

Prescription Drugs: Making Coverage Affordable for Medicare Beneficiaries

Presented by:

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**BlueCross BlueShield
Association**

*An Association of Independent
Blue Cross and Blue Shield Plans*

PRESCRIPTION DRUGS: MAKING COVERAGE AFFORDABLE FOR MEDICARE BENEFICIARIES

The benefits of the traditional Medicare fee-for-service program fall far short of coverage provided in most private sector health benefit plans today:

- Medicare does not cover costs associated with catastrophic illnesses: coverage for inpatient hospital care is limited to only 90 days per spell of illness (plus 60 lifetime reserve days) and there is no limit or cap on out-of-pocket spending for outpatient services; and
- There is no coverage for outpatient prescription drugs.

While Washington previously has debated addressing both coverage gaps, the current debate is focused on outpatient prescription drugs. Prescription drug therapies are increasingly important in treating disease and improving health status for older people, who are at high risk for chronic illness. The rationale is clear: the cost of outpatient prescription drugs is an increasing financial burden for seniors. The average Medicare beneficiary spent \$673 on drugs in 1996 (Poisal and Chulis, 2000).

How does 2000 stack up to previous debates? The political and financial environments appear ripe for action. There is bipartisan consensus that seniors need significant federal assistance with their prescription drug bills. And for the first time in a generation, the country now has a budget surplus -- with federal funds available for a major new benefit. Moreover, the Medicare trust fund -- while still expected to deplete its funds as the boomers retire -- is now expected to remain solvent until 2025 -- the brightest forecast in decades.

Even with this rosy scenario, enactment of a prescription drug benefit for Medicare beneficiaries may prove elusive. The biggest stumbling block: the skyrocketing cost of providing prescription drugs for older people. Prescription drug costs are growing at 15 to 18 percent annually, 4 times the growth rate of hospital and physician spending. The challenge facing the federal government is how to provide coverage for this needed benefit at a price that is affordable to seniors, without jeopardizing the financial stability of the overall program.

This paper provides the Blue perspective on this critical debate and addresses four areas:

- I. Overview: current coverage for Medicare beneficiaries
- II. Difficulty in addressing THE problem: rapidly increasing costs
- III. Discussion of Federal proposals
- IV. Blue Cross and Blue Shield Association recommendations.

As collectively the nation's leading insurer, the 48 Blue Cross and Blue Shield Plans are uniquely positioned to advise policymakers on designing a Medicare prescription drug benefit. We have extensive experience with:

- Private insurance – including prescription drug coverage -- insuring one of every four Americans;
- Medigap, as the leader in providing supplemental coverage including -- prescription drugs -- to Medicare beneficiaries;
- Medicare administration, handling the day-to-day operations of the traditional Medicare fee-for-service program under contracts with the Health Care Financing Administration;
- Medicare+Choice, providing private HMO coverage to over 1 million Medicare beneficiaries; and
- Federal Employee Health Benefits Program (FEHBP), underwriting and delivering health coverage to almost 4 million people, many of whom are retirement age.

I. OVERVIEW: CURRENT COVERAGE FOR MEDICARE ELIGIBLES

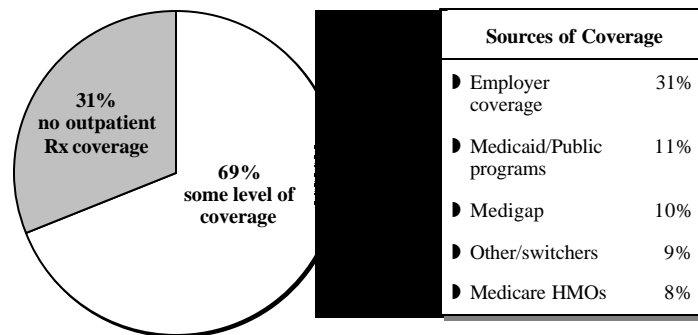
The extent of coverage for outpatient prescription drugs varies widely among America's seniors. Slightly more than one-third of the elderly report having no coverage at all.

The 69 percent of beneficiaries who have coverage either get it via their employer-based plan, Medicaid, Medigap, Medicare+Choice or other means.

Policymakers are particularly concerned because coverage for this benefit is declining.

