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Medicare: Beneficiary Cost-Sharing Under Prescription Drug Legislation

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Summary

In late June 2003, both the Senate and the House passed legislation to add a prescription drug benefit to the Medicare program. Although the Prescription Drug and Medicare Improvement Act of 2003 (S. 1) and the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 1) have many differences, the structure of the proposed standard prescription drug coverage is similar. This report provides an analysis of how the cost-sharing and premium provisions under each bill would affect the amount that a beneficiary would pay annually for prescription drugs.

Each of these proposals has a different form of cost-sharing (that is, the share of an enrollee's drug costs that is not paid by the Medicare prescription drug plan). Under S. 1, the plan would pay 50% of drug costs after the enrollee paid the $275 deductible (in 2006). After $4,500 in total drug spending (the "coverage limit"), the enrollee would pay for *all* prescription drug spending until reaching the $3,700 "true" out-of-pocket maximum (that is, cost-sharing amounts excluding those paid on behalf of the enrollee by private health insurance). This occurs when the total spending on prescription drugs exceeds $5,813, assuming none of the cost-sharing is paid for by private insurance. After reaching this threshold, Medicare would cover 90% of all additional drug expenses.

Standard prescription drug coverage under H.R. 1 includes a deductible of $250, after which the plan would cover 80% of spending up to the $2,000 coverage limit. The beneficiary would then be responsible for *all* prescription drug costs until reaching the "true" out-of-pocket maximum of $3,500, when total expenditures reach $4,900, assuming none of the cost-sharing is paid for by private insurance. Once the true out-of-pocket maximum is reached, the plan would cover all additional prescription drug expenses.

Under both bills, Medicare does not contribute directly toward the cost of drugs when annual drug expenses fall in a certain range, although Medicare contributes directly toward beneficiary drug expenses at levels below and above this range. This aspect of the coverage is often referred to as the "doughnut hole."

Low-income beneficiaries receive subsidies under both bills resulting in zero or small deductibles, premiums and coinsurance rates or copayments. While S. 1 requires minimal coinsurance below the coverage limit (2.5%, 5% or 10% depending on the beneficiary's low-income category), H.R. 1 requires fixed copayments of $2/generic prescription or $5/brand name prescription. In addition, low-income beneficiaries would still face a "doughnut hole" under H.R. 1 but not under S. 1.

Based on beneficiaries' expected out-of-pocket costs under the two plans, neither can be said to be more or less generous than the other for all beneficiaries. Out-of-pocket costs could be lower under S. 1 or H.R. 1, depending on a beneficiary's total annual drug expenditures. However, the absence of a "doughnut hole" in S. 1 for low-income beneficiaries means that, for many of these individuals, S. 1 would result in lower out-of-pocket costs than H.R. 1.

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Introduction

In late June 2003, both the Senate and the House passed legislation to add a prescription drug benefit to the Medicare program. The structure of the proposed standard prescription drug coverage is similar under both the Prescription Drug and Medicare Improvement Act of 2003 (S. 1) and the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 1). Within that structure, however, the amounts paid in cost-sharing by beneficiaries can differ substantially between the bills, depending on each beneficiary's total prescription drug spending and whether the beneficiary qualifies for low-income assistance. This report provides an analysis of how the cost-sharing and premium provisions under each bill would affect the amount that a beneficiary would pay annually for prescription drugs.[1] In addition, this report gives examples of how annual cost-sharing would differ for beneficiaries with various levels of total prescription drug spending in 2006 under the two plans.

Cost-Sharing and Insurance

Insurance acts to reduce uncertainty and individuals' exposure to high costs due to catastrophic events such as severe illness. In general, individuals pay a premium, and in exchange, insurers pay for their covered benefits. Premiums are paid regardless of whether covered expenses are actually incurred.

In addition to premiums, enrollees may also face cost-sharing, which is the portion of total expenses that enrollees must pay for covered benefits. Cost-sharing in a health plan generally includes some combination of deductibles, coinsurance, copayments, and limits on individuals' total out-of-pocket expenses. Because these concepts are necessary to evaluate and compare the prescription drug coverage in S. 1 and H.R. 1, they are described in **Box 1**.

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[1] For a discussion of other issues associated with a prescription drug benefit, such as how much risk would be borne by private insurance, see CRS Report RL31966, *Medicare Prescription Drug and Reform Legislation,* by Jennifer O'Sullivan et al.

Box 1. Terms Used to Describe Cost-Sharing

Deductible: The amount an enrollee in an insurance plan must pay out-of-pocket before the insurer begins paying for covered services. Generally, the enrollee must meet this amount each year. Plans with no deductible are said to provide "first-dollar" coverage.

Coinsurance rate: The percentage of covered costs paid by the enrollee. The terms of coverage can specify various coinsurance rates for different aspects of coverage, for instance before and after a threshold of expenses.

Copayment: A fixed dollar amount that the enrollee must pay for each covered benefit — for instance, a filled prescription. A copayment differs from coinsurance in that the copayment amount does not vary with the cost of the service. However, copayments may differ based on the type of drug (for example, one copayment amount for brand-name drugs, another for generic drugs).

Coverage limit: The total amount of incurred expenses at which the insurer (federal government, health care plan, etc.) reduces its contributions to the enrollee's expenses. For example, once an enrollee's drug costs exceed the coverage limit, the enrollee must pay for most or all the additional drug expenses.

Out-of-pocket maximum, or catastrophic coverage threshold: The amount that enrollees are required to pay each year out-of-pocket (excluding premiums), before stop-loss (or "catastrophic") coverage begins. Typically, the insurer (for instance, Medicare or a private health plan) pays almost all additional expenses once an enrollee meets the annual catastrophic threshold.

Proposed Cost-Sharing Arrangements

Both S. 1 and H.R. 1 would create a "standard" prescription drug benefit in Medicare that would take effect in 2006. Variations in the beneficiary cost-sharing requirements of the two proposed plans will affect the level of potential out-of-pocket costs to individual beneficiaries. Since participation is voluntary under both bills, expected out-of-pocket expenses are likely to be a critical factor when beneficiaries consider whether to enroll.

