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DESIGNING A TARGETED DRUG BENEFIT FOR AMERICA'S SENIORS

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Congress is now debating how to give a prescription drug benefit to Medicare patients. The best option would be to give senior citizens the opportunity to participate in a new Medicare program that resembles the Federal Employees Health Benefits Program (FEHBP), which covers Members of Congress and other federal workers. This was the model proposed last year by the majority of members of the National Bipartisan Commission on the Future of Medicare. In the FEHBP, members have a choice of private plans; all of the competing plans, without exception, have prescription drug coverage; most plans pay between 80 percent and 90 percent of drug costs; and members are not pressured to buy additional insurance policies and pay two premiums to bridge huge gaps in coverage. Short of this comprehensive reform, the next best solution would be to design a targeted subsidy for low-income seniors.

Best Solution. The best policy option, creating a structure based on the FEHBP model, administratively would be the easiest to implement. By allowing enrollees to choose among private plans, competitive market forces would restrain pharmaceutical prices, and seniors would have the protection of private catastrophic coverage. Insurance companies in the FEHBP know, for example, that it is in their interest to pay for an expensive drug therapy, since this is often the alternative to more expensive surgery or institutionalization. Moreover, integrating drug coverage into an overall system of health insurance coverage would reduce adverse selection problems, whereby only those with high drug costs purchase the coverage.

President Clinton firmly rejects this solution. Instead, he would add a prescription drug subsidy to the old Medicare program. Although the President's proposal calls for using pharmacy benefit managers (PBMs) to administer this benefit, as private insurers do, the PBMs would become geographic monopolies controlled by the Health Care Financing Administration (HCFA). HCFA, under budget pressures, would control the prices and the supply of drugs for seniors. The Clinton plan offers only front-end prescription drug subsidies, not a solid catastrophic stop-loss insurance program. Seniors facing high drug costs would have to rely on a special reserve fund, which would not go into effect until 2006, to cover catastrophic expenses. The fund would be subject to the uncertain politics of the federal budgetary process.

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Second Best Solutions. If Congress cannot or will not enact a comprehensive Medicare reform, it has limited options, and the design problems will be

difficult. But if Congress elects to adopt a limited solution to the problem of drug coverage, then it should also establish a framework for a more comprehensive reform based on competing private plans that is similar to, or better than, the FEHBP. The key elements of this framework:

1. **Subsidies targeted to low-income seniors.** Most seniors already have coverage from employers or other sources. The priority for a new drug program should be those who cannot afford coverage, not middle- and upper-income seniors who already have insurance. Administratively, "Qualified Medicare Beneficiaries" and seniors eligible for the "Specified Low Income Medicare Beneficiary" payments, who already are recipients of public assistance, would be the easiest group to target for subsidies.

2. **Guaranteed protection from high drug costs, rather than subsidies for routine minor drug costs.** The purpose of insurance is to protect individuals from catastrophic financial losses. The threat to seniors today is an expensive drug therapy, which may cost thousands of dollars per year. A properly designed policy would include a deductible but cap the beneficiary's financial liability so that seniors need not fear being stuck with enormous bills. Congress should not create a benefit that covers small, more predictable costs yet leaves seniors exposed to potentially catastrophic costs. In this respect, Congress should explore ways to upgrade Medigap rules so that these plans cover real catastrophic costs, including prescription drug costs, and not serve as a payment system for small bills such as Medicare Part A and Part B co-payments and deductibles.

3. **Guaranteed access to competing private plans.** Seniors, regardless of where they live, should be able to choose from competing private plans to have access to discounted drugs.

4. **A Medicare Board that approves the new benefit.** A new Medicare Board could approve the level of drug benefits offered through private insurance, while enforcing consumer protection and solvency requirements—as the Office of Personnel Management does today in the FEHBP system. Such a board could evolve into the administrative agency to oversee an entirely reformed new Medicare system, as envisioned by the Medicare Commission, leaving HCFA to concentrate on running a competitive fee-for-service plan.

5. **Minimum contract lengths and waiting periods for the purchase of coverage.** For a drug benefit to work, seniors must not be able to "game" the system and aggravate adverse selection problems by purchasing coverage for short periods or only when they need it.

Tackling Adverse Selection. The major problem of designing a stand-alone drug benefit is adverse selection, where the only purchasers of coverage are those who already have high fixed expenses. To deal with this problem, Congress could craft a policy to create a re-insurance mechanism known as "high-risk pools." In a high-risk pool, private insurers cross-subsidize each other so that each participating plan is protected from getting a disproportionate share of bad risks. This mechanism spreads the risk and the costs, and would protect insurers from getting a disproportionate number of high-cost patients among their enrollees.

Designing a sustainable, accessible, high quality, and targeted drug benefit for low-income seniors will require close attention to programmatic detail, especially if the changes are to be compatible with the transition to a superior system of comprehensive private coverage based on choice and competition. In the meantime, Medicare beneficiaries should be spared an ill-designed, stop-gap drug benefit plan destined for failure.

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