69% of non-institutionalized Medicare beneficiaries
have some level of coverage for outpatient
prescription drugs

Non-Institutionalized Medicare Beneficiaries



1996: 37 Million Medicare Beneficiaries

Note: Data are based on non-institutionalized Medicare beneficiaries.
Poisal, J.A. and Chulis, G.S., *Health Affairs*, March/April 2000

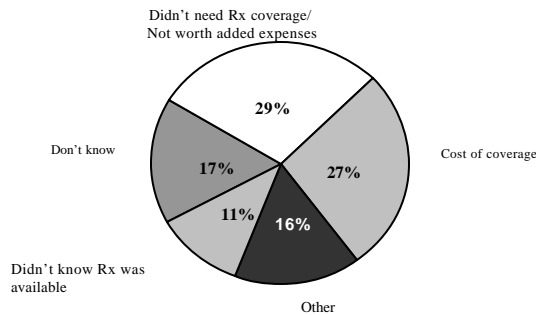
Between 1991 and 1996, the percentage of large employers offering retiree coverage

decreased from 92 percent to 87 percent. Among smaller employers, the rate dipped from 40 percent to 31 percent between 1993 and 1997 (Medicare Commission, HCFA).

It is important to note that lack of access to coverage is not the problem. While all Medicare beneficiaries have an opportunity to purchase a Medigap policy that covers outpatient prescription drugs at age 65, only 15 percent of them do so. BCBSA commissioned American ViewPoint (September 1999) to ask why. The American ViewPoint findings on why seniors did not buy private coverage: 27 percent cited the cost of coverage and 29 percent either felt that they did not need the coverage or it was not worth the added expense.

Many healthy seniors choose not to have drug coverage

What is the main reason you selected a Medigap plan without an Rx drug benefit?



Source: American Viewpoint Survey, September 1999

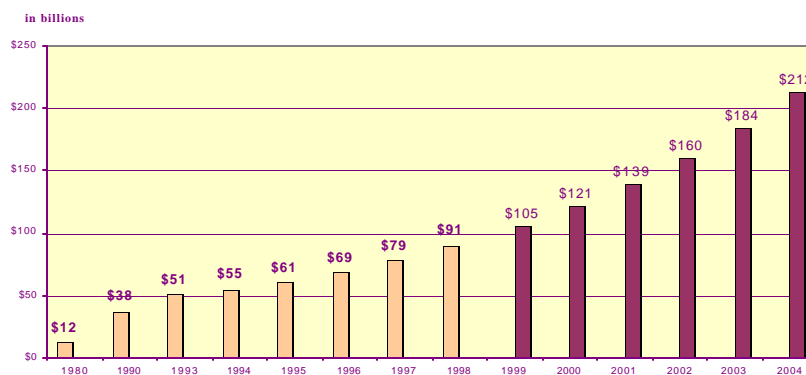
II. DIFFICULTY IN ADDRESSING THE PROBLEM: HIGH AND RAPIDLY INCREASING COSTS

The Trends

Prescription drug costs are increasing 15 to 18 percent per year -- four times faster than general health spending. Between 1993 and 1998, prescription drug expenditures grew 84 percent, from \$51 billion to \$91 billion.

This trend is expected to continue. An April 2000 study conducted by the University of Maryland (commissioned by BCBSA and the Health Insurance Association of America) estimated that total prescription drug expenditures would double between 1999 and 2004, growing from \$105 billion to \$212 billion.

Overall, Rx expenditures will increase 15-18% annually from 1999-2004



Source: The Impact of Pipeline Drugs on Pharmaceutical Spending, University of Maryland School of Pharmacy, 2000

For Blue Plans, these trends translate into an explosive growth in premium dollars spent on prescription drugs. Between 1993 and 1999, BCBS Plans' aggregate spending on outpatient drugs increased an estimated 92 percent, from \$7.6 billion to \$14.6 billion. Some Plans are experiencing even more rapid growth in annual pharmacy costs. For example, one BCBS Plan reported that payments rose by 26 percent in 1997 and 25 percent in 1998.

Other private insurers have experienced similar increases. In May 1999, the Employee Benefit Research Institute reported that private insurance payments for prescription drugs increased 18 percent in 1997, after growing 22 percent in 1995 and 19 percent in 1996. This growth in prescription drug payments compares with 4 percent or less annual growth in overall private payments for each of these three years.