Under S. 1, the standard coverage would pay 50% of drug costs after the enrollee has paid the $275 deductible. The coverage limit is $4,500. That is, after $4,500 in total drug spending (again, in 2006 dollars), the enrollee would pay for *all* prescription drug spending until reaching the out-of-pocket maximum. Under this plan, the out-of-pocket maximum is $3,700. This amount is often referred to as the "true" out-of-pocket maximum because, under S. 1, cost-sharing paid on behalf of the enrollee by private health insurance does not count toward the $3,700. After reaching that level of prescription drug spending, the plan would cover 90% of spending. Under this proposal, enrollees would pay a $35 monthly premium in 2006.[2]

The standard prescription drug coverage in H.R. 1 has a deductible of $250, after which the plan would cover 80% of spending, until total prescription drug spending reaches the coverage limit of $2,000. The true out-of-pocket maximum in

[2] The premium amount is an estimate from the Congressional Budget Office, which also provided the premium estimate for H.R. 1.

H.R. 1 is $3,500; as in S. 1, private health insurance payments do not apply toward the out-of-pocket maximum. However, under H.R. 1, once the true out-of-pocket maximum is reached, the plan would pay for *all* additional prescription drug spending. Under this proposal, enrollees would also pay a $35 monthly premium in 2006. **Table 1** summarizes the major cost-sharing provisions of the standard prescription drug coverage in S. 1 and H.R. 1.

Table 1. Summary of Prescription Drug Standard Coverage Under S. 1 and H.R. 1, 2006

	S. 1	H.R. 1
Annual premium	$420 ($35/month)[a]	$420 ($35/month)[a]
Annual deductible	$275	$250
Coinsurance on drug costs above deductible and up to coverage limit	50%	20%
Coverage limit	$4,500	$2,000
Range of expenditures where enrollee pays for 100% of drug costs	$4,500-$5,813[b]	$2,000-$4,900[b]
Catastrophic threshold	$3,700 out-of-pocket ($5,813 total expenditures[b])	$3,500 out-of-pocket ($4,900 total expenditures[b])
Cost-sharing payments that apply toward out-of-pocket maximum	Cost-sharing paid by enrollee, another individual, Medicaid, or a state pharmaceutical assistance program	Cost-sharing paid by enrollee, another individual, Medicaid, or a state pharmaceutical assistance program
Coinsurance beyond catastrophic threshold	10%	None

[a] Amount estimated by the Congressional Budget Office (CBO).
[b] Assumes none of the cost-sharing is paid by private insurance.

The "doughnut hole"

Under both S. 1 and H.R. 1, Medicare does not contribute toward the cost of drugs when an individual's annual drug expenses fall in a certain range — that is, when expenses are above the coverage limit but below the total amount necessary to reach the out-of-pocket maximum. This aspect of the coverage has been referred to as the "doughnut hole."[3]

Under S. 1, beneficiaries receiving the standard benefit must pay the full cost of drugs once they reach the coverage limit of $4,500 and until their out-of-pocket payments reach the catastrophic cap of $3,700. Because of the $275 deductible and the 50% coinsurance up to the initial coverage limit, beneficiaries with the standard benefit will have spent $2,387.50 out-of-pocket (excluding the premium) when they accumulate $4,500 worth of drug costs. Assuming none of the cost-sharing is paid for by private insurance, they will have to spend an additional $1,312.50 to reach the catastrophic cap of $3,700. Since there is no Medicare contribution over this range, the beneficiary will bear the full cost of drugs from the coverage limit of $4,500 until accumulated drug expenses reach $5,812.50, as shown in **Figure 1**.

The drug benefit is structured similarly in the House bill, however the amounts are different. Beneficiaries are responsible for the entire cost of drugs between $2,000 and $4,900, assuming none of the cost-sharing is paid for by private insurance. Although this range is larger than the one in the Senate bill, H.R. 1 has lower coinsurance rates than S. 1.

