PBMs): Benefit administering agencies that control cost-limiting components of plans such as formularies and pharmacy networks.

Pharmacy Network: A group of pharmacies at which plan enrollees may have their prescriptions filled under benefit provisions.

Pharmacy and Therapeutics Committee (P&T Committee): A committee, including healthcare professionals and possibly laypeople, that weighs drugs' therapeutic value and costs to determine which drugs will be included in formularies.

Premium: Monthly payments plan enrollees must make to administering entities as part of their agreement for prescription drug coverage.

Stop-Loss Threshold: The amount of total drug spending, either incurred solely by the enrollee or jointly by the administering entity and the enrollee, after which the managing entity would pay all costs associated with covered prescription drugs.

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