Analysts estimate that prescription drugs now account for 11 to 14 percent of total medical expenses for most health plans, up from 7 percent just a few years ago. Spending is even higher for some plans, especially employer-sponsored health plans that

have a relatively larger retiree population. For some health plans, total spending for prescription drugs now exceeds spending for inpatient hospitalization. The Blue Cross and Blue Shield standard option plan under the Federal Employees Health Benefits Program, which covers a large number of retired workers, has prescription drug costs that are approaching 30 percent of total benefits.

Factors Contributing to Rapid Increase in Costs: High Cost of These New Drugs

These spending trends are being propelled by a number of forces. Some of the most important are described below.

Rapid Flow of New Drugs to Market; High Cost of these New Drugs

Over the past decade, the flow of new drugs to market has accelerated at a record pace. In assessing the flow of new technology, many analysts look to the annual number of new molecular entities (NMEs) approved by the Federal Drug Administration (FDA). By definition, NMEs are compounds that have never before been marketed in this country; some, but not all, represent clinical breakthroughs. From the early 1960s to the mid-1990s, the annual number of NMEs receiving FDA approval nearly doubled from an average of 14 in the 1960s to 26 in the first half of the 1990s. From 1996 to 1999, the annual average number rose again by about 50 percent to 39 per year.

Some of these new drugs are “breakthrough” products, which treat diseases and conditions for which no effective treatment currently exists. These breakthrough drugs are likely to bring valuable benefits to individuals and their families.

However, many of these new drugs are replacements for drugs already on the market. These new substitutes often differentiate themselves from existing older drugs by having less prevalent or less severe side effects, or easier dosing forms, and they are generally much more expensive than the drugs they replace. Replacement therapies are thus a major area of prescription drug spending.

Physicians tend to adopt such new drugs rapidly. For example, the University of Maryland study found that when a new pain reliever, Cox-2 inhibitors, came on the market in early 1999, the cost of treating patients increased by almost 50 percent, even though the number of prescriptions written for this category of drugs stayed the same. This spending increase can be attributed solely to the substitution of a much more expensive new drug, for an older, less expensive alternative for most patients.

And while direct-to-consumer advertising sends the message that Cox-II inhibitors are better than existing therapies, Cox-II inhibitors are not better at treating the symptoms of osteoarthritis or rheumatoid arthritis. They are not better at relieving pain or reducing inflammation. What they do is modestly lower the risk of gastrointestinal bleeding for those patients who are at high risk for a bleed. These high-risk patients represent only 2-5 percent of the population. Yet Cox-IIs make up 30 percent of all prescriptions for non-steroidal anti-inflammatory drugs. A lot of people are spending a lot more money, believing that they are getting a superior pain and inflammation-reliever. But there is no evidence to support their widespread use.

A 1999 Barents Group LLC report, commissioned by the National Institute for Health Care Management (NIHCM), provides additional data on the impact of newly approved drugs:

- Two-thirds of the increased spending from 1993 to 1998 (\$43 billion) was associated with new prescription drugs, approved by the Food and Drug Administration after 1991.
- By 1998, total spending for new drugs accounted for \$30 billion -- or 32 percent -- of retail drug expenditures even though they represented just 17 percent of all prescriptions.
- In 1998, the average price per prescription of a new drug was \$71.49 per prescription, compared with \$30.47 for older drugs. For some new drugs, however, the average price per prescription was three to seven times that of the older drug it replaced.

The University of Maryland study drew similar conclusions:

- Of the 15-18 percent annual expenditure increase in prescription drugs expected through 2004, 40 percent is attributed to drugs in the pipeline. The remaining 60 percent is attributable to expected increases in the price and use of existing drugs.
- Prescription drugs recently brought to market are much more likely to show a price increase: 70 percent of the most commonly used new drugs show an annual increase in price compared to only 3 percent of drugs already on the market.

This rapid increase in the number of new, expensive drugs on the market is expected to continue. Over the past two decades, the pharmaceutical industry and the federal government have made massive investments in research and development. And on the horizon, discoveries in genetics are expected to increase exponentially the number of targets for drug intervention in just a few years.

Given the significant increase in prescription drugs being approved for the market and the much higher cost of these new drugs, more information is needed to judge value, particularly the relative value of the replacement therapies. Consumers, physicians, government, employers, health plans, and hospitals need information to evaluate the relative benefits, risk and costs of these new treatments, compared to the benefits, risks and costs of alternative therapies.