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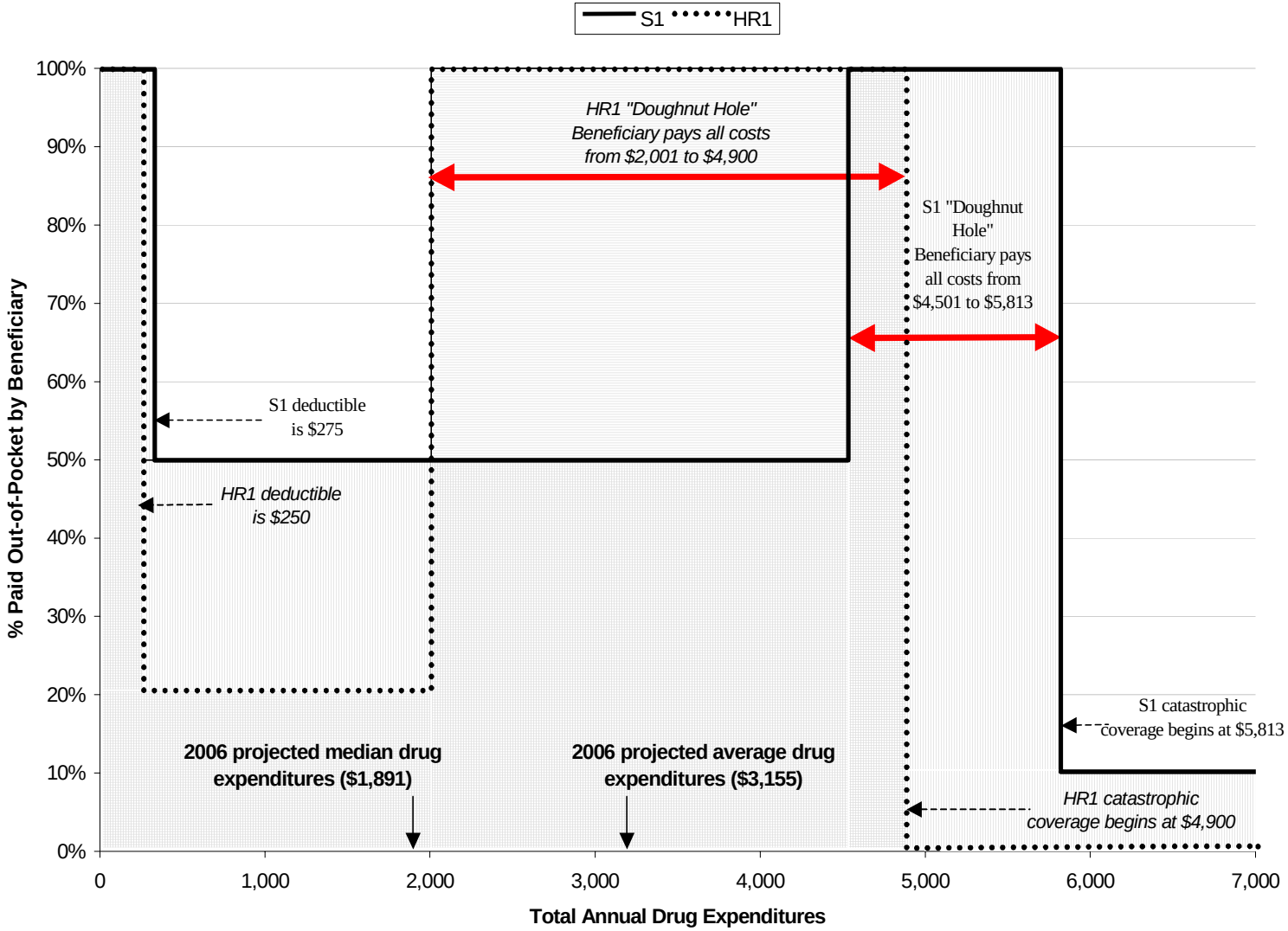
[3] Some have referred to this as a "gap in coverage," which can be misleading. Coverage continues to be in effect even when Medicare is not contributing directly to the cost of drugs, and the beneficiaries' out-of-pocket expenditures contribute toward the catastrophic cap. While there may be a gap in Medicare payments, there continues to be coverage.

Figure 1. Beneficiary Cost-Sharing by Total Annual Drug Expenditures Under S. 1 and H.R. 1, 2006



Source: Congressional Research Service (CRS). The projected median and average prescription drug expenditures for 2006 are from the 2003 baseline of the Congressional Budget Office (CBO) and represent spending by or for Medicare enrollees.

Income-based provisions

Both S. 1 and H.R. 1 alter the standard benefit's cost-sharing requirements for beneficiaries at certain income levels (sometimes with additional eligibility criteria). S. 1 provides assistance for various categories of low-income beneficiaries through reduced premiums, deductibles, and coinsurance. H.R. 1 also reduces premiums and deductibles for low-income beneficiaries, but requires low fixed-dollar copayments for each prescription rather than coinsurance for spending below the coverage limit. In addition, H.R. 1 modifies the cost-sharing limits for higher income beneficiaries.

Low-income subsidies. In **Table 2**, the provisions in S. 1 and H.R. 1 for low-income Medicare beneficiaries are summarized using three income categories. Besides a deductible that may be required, beneficiaries in each income category face three cost-sharing rates, depending on their cumulative annual drug expenditures. There is one coinsurance/copayment rate for cumulative annual drug expenditures up to the coverage limit, a second rate when annual expenditures exceed the coverage limit but the beneficiary's total out-of-pocket costs are less than the catastrophic threshold, and a third rate once a beneficiary has exceeded the catastrophic threshold.

The bills' provisions are summarized in **Table 2** using the following three income categories: beneficiaries with countable income at or below 100% of poverty, beneficiaries with countable income between 100% and 135% of poverty, and other subsidy eligible beneficiaries.[4] There are two additional eligibility criteria besides income, which differ between the bills. Under S. 1, Medicare beneficiaries who are also eligible for Medicaid ("dual eligible") are not permitted to enroll in one of the three low-income categories; dually eligible beneficiaries would receive their prescription drugs through their state's Medicaid program. Under H.R. 1, however, dually eligible beneficiaries could qualify in one of the low-income categories, with states required to maintain Medicaid prescription drug benefits as a "wraparound" to the Medicare coverage. In addition, to qualify for low-income assistance under the bills, beneficiaries must have assets below various thresholds, as discussed below.[5]

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[4] "Countable income" means the amount of income counted for determining eligibility for Supplemental Security Income (SSI) and is defined in Section 1612 of the Social Security Act, as amended. "Poverty line," or "poverty," refers to the federal poverty guidelines published by the Department of Health and Human Services. The 2003 federal poverty guideline for an unmarried, aged Medicare beneficiary is $8,980 in countable income in the 48 contiguous states and the District of Columbia, $11,210 in Alaska, and $10,330 in Hawaii. The 2003 federal poverty guideline for a married, aged Medicare beneficiary is $12,120 in the 48 contiguous states and the District of Columbia, $15,140 in Alaska, and $13,940 in Hawaii. Because the guidelines apply to "countable income" (which excludes certain amounts and types of income), persons may qualify even though their *total* income is above these amounts. For further information, see CRS Report RL31736, *Medicare Prescription Drug Proposals: Estimates of Aged Beneficiaries Who Fall Below Income Criteria, by State*, by Chris L. Peterson and Paulette C. Morgan.

[5] For additional details on these and other provisions in S. 1 and H.R. 1, see CRS Report RL31992, *Medicare Prescription Drug Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House*, by Jennifer O'Sullivan.