Direct-to-Consumer Advertising of Prescription Drugs

Another factor contributing to increased costs is the greater utilization due to the explosion in direct-to-consumer (DTC) advertising. Since the FDA lifted its moratorium on DTC advertising in 1985, this form of promotion has become a significant market force. In 1991, pharmaceutical companies spent \$55 million to promote prescription products directly to consumers. By 1999, drug companies had increased their spending over 30-fold to \$1.8 billion, up 40 percent from 1998, according to IMS Health.

Is the advertising effective? According to the 1999 NIHCM study, the 10 most heavily promoted drugs in 1998 accounted for over a fifth (22 percent) of the total growth in

prescription drug expenditures from 1993 to 1998. In total, these 10 drugs had 1998 sales of \$11.2 billion – about 12 percent of all retail drug spending.

In addition to the costs of the drugs, the increased advertising is encouraging more visits to physicians. Although overall visits to physicians increased only 2 percent during the first half of 1998, visits related to heavily advertised drugs rose 11 to 19 percent, according to a 1998 Scott-Levin survey. Based on their 1999 survey of U.S. consumers, *Prevention* estimated that 25 percent of adults who saw a DTC ad began talking to physicians about health problems as a direct result of those ads.

The major consideration with this use-inducing advertising is safety. While the most heavily advertised drugs tend to be those widely used with minimal side effects, there most always are risks associated with drugs. Do consumers understand the risks associated with these heavily advertised drugs? DTC ads are not subject to mandatory review or approval by FDA. And the FDA's "fair balance" rule (which requires that DTC ads provide a balance of information on the benefits and the risks of the drug being advertised) does not require complete disclosure of risks by manufacturers. As a result, manufacturers can reduce the amount of risk information they provide in these ads by reducing the amount of benefit information they provide.

In a market that relies on competition – rather than price controls – a balance of information is critical to ensure fair pricing of prescription drugs. Today, the primary source of information on the value of prescription drug therapies is the manufacturers of these drugs. If a competitive market model for prescription drugs is to be successful, it is critical that all purchasers – consumers, physicians, employers, and health plans – have access to independent, clinically-sound information on the relative value of alternative, competing drug therapies.

Increases in Generic Drug Prices and Decreases in Use of Generic Drugs

Generic drugs are the chemical and therapeutic equivalent to brand name drugs. They are equal to brand drugs in terms of quality and effectiveness, but generally are significantly less expensive. While generic drugs are typically used to lower health care spending, the price of generic drugs has begun to increase as a result of consolidation in the industry. In fact, 1999 was the first time since 1992 that there was an increase rather than a decrease in the cost of generic drugs. While the impact is not as great as the other trends that we have highlighted, higher generic drug prices are contributing to overall higher prescription drug costs.

In addition, the market share of generic drugs has declined since 1996. Generic drugs comprised 42.5 percent of total prescriptions in 1996; by 1998, this percentage dropped to 41.3 percent. During the same time, the percentage of overall prescription drug sales attributable to generic drugs dropped markedly, from 12.2 percent in 1995 to only 8.6 percent in 1998. A major reason for this is that "we never get to generics." Rather, new, higher cost therapies are introduced to the market and are adopted rapidly, before the generic version of the older therapy even becomes available.

Demographic Trends

Finally, the aging of our country is contributing to increased drug spending. The number of Americans over age 65 is expected to mushroom from 38 million in 2000 to 75 million in 2050. The aging of the population is resulting in a dramatic rise in the number of people at risk for chronic and disabling diseases, which require prescription drug therapies -- often for multiple conditions.

III. STRATEGIES FOR MANAGING DRUG COSTS

A major responsibility of Blue Cross and Blue Shield Plans is to manage costs in order to keep the price of coverage affordable while ensuring that enrollees receive appropriate care and services -- so employers can afford to continue offering health benefits and so employees can afford to pay their share of the premium.

BCBS Plans use a range of strategies to achieve this objective with respect to pharmacy benefits. Some BCBS Plans contract with outside prescription benefit managers (PBMs) to perform claims processing, negotiate volume discounts on their behalf and oversee the retail distribution of drugs to their members. Others provide these management functions in-house, and a few BCBS Plans have created their own PBMs. Some of the most important strategies for managing drug benefits include:

Formulary Administration

Formularies are lists of drugs that health plans cover. Some Blue Cross and Blue Shield Plans maintain open formularies, which provide beneficiaries with broad access to all approved medications. However, many health plans are moving to selective formularies, which give certain drugs preferential status. BCBS Plans generally have avoided the use of so-called closed formularies, which limit coverage to drugs on an approved list without exception.

Most health plans develop formularies under the guidance of a pharmacy and therapeutics -- or P & T -- committee. P & T committees are comprised of pharmacists and physicians representing a range of clinical specialties. They evaluate available drugs on their clinical effectiveness, safety and cost before deciding which drugs will be given preferential status on the plan's formulary. Typically, P & T committees give preferred status to breakthrough drugs or those lacking effective alternatives, and to safe and effective drugs that cost less than other drugs in the same therapeutic class.

Preferred Provider Arrangements with Retail Pharmacies

Health plans also may negotiate discounts on pharmaceuticals by contracting with networks of retail pharmacies to become preferred providers in their geographic area. In general, networks will provide higher discounts in exchange for greater exclusivity (i.e., more volume). However, reducing network participation may limit beneficiaries access to pharmacies. Hence, health plans must make a trade-off between providing their

members with convenient access to retail outlets and reducing costs. Some plans offer mail order pharmacies to obtain volume discounts and provide financial incentives (e.g., eliminating front-end deductibles) to encourage their members to use them.

The recent emergence of Internet pharmacies may pose a challenge to the level of discounts negotiated with preferred provider networks. Most plans have arrangements to reimburse members who purchase drugs outside preferred networks (e.g., in an emergency or when they travel). However, the Internet provides consumers with access to Web sites from which they can obtain prescriptions for popular drugs, such as Viagra (Pfizer's drug to treat impotence), simply by filling out an online questionnaire and paying a fee. Consumers may then visit an online pharmacy to have the prescription filled and be reimbursed by their health plans. Enrollees' use of Internet pharmacies also creates a challenge for health plans in ensuring that their enrolled populations use drugs safely and appropriately. This challenge arises because the physicians and pharmacies that participate in this online drug distribution system may lack appropriate credentials and may operate beyond the reach of traditional regulatory safeguards.

Three-Tier Copayment Designs: Achieving Value in Drug Therapy

BCBS and other health plans have begun recently to structure financial incentives so that enrollees make cost effective drug purchases from a wide range of choices. Many plans are implementing tiered-copayment programs. Under these programs, plan members have more choices available to them than they would under more traditional benefit designs, but they pay a higher share of the cost of expensive drugs that have safe and effective, but less costly, alternatives. The intent is to encourage members to use drugs that are both clinically efficacious and cost effective.

Three-tiered structures, which classify drugs into three categories with differing levels of copayment, are new, but have had almost instant popularity because of the choice they offer plan enrollees. Nearly half of employers intent to use three-tiered copays in 2000 to keep drug costs down, according to the Fifth Annual Survey on Purchasing Value in Health Care, conducted by Watson Wyatt Worldwide, the Washington Business Group on Health and the Healthcare Financial Management Association.

For example, one BCBS Plan recently established the three-part classification shown below. Tier 1, consisting of generic drugs, has the lowest copayment. Tier 2 contains branded drugs that are clinically effective, cost effective, and meet the needs of most patients. These drugs require a moderate copayment. Tier 3 drugs, with the highest copayment, generally include branded drugs with a generic equivalent or branded therapeutic equivalent in Tier 2.

An Example of Prescription Drug Tier Definitions and Copayments

Tier 1	Tier 2	Tier 3
All generic drugs	Preferred brand drugs	Non-preferred brand drugs
	Brand name drugs that are clinically effective, cost-effective and meet the needs of most patients.	Brand name drugs that have a generic equivalent or a therapeutic alternative available in Tier 2.
		Brand name drugs not usually used as the first line of treatment.
Lowest copayment	Second lowest copayment	Highest copayment

Health plans that use 3-tier programs set their copayment structure using one of two approaches. Some plans require a fixed dollar copayment that varies by tier. Other plans prefer to use different percentages of coinsurance for tiers 1, 2 and 3.

Clearly, tiered cost sharing will be most effective in controlling costs in situations where generic drugs or less expensive branded alternatives exist. However, they will have little impact on the spending associated with breakthrough technology. The goal is to target multi-brand therapeutic classes of drugs or new drugs that are replacing existing therapies, and to evaluate the evidence available regarding the efficacy, safety, and uniqueness of the multi-brand or replacement therapy drug.