Under S. 1, the lowest cost-sharing is available to Qualified Medicare Beneficiaries (QMBs). These are beneficiaries with **countable income at or below 100% poverty** who do not qualify for full Medicaid benefits (as previously mentioned) and have countable assets, or resources, of less than $4,000 for an individual or $6,000 for a married couple.[6] QMBs would pay no premiums[7] or deductibles under S. 1. QMBs would pay coinsurance of 2.5% up to the coverage limit of $4,500, and then 5% for additional drug expenditures until they have spent $3,700 out-of-pocket. Should they reach the out-of-pocket maximum (by incurring $76,250 in total drug expenditures, assuming none of the cost-sharing is paid for by private insurance), they would then be responsible for a 2.5% coinsurance for all additional drug expenditures.

For beneficiaries who would qualify as QMBs except that their countable income is too high — in this case, those with **countable income between 100% and 135% of poverty** — separate cost-sharing amounts would be in place.[8] Like, QMBs, these individuals would not be required to pay premiums or deductibles. However, some of their coinsurance rates would be higher than QMBs'. These beneficiaries would pay coinsurance of 5% up to the initial coverage limit of $4,500, then pay 10% of additional drug expenditures until they have spent $3,700 out-of-pocket (by incurring total drug expenditures of $39,250, assuming none of the cost-sharing is paid for by private insurance). Like QMBs, they would then be responsible for a 2.5% coinsurance for all drug expenditures above the out-of-pocket maximum.

For beneficiaries who are not eligible for the previous two categories (or for Medicaid), they may be eligible as **other subsidy eligible beneficiaries**. Under S. 1, those in this category must have income below 160% of poverty.[9] No assets test is required for this category. The monthly premium for these beneficiaries is eliminated for those with income below 135% of poverty. For subsidy eligible beneficiaries between 135% and 160% of poverty, the premium is determined by income on a linear sliding scale.[10] The annual deductible would be $50. These

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[6] States may waive the assets test. For those states that did not eliminate the assets test, S. 1 raises the limits to $10,000 for an individual and $20,000 for a married couple beginning in 2009. Throughout this report, "countable assets" refers to the amount of assets counted for determining eligibility for Supplemental Security Income (SSI), defined in Section 1613 of the Social Security Act, as amended.

[7] Additional amounts may be required for prescription drug plans with relatively high premiums.

[8] This group consists of Specified Low-income Medicare Beneficiaries (SLMBs), with countable income between 100% and 120% of poverty, and Qualified Individuals (QI-1s), with countable income between 120% and 135% of poverty.

[9] Note that the term "countable" income is not used here. S. 1 does not specify the definition of income for this category of beneficiaries. However, eligibility determinations would be made by the states, just as they are for Medicaid, QMBs, SLMBs and QI-1s.

[10] Beneficiaries with income at 135% of poverty will have no premium, while those with incomes equal to 160% of poverty would be responsible for the full $35 monthly premium. In general, individuals with incomes equal to 147.5% of poverty (the midpoint of the range) would have a $17.50 monthly premium.

beneficiaries would pay coinsurance of 10% between the deductible and the initial coverage limit of $4,500, then pay 20% of additional drug expenditures until they have spent $3,700 out-of-pocket. They would then be responsible for a 10% coinsurance for all drug expenditures above the out-of-pocket maximum, as in standard coverage.

Table 2. Summary of Prescription Drug Coverage for Low-Income Individuals Under S. 1 and H.R. 1, 2006

	Countable income[a] at or below 100% of poverty, plus assets test[b]		Countable income[a] between 100% and 135% of poverty, plus assets test[b]		Other subsidy eligible beneficiaries[c]	
	S. 1	**H.R. 1**	**S. 1**	**H.R. 1**	**S. 1**	**H.R. 1**
Monthly premium[d]	$0	$0	$0	$0	$0-$35	$0-$35
Annual deductible	$0	$0	$0	$0	$50	$250
Beneficiary's coinsurance/copayment						
Up to coverage limit	2.5%	$2/generic, $5/brand	5%	$2/generic, $5/brand	10%	20%
Coverage limit	$4,500	$2,000	$4,500	$2,000	$4,500	$2,000
From coverage limit to out-of-pocket maximum	5%	100%	10%	100%	20%	100%
Out-of-pocket maximum	$3,700	$3,500	$3,700	$3,500	$3,700	$3,500
Beyond out-of-pocket maximum	2.5%	0%	2.5%	0%	10%	0%

[a] "Countable income" means the amount of income counted for determining eligibility for Supplemental Security Income (SSI), defined in Section 1612 of the Social Security Act, as amended. "Poverty" refers to the federal poverty guidelines published by the Department of Health and Human Services.

[b] Under both S. 1 and H.R. 1, eligibility in these income categories also requires that beneficiaries have countable assets below certain thresholds. "Countable assets" refers to the amount of assets counted for determining eligibility for SSI, defined in Section 1613 of the Social Security Act, as amended. In 2006, countable resources in these categories are limited to $4,000 for an individual and $6,000 for a married couple under S. 1. Under H.R. 1, countable resources in these categories are limited to $6,000 for an individual and $9,000 for a married couple. Additional eligibility criteria for these categories are mentioned in the text of this report and discussed in greater detail in CRS Report RL31992, *Medicare Prescription Drug Provisions of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House*, by Jennifer O'Sullivan.

[c] For S. 1, these are beneficiaries who have income below 160% of poverty and do not qualify for full Medicaid or in the other two categories in the table; no assets test applies. For H.R. 1, these beneficiaries are those with countable income between 135% and 150% of poverty who have countable assets of less than $6,000 for an individual or $9,000 for a married couple.

[d] Additional amounts may be required for prescription drug plans with relatively high premiums. The full $35 premium is an estimate from the Congressional Budget Office (CBO).

Under H.R. 1, the most generous cost-sharing assistance is available to those with countable income at or below 135% of poverty who have countable assets, or resources, of less than $6,000 for an individual or $9,000 for a married couple. This category of beneficiaries under H.R. 1 is comparable in terms of income criteria to two categories of beneficiaries in S. 1, beneficiaries with **countable income at or below 100% poverty** and those with **countable income between 100% and 135% of poverty**, even though other eligibility criteria (that is, the assets test and whether they can be dually eligible) differ.