To ensure value purchasing by health plans and consumers, much more research is needed to understand the comparative costs, benefits, and risks of drugs and other therapies, that treat the same condition. With this information, consumers, providers and health plans will be able to make better decisions about which therapies provide the most value for the health care dollar.

Ironically, some policymakers, at both the state and federal level, support proposals that would undermine this important incentive for all purchasers to pursue value. For example, the federal “Patients’ Bill of Rights” legislation that is now in conference includes a provision that could force health plans that have 3-tier copayment structures to cover tier 3 drugs at tier 1 or 2 copayment levels. This provision would undermine a strategy that has the best hope for assuring consumers a wide range of choices by providing all purchasers the incentive to examine whether a large additional cost is worth the added benefit of a higher-tier drug (e.g., minimally reduced side effects).

With respect to Medicare beneficiaries, the ability of insurers to use tools like 3-tier copays to manage the skyrocketing costs of prescription drug coverage may mean the difference between employers providing drug benefits to their retired employees or not, or the program being able to afford a new benefit.

If legislative efforts prevent use of these strategies – which preserve consumer choice while promoting cost-effective prescription drug use -- we risk two undesirable consequences for the general population. First, further unconstrained growth in pharmacy costs risks having private employer-sponsored plans drop prescription drug coverage entirely. Second, we risk a return to more draconian efforts to rein in run-away prescription drug spending, such as tight limits on the therapeutic categories of drugs that will be covered, caps on the amount of prescription drug spending that will be covered, and/or increased cost-shifting to consumers in the form of higher copayments or coinsurance.

III. FEDERAL PROPOSALS

In this environment of rapidly escalating prescription drug expenditures and newly evolving strategies for managing these costs, Congress is debating the issue of providing prescription drug coverage to Medicare beneficiaries. There are essentially four approaches under consideration:

- 1) **Integrating prescription drug coverage as part of comprehensive Medicare reform.** Many believe that the addition of this new benefit would make most sense in the context of larger, comprehensive program reform. The intent of overall reform is to ensure solid financial footing for Medicare for the foreseeable future, relying heavily on expanded private sector participation. While the financial position of the Medicare trust fund has improved significantly, Medicare is still projected to become insolvent, as the baby boomers retire. Many are concerned that adding the fastest growing health care benefit to Medicare in the absence of comprehensive reform could further strain the trust fund and jeopardize Medicare's current benefits. As prescription drugs become a more important component of health care treatment, it is essential to integrate their coverage and thus the management of prescription drug use into an overall medical management model.

However, the political reality is that such fundamental reform is unlikely this year, and the momentum for action on prescription drugs is intense. As a result, drug coverage for Medicare beneficiaries is being considered outside the context of larger Medicare reform.

- 2) **Adding a drug benefit to the current Medicare program.** The President has proposed adding a new voluntary, Medicare Part D program to provide coverage of prescription drugs for all beneficiaries. Medicare would pay half the cost of drugs up to a maximum amount of \$1,000 in 2002, increasing to \$2,500 by 2008. The cost of the program would be equally financed through new beneficiary premiums and general revenues. Subsidies would be available for the low income. Private contractors, selected through a competitive bidding process, would administer the program. While originally proposed as part of the President's overall Medicare reform plan, the Administration has most recently been urging Congress to separately adopt the Part D program this year.

The President's proposal has the advantage of ensuring coverage for all Medicare beneficiaries, consistent with the social insurance nature of the overall program. By using prescription benefit managers (PBM) to administer the program, the intent is to make drugs more affordable by giving beneficiaries access to private sector cost management strategies and discounts.

Some have questioned whether, with drug expenditures rising so rapidly, the federal government will be willing and able to finance the program adequately over the long term. The Administration originally estimated a cost of \$118 billion over 10 years, only to increase those estimates to \$160 billion a few months later. However, even the higher estimate uses substantially lower annual growth rates than the projected 15 to 18 percent estimated by the University of Maryland study.