For these beneficiaries in H.R. 1, no premiums or deductible would be required, as in S. 1. However, rather than facing a coinsurance rate, copayments are required up to the coverage limit for these beneficiaries in H.R. 1: $2 per generic prescription drug and $5 per brand drug. Under H.R. 1, these beneficiaries are responsible for all prescription drug costs in the doughnut hole, unlike S. 1. However, once reaching the true out-of-pocket maximum, beneficiaries under H.R. 1 would have no cost-sharing, whereas S. 1 requires a 2.5% coinsurance.

For H.R. 1, **other subsidy eligible beneficiaries** are defined as those with countable income between 135% and 150% of poverty who have countable assets of less than $6,000 for an individual or $9,000 for a married couple. The cost-sharing for these beneficiaries is the same as for those in the bill's standard coverage. The only additional benefit for these individuals is that the premium is determined on a linear sliding scale.[11]

Other income-related provisions. The standard prescription drug benefit under H.R. 1 is also modified for some higher income individuals.[12] The annual out-of-pocket maximum is increased for beneficiaries with adjusted gross income(AGI) above $60,000 in 2006.[13] For those with AGI of $200,000 or higher in 2006, the out-of-pocket maximum is $11,620, rather than $3,500 for standard coverage. For those beneficiaries with AGI between $60,000 and $200,000, the out-of-pocket maximum is determined on a linear sliding scale.

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[11] Beneficiaries with income at 135% of poverty will have no premium, while those with incomes equal to 150% of poverty would be responsible for the full $35 monthly premium. In general, individuals with incomes equal to 142.5% of poverty (the midpoint of the range) would have a $17.50 monthly premium.

[12] S. 1 does not modify drug benefits to more affluent beneficiaries.

[13] For married couples, the AGI would be divided by two and the income test applied for each beneficiary. AGI is derived by reducing total, or gross, income by certain amounts, such as for an IRA or student loan interest.

Cost-Sharing Examples

The following section compares how much a hypothetical enrollee with a given level of drug costs would pay under the standard coverage in S. 1 and H.R. 1. For a given level of prescription drug expenses, a beneficiary's out-of-pocket payments will vary depending on each plan's deductible, coinsurance, coverage limit, and out-of-pocket maximum. The cost to the government of providing coverage will also vary depending on these plan characteristics as well as the premium charged to enrollees. More specifically, if a plan is designed to increase the beneficiary's share of the cost, the government's share of the cost will decrease.

Each of the following examples assumes that none the cost-sharing is paid by private insurance. The calculations do not consider reductions in expenditures due to negotiated discounts, the effects of formularies and pharmacy benefit managers (PBMs), or the consequences of incentives to use generic medications.

Example 1: Enrollee has zero annual drug costs

S. 1		H.R. 1	
Premium	$420	Premium	$420
Total payments	$420	Total payments	$420

In Example 1, the enrollee does not have any drug expenditures, and therefore would only pay the premiums.

Example 2: Enrollee's annual drug costs equal $50

S. 1		H.R. 1	
Deductible	$50	Deductible	$50
Premium	$420	Premium	$420
Total payments	$470	Total payments	$470

In the second example, the enrollee's annual drug expenditures equal $50. The $50 in drug costs fall below both of the plans' deductibles. Consequently, the enrollee pays the entire $50 plus the premiums under both proposals.

Example 3: Enrollee's annual drug costs equal $750

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $475[a])	$238	Coinsurance (= 20% of $500[b])	$100
Premium	$420	Premium	$420
Total payments	$933	Total payments	$770

[a] Equal to total drug expenditures ($750) minus the deductible ($275).
[b] Equal to total drug expenditures ($750) minus the deductible ($250).

In Example 3, the enrollee has $750 in total annual drug spending. This amount exceeds the deductibles proposed in both plans. Under S. 1, the enrollee's total prescription drug spending would exceed the deductible by $475. Thus, this enrollee would pay the premiums, the full $275 deductible and 50% of the $475 amount. In the case of H.R. 1, the enrollee's costs would exceed the deductible by $500. The enrollee would pay the premiums, the full $250 deductible and 20% of the $500 amount.

Example 4: Enrollee's annual drug costs equal $1,500

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $1,225[a])	$613	First coinsurance (= 20% of $1,250[a])	$250
Premium	$420	Premium	$420
Total payments	$1,308	Total payments	$920

[a] Equal to total drug expenditures ($1,500) minus the deductible.

The fourth example illustrates enrollee out-of-pocket spending when the enrollee's total drug costs equal $1,500. The proposals would work the same way in this example as in the previous example. Under S. 1, the enrollee would pay the premiums as well as the $275 deductible and 50% of expenses above the deductible. Under H.R. 1, the enrollee would pay the premiums, the $250 deductible and 20% of expenses above the deductible.

Example 5: Enrollee's annual drug costs equal $3,000

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $2,725[a])	$1,363	Coinsurance (= 20% of $1,750[b])	$350
		Expenditures above $2,000 coverage limit	$1,000
Premium	$420	Premium	$420
Total payments	$2,058	Total payments	$2,020

[a] Equal to total drug expenditures ($3,000) minus the deductible.
[b] Equal to the coverage limit ($2,000) minus the deductible ($250).

In Example 5, the enrollee's cumulative drug costs for the year equal $3,000.[14] Under S. 1, the enrollee's payments would be calculated in a similar manner to the previous two examples, resulting in total payments of $2,058.

Under H.R. 1, coverage would be limited to the first $2,000 of drug expenses. Thus, the $3,000 in expenses generated by the enrollee would exceed the initial coverage limit by $1,000. The enrollee would pay these excess expenses out-of-pocket. In total, the enrollee would pay the premiums as well as the following cost-sharing: (1) the $250 deductible; (2) 20% of $1,750, where $1,750 equals the difference between the deductible and the coverage limit of $2,000; and (3) those expenditures exceeding the initial coverage limit.