Given the difficulty of accurately predicting drug costs, some argue that federal funding shortfalls are unavoidable and would result in reductions in current benefits. In addition, while the private contractors in theory would manage program costs, much as PBMs do in the private sector, many believe that these new entities would be precluded from using the same kinds of cost management strategies adopted by the private sector and would be able to do little more than process bills. For example, would federal policymakers allow a PBM in California to implement an entirely different formulary than a PBM in New York? Both Congress and the Administration are likely to pursue a policy that the drug benefit be uniform for all beneficiaries; to date, uniformity has been a political imperative of the Medicare program.

The pharmaceutical manufacturers who have a keen interest in this proposal oppose adding a drug benefit to the existing Medicare program because they believe the government will inevitably turn to price controls to address rising prescription drug expenditures. Such price controls, if imposed, could impact private sector pharmaceutical expenditures as well. Manufacturers, seeking to recoup losses in the Medicare program, would shift costs to private payers. This cost shift would make drug coverage that much less affordable to the private sector.

- 3) **Providing federal subsidies to private insurance policies that would include only prescription drug coverage.** Some Members of Congress and some pharmaceutical manufacturers are proposing federal subsidies to encourage a new Medigap-type private insurance policy which would cover only prescription drugs. Subsidies would be provided for low-income beneficiaries and, possibly, for individuals with high drug expenses.

Proponents view this plan as a way to use private competition to increase access to and affordability of drugs for Medicare beneficiaries, and to avoid price controls. Blue Cross and Blue Shield Plans have been vocal in their belief that it will not be possible to offer a stand-alone prescription drug policy to Medicare beneficiaries. The issue: affordability. It simply is not possible to design a drug-only insurance policy for older people that would be affordable.

The absolute cost of and annual rate of increase in the cost of prescription drugs would make a drug-only benefit package so expensive that only those who expect to have very high drug costs would be likely to purchase such a policy. With drug spending projected to double over the next five years, the large annual price increases would result in a significant number of relatively healthier enrollees examining the cost of their coverage and dropping their policies each year. This adverse selection (concentration of higher risks), in turn, would lead to even higher prices for those who remain. This spiral would continue each year, resulting in premium levels and increases that would infuriate seniors and would leave more and more seniors without coverage.

Sizeable Federal subsidies would not eliminate these inherent risk selection problems. No matter how small the dollar amount left for the insurer to underwrite, if it is increasing annually in the range of 15 to 20 percent, it would lead quickly to unmanageable adverse selection. Moreover, a subsidy would entail a number of difficult administrative issues: How would eligibility be determined? A significant proportion of Medicare beneficiaries do not even file tax returns. How would the subsidy be calculated? Would the subsidy be tied to the premium charged, which would vary greatly by geographic and age factors, or would it be a set dollar amount? And, given expected rates of increase in spending on prescription drugs, is it realistic to expect that the real value of the subsidy would stay constant over time?

- 4) Establishing state grant programs targeted to provide coverage to low-income seniors.** Finally, there are those who propose targeting drug coverage to low-income seniors to ensure that the most vulnerable seniors have protection against the high cost of prescription drugs.

Proponents believe that targeting the low-income would be a good first step in providing affordable prescription drug coverage to seniors. Medicare beneficiaries in the 135-200 percent of poverty range have the highest out-of-pocket costs for prescription drugs. By covering all seniors with incomes below 200 percent of poverty, nearly two-thirds of all seniors who currently lack prescription drug coverage would be helped.

Fourteen states already have successful prescription drug assistance programs in place, and 18 others are considering following suit. This strategy could be implemented quickly and with relative ease, since states have the infrastructures and expertise in place to move forward. However, if this approach is to be effective, the federal government must fully fund the program

Critics of this approach say that any plan should be available to **all** Medicare beneficiaries and should be consistent with plans to comprehensively reform the overall program. Importantly, states are particularly concerned that funding responsibility would be shifted to the states as drug costs continue to explode.

IV. BCBSA RECOMMENDATIONS

The Blue Cross and Blue Shield Association believes that providing access to affordable prescription drug coverage for seniors is critical. We recommend adoption of a five-part strategy.

- 1) **Examine and Revise Federal Policies Contributing to Escalating Drug Costs:** BCBSA believes that a vigorous competitive market – rather than price controls – is the best way to improve the affordability of prescriptions. To ensure vigorous competition, however, the United States will have to eliminate any market protections that do not have a clear benefit for consumers and will need to foster actions that promote competition.