Example 6: Enrollee's annual drug costs equal $4,500

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $4,225[a])	$2,113	Coinsurance (= 20% of $1,750[b])	$350
		Expenditures above $2,000 coverage limit	$2,500
Premium	$420	Premium	$420
Total payments	$2,808	Total payments	$3,520

[a] Equal to total drug expenditures minus the deductible ($250). Total spending of $4,500 is the coverage limit for this plan. Thus, any additional prescription drug spending, up to the out-of-pocket maximum, would be paid for by the enrollee.
[b] Equal to the coverage limit ($2,000) minus the deductible ($250).

[14] CBO projects that in 2006, Medicare beneficiaries will spend an average of $3,155 annually on drugs

In Example 6, the enrollee's cumulative drug costs for the year equal $4,500. The enrollee's payments under these proposals would be calculated in a similar manner as in the previous example. Under S. 1, the beneficiary would pay $2,808 while under H.R. 1, the total out-of-pocket costs would be $3,520.

Example 7: Enrollee's annual drug costs equal $6,000

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $4,225[a])	$2,113	Coinsurance (= 20% of $1,750[b])	$350
Expenditures between $4,500 coverage limit and $5,813[c]	$1,312	Expenditures between $2,000 coverage limit and $4,900[d]	$2,900
10% of $187[e]	$19		
Premium	$420	Premium	$420
Total payments	$4,139	Total payments	$3,920

[a] Equal to coverage limit ($4,500) minus the deductible ($275).
[b] Equal to the coverage limit ($2,000) minus the deductible ($250).
[c] The level of cumulative expenditures at which enrollee spends $3,700 out-of-pocket is $5,813.
[d] The level of cumulative expenditures at which enrollee spends $3,500 out-of-pocket is $4,900.
[e] Equal to total drug expenditures ($6,000) minus $5,813.

Example 7 illustrates a situation in which an enrollee's payments exceed the bills' out-of-pocket maximums. H.R. 1 limits enrollee out-of-pocket payments (excluding premiums) to $3,500. In this example, the enrollee's cost-sharing would have otherwise exceeded this limit. With total drug expenses of $6,000, the enrollee would have paid $4,600, in cost-sharing (excluding premiums) without the plan's out-of-pocket maximum.[15] However, because $4,600 exceeds the plan's out-of-pocket limit, the enrollee would pay only $3,500 in cost-sharing for the year. With a $250 deductible, a 20% coinsurance rate up to $2,000 in total spending, and no coverage above the $2,000 coverage limit, an enrollee would reach the $3,500 limit on out-of-pocket payments once the enrollee's drug expenses exceeds $4,900 for the year. Thus, any enrollee with drug expenses above $4,900 per year would pay a total of $3,500 plus premiums under H.R. 1 (assuming all cost-sharing applies to the out-of-pocket maximum).

Under S. 1, an enrollee reaches the $3,700 out-of-pocket maximum once cumulative drug costs exceed $5,813 (assuming all cost-sharing applies to the out-of-pocket maximum) plus premiums. The enrollee would then pay 10% of all expenditures above that amount. In total, this enrollee would pay premiums, the $3,700 amount plus $19, which equals 10% of prescription drug expenditures above $5,813.

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[15] Without the out-of-pocket limit, the beneficiary would have to pay a $250 deductible, $350 in coinsurance up to coverage limit of $2,000, and the full $4,000 between $2,000 and $6,000 for a total of $4,600.

Example 8: Enrollee's annual drug costs equal $12,000

S. 1		H.R. 1	
Deductible	$275	Deductible	$250
Coinsurance (= 50% of $4,225[a])	$2,113	Coinsurance (= 20% of $1,750[b])	$350
Expenditures between $4,500 coverage limit and $5,813[c]	$1,312	Expenditures between $2,000 coverage limit and $4,900[d]	$2,900
10% of $6,187[e]	$619		
Premium	$420	Premium	$420
Total payments	$4,739	Total payments	$3,920

Note: Assumes all cost-sharing applies to the out-of-pocket maximum.

[a] Equal to coverage limit ($4,500) minus the deductible ($275).
[b] Equal to coverage limit ($2,000) minus the deductible ($250).
[c] The level of cumulative expenditures at which enrollee spends $3,700 out-of-pocket is $5,813.
[d] The level of cumulative expenditures at which enrollee spends $3,500 out-of-pocket is $4,900.
[e] Equal to total drug expenditures ($12,000) minus $5,813.

In Example 8, the enrollee's cumulative drug costs for the year equal $12,000. The enrollee's payments would be calculated in a similar manner as in the previous example. This enrollee would pay $4,739 under S. 1 and $3,920 under H.R. 1.

Comparing Beneficiary Out-of-Pocket Expenses

Beneficiaries receiving the standard benefit

Based on the out-of-pocket costs to Medicare beneficiaries, neither plan can be said to be more or less generous than the other for all beneficiaries. Out-of-pocket costs can be either higher or lower under S. 1 or H.R. 1, depending on an individual's total annual drug expenditures. **Figure 2** and **Figure 3** illustrate beneficiaries' out-of-pocket payments plus premiums at different levels of total drug spending, based on the cost-sharing requirements listed in **Table 1**. **Figure 2** displays total prescription drug spending up to $2,000, while **Figure 3** shows spending up to $12,000.[16] The figures assume that all cost-sharing applies to each plan's out-of-pocket maximum and does not account for the plans' reduced cost-sharing for low-income beneficiaries or, under H.R. 1, increased cost-sharing for high-income beneficiaries.

The structure of the benefit and cost-sharing in S. 1 and H.R. 1 produces many changes in coinsurance rates and out-of-pocket costs as total annual drug spending increases, as can be seen in the kinks and corners in the figures. For beneficiaries receiving the standard benefit, H.R. 1 requires less beneficiary out-of-pocket and

[16] CBO projects that 4.5% of beneficiaries will spend more than $12,000 on prescription drugs in 2006. See CBO, *March 2003 baseline projections*.

premium spending at levels of total drug spending between $250 and $3,100 and when spending exceeds $5,600. However, for individuals with total annual drug expenditures between $3,100 and $5,600, S. 1 would be less costly in out-of-pocket and premium spending.

Breakeven. The breakeven point is the point where the amount that an individual pays for a plan's cost-sharing and premiums is equal to what would have been paid in drug costs in the absence of any drug coverage. The line in the **Figure 2** and **Figure 3** labeled "No drug coverage" represents the amount that an individual would pay if he or she did not have any insurance coverage for prescription drugs. Where the lines representing out-of-pocket spending under S. 1 and H.R. 1 cross this line is the "breakeven point" of the respective plans. In the figures, line segments to the right of the "No drug coverage" line represent levels of drug spending where the enrollee pays *less* in out-of-pocket expenses and premiums than if they had no drug coverage; line segments to the left of this line represent levels of drug spending where the enrollee pays *more* in out-of-pocket expenses and premiums than if he or she had no drug coverage. Based on the premium and cost-sharing outlined in H.R. 1, the breakeven point is at $775 in total annual drug spending. Under S. 1, enrollees would receive more in benefits from the plan than if they lacked such coverage after spending $1,115 in prescription drugs. In 2006, 35% of seniors are expected to have less than $1,000 in annual drug expenditures.[17]

While the breakeven point is one factor in a beneficiary's decision whether to participate in this insurance plan, other factors, such as attitudes toward risk and uncertainty, are also important. Many beneficiaries will be making their decision about whether to purchase the insurance based on their expected annual prescription drug costs and their attitudes towards risk. All other things being equal, the higher the breakeven point, the less likely beneficiaries will be to join voluntarily.

Low-income beneficiaries

Comparing the cost-sharing of S. 1 and H.R. 1 for low-income beneficiaries' expenses below each bill's coverage limit is difficult because copayments are used under H.R. 1 rather than coinsurance. H.R. 1 proposes fixed copayments of $2 per prescription for generics and $5 per prescription for brand name products. To make a consistent comparison, data are needed about how the fixed copayments compare with the average cost of generic and brand-name prescription expected in 2006.[18] Based on data and projections from one of the largest pharmacy benefit management (PBM) companies in North America, a $2 copayment per generic prescription and a $5 copayment per brand name prescription imply an effective coinsurance rate of about 7% in 2006. Therefore, low-income beneficiaries who have not reached the coverage limit will have a higher average effective coinsurance rate under H.R. 1 (7%) than under S. 1 (2.5% or 5%, depending on the income category).

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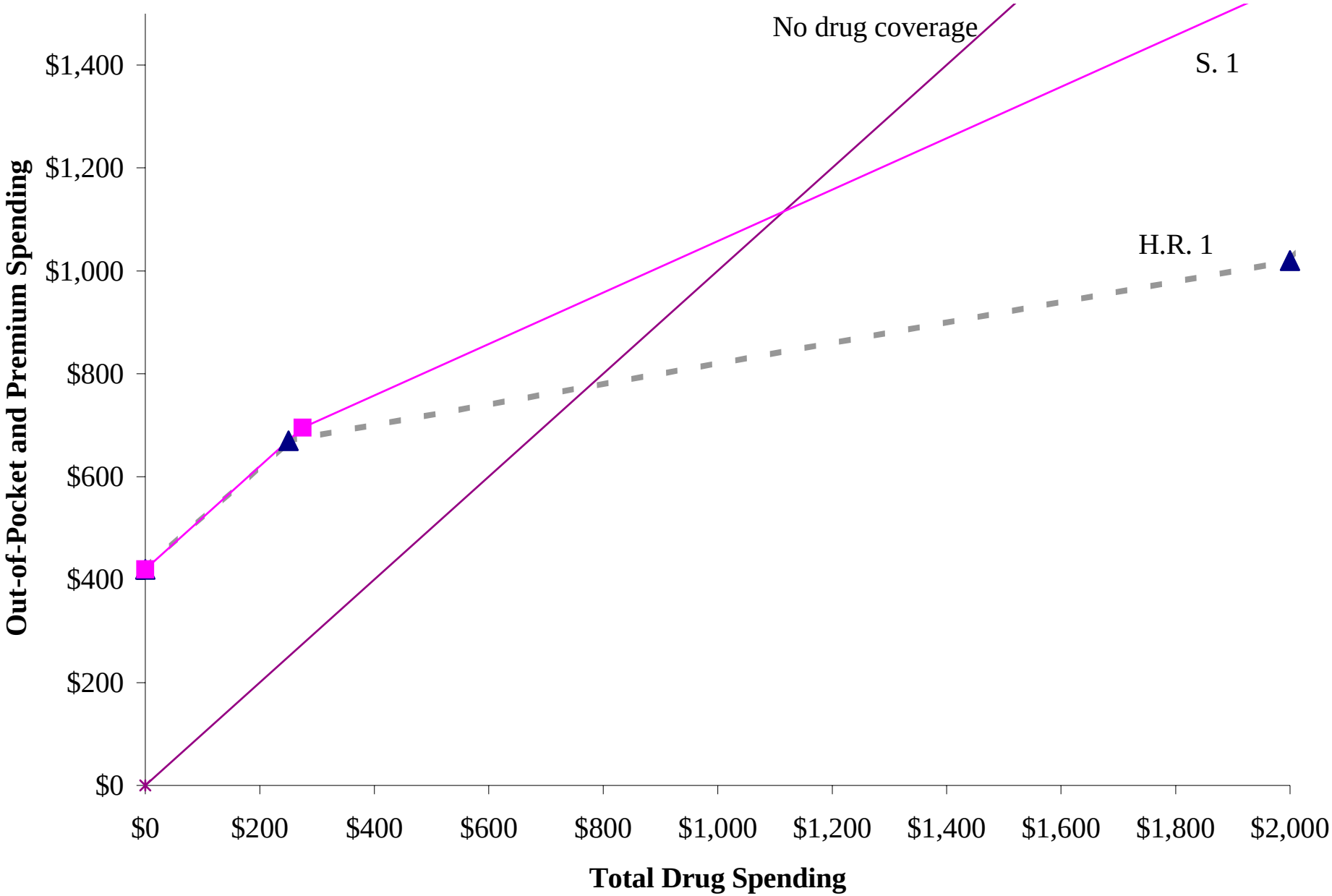
[17] Ibid.