Ideally, before the federal government subsidizes prescription drug costs for Medicare beneficiaries, the government would conduct a careful review of the vast array of prescription drug policies throughout the federal government to identify those areas that contribute to accelerating drug costs. This review should recommend appropriate regulatory or legislative policy changes in such areas as:

- Current and proposed legislative initiatives to extend market protections (patent and market exclusivity protections) for prescription drugs.
- Whether, and in which cases, federally subsidized research should be made available to private pharmaceutical companies to develop prescription drugs with no economic advantages to the federal government (i.e., taxpayers).
- Patent extensions for individual drugs, such as the legislation now pending before Congress that would extend the patent for Claritin. Granting Claritin a 3-year patent extension would cost consumers up to \$5.3 billion from 2002 to 2007, according to researcher Stephen Schondelmeyer.
- Provisions in the “Patient Bill of Rights” legislation that would gut the ability of private plans to control rising costs in the private sector, including retiree programs.
- The current rules governing the designation of drugs as a prescription or over-the-counter and the movement between these designations.
- The requirement that any private sector negotiated rate (generally based on use of a formulary) be automatically made available to Medicaid -- the so-called “best price” requirement.

- 2) **Support the Focus of All Purchasers on Prescription Drug Value:** It is critical that consumers, clinicians, government and private payers have information to make wise choices, and to assure that scarce health care dollars are not spent for drugs that are high cost alternatives to equally effective, existing drugs. The federal government should support efforts of independent private sector entities to evaluate the relative value of competing new drug therapies, and should:

- Support research to assure that consumers, physicians, and purchasers have adequate information to evaluate the value of prescription drugs (e.g., the benefits, risks, cost of a drug) and the relative value of alternative therapies.

- Ensure that direct-to-consumer advertising is accompanied by clear and understandable information for consumers of the risk of the prescription drug advertised and that sources exist for consumers and physicians to obtain unbiased information on the cost of advertised drugs, and the benefit, risk and cost of alternative drug therapies (prescription or over-the-counter).

These steps are needed to ensure that we, as a country, are not using scarce health care dollars on prescription drugs that are: of no therapeutic value in the case used; a high cost alternative to equally effective, lower-cost alternatives; or used in a manner that is inappropriate or unsafe.

- 3) **Congress Should Comprehensively Reform Medicare:** BCBSA supports comprehensive reform of the Medicare program to assure the program will remain financially stable and secure to serve both current and future beneficiaries. We believe Congress should provide coverage for prescription drug as an integrated benefit in the options envisioned under comprehensive program reform.
- 4) **Interim Step: Stage Coverage and Focus on Most Vulnerable:** If comprehensive reform is not feasible this year, an effective interim step would be target assistance to those seniors who have the greatest need. Ideally, we would recommend establishing a Federal program for low-income Medicare beneficiaries. However, the reality is that the administrative infrastructure and resources do not now exist at the Federal level for income eligibility determinations for Medicare beneficiaries.

The most practical solution would be to provide full Federal funding to states to subsidize pharmacy costs for low-income Medicare beneficiaries. As noted earlier, a number of states have already implemented targeted pharmacy assistance programs. Federal funding would allow these states to expand their programs and allow the remaining states to implement similar programs.

- 5) **Improve the Medicare+Choice program.** By enhancing and stabilizing funding and providing Medicare+Choice plans regulatory relief, more plans are likely to stay in the program and continue to provide prescription drug coverage to seniors at an affordable price. Improving the Medicare+Choice program is critical; it is the foundation of any broader private sector-based reform. Not only would a continued departure of plans from the program bode ill for reform, but continued turbulence in the Medicare+Choice program might turn many Medicare beneficiaries against any private-sector based reform.

CONCLUSION

Making drug coverage affordable to our customers continues to be one of the most difficult challenges facing BCBS Plans. As the cost of prescription drugs continue to rise at 15 to 18 percent per year, Plans are continuing to develop a range of techniques to offer customers choice while focusing on the relative value of drug therapies. We encourage all parties to support this approach; the alternative is less access to prescription drugs in the private sector.

BCBSA supports providing affordable prescription drug coverage for seniors. As policymakers debate providing coverage to Medicare beneficiaries, it is critical that all stakeholders review carefully the factors that are fueling the explosion in drug spending and the Federal government take appropriate action to limit those factors under its control. Policymakers also should ensure that any approaches to providing needed prescription drug coverage support value based purchasing. This is the only way we can be sure that scarce federal resources are used appropriately.