[18] These figures can be highly variable and may change substantially with different data, years, and assumptions. For instance, in a year when a popular brand name goes off patent and generics enter the market, the market share of generics and the average cost of a prescription will change in response.

Standard coverage in both S. 1 and H.R. 1 includes a doughnut hole. Under S. 1, low-income beneficiaries are not responsible for all of the expenses in that range, although some cost-sharing is still required (5%, 10% or 20% coinsurance). In contrast, low-income beneficiaries under H.R. 1 would still face the doughnut hole, identical to the one in H.R. 1's standard benefit.

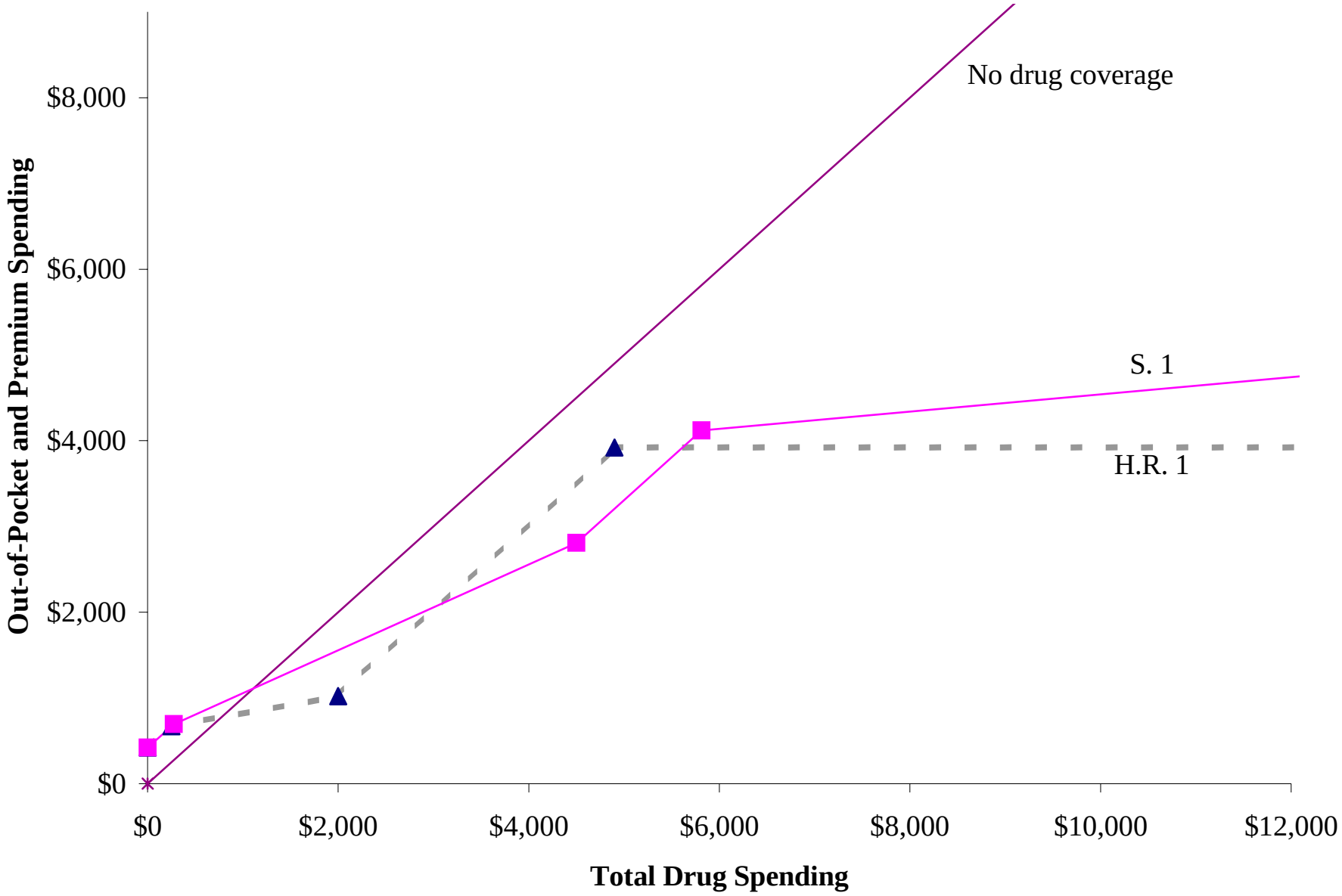
The absence of a "doughnut hole" combined with a lower effective coinsurance rate means that for many low-income Medicare beneficiaries, S. 1 would be more generous than H.R. 1.

Figure 2. Annual Out-of-Pocket and Premium Spending, by Total Drug Spending, Up to $2,000



Source: Congressional Research Service (CRS).
Note: The figure assumes that all cost-sharing applies to each plan's out-of-pocket maximum. The figure does not reflect the plans' reduced cost-sharing for low-income beneficiaries or, under H.R. 1, increased cost-sharing for high-income beneficiaries.

Figure 3. Annual Out-of-Pocket and Premium Spending, by Total Drug Spending, Up to $12,000



Source: Congressional Research Service (CRS).

Note: The figure assumes that all cost-sharing applies to each plan's out-of-pocket maximum. The figure does not reflect the plans' reduced cost-sharing for low-income beneficiaries or, under H.R. 1, increased cost-sharing for high-income beneficiaries.