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The Shrinking Medicare Part D Benefit

Mark Duggan, Patrick Healy, and Fiona Scott Morton provided an exhaustive description of the Medicare Part D pharmaceutical benefit in "Providing Prescription Drug Coverage to the Elderly: America's Experiment with Medicare Part D" (Fall 2008, pp. 69–92). Like all other accounts of the Part D that I have seen, however, it does not assess how the program's unique use of inflation-adjustments will influence the value of Part D benefits over the long term.

Unlike other social insurance programs, Part D annually adjusts its benefits to shield the *government* from the effects of inflation; this is the opposite strategy of both Social Security and Medicare Part B, the benefits of which *increase* over time to keep the value to beneficiaries more or less stable. But the government actually *reduces* the value of Part D (adjusted for Social Security income) from year to year as the government adjusts deductibles, copayments, and the size of the "doughnut hole" for medical inflation.

For example, the limitation on out-of-pocket payments in Medicare Part D policies is indexed to the pharmaceutical inflation rate, a rate that in recent years has been about twice the average rise in the Consumer Price Index. Each year, the government also prospectively adjusts Part D deductibles, copayments, and out-of-pocket limitations, in line with overall pharmaceutical cost inflation—rather than the increase or decrease in actual plan costs. Therefore, deductibles for 2009 were increased 6.5 percent from the preceding year, even though Social Security increased only 5.8 percent and per beneficiary costs in the program *decreased* 0.4 percent. For 2010, the U.S. Department of Health and Human Services (HHS) lifted deductibles, cost limitations, and out-of-pocket thresholds by 3.5 percent, which is *greater* than prescription drug inflation, which has been hovering between 1.5 and 2.5 percent. If expenditures per beneficiary have been flat at a little more than $1,500 per enrollee since the program began in 2006 (even as the Consumer Price Index for All Urban Consumers (CPI-U) for prescription drugs has risen nearly 8 percent), it probably has more to do with the HHS actuaries' management of deductibles, copayments, and out-of-pocket limitations than any "market mechanisms" at work in the Part D program.

Moreover, 2009 was an unusual year. Typical Social Security cost-of-living adjustments hover around the rate of inflation, and therefore the 5.8 percent increase for Social Security payments in 2009 won't likely be repeated any time soon. But long-term projections for pharmaceutical prices typically peg the long-term drug inflation rate at more than 6 percent, or about three percentage points per year above the inflation rate. Over a period of 5–10 years, these changes will substantially erode the value of Medicare Part D benefits.

The program does cap the maximum gains in out-of-pocket costs if program costs rise faster than general pharmaceutical inflation. But out-of-pocket costs will still outpace Social Security incomes even if program cost inflation is only equal to overall pharmaceutical inflation. The only chance that income-adjusted benefits will remain affordable is if either medical inflation

or Part D program cost growth fall to the rate of income growth. Otherwise, bias in the adjustment of deductibles and copays relative to actual costs works against the interest of the beneficiaries, leaving them with a forever shrinking benefit.

These observations are restricted to the benchmark Part D insurance policy, whose terms are set annually by the government. Private insurance providers are allowed to offer different terms. However, if the economic value of the privately designed plans must still reflect that of the official plan (in the language of the legislation, they must maintain approximate "actuarial equivalence") then the private plans must also gradually increase in price through higher premiums to beneficiaries, or decrease in value.

There are at least two basic strategies for improving the Part D benefit. The easiest fix would be to convert Part D into a premium support program. Instead of the current opportunity to buy insurance, beneficiaries would receive a credit equal to the current per beneficiary benefit of about $2,000 that could be used to buy drug insurance. This amount would be indexed to match changes in per beneficiary program costs, including out-of-pocket expenses and premiums. The value of the benefit would then rise with program cost inflation in a straightforward manner. Insurers would have an incentive to keep premiums and out-of-pocket costs down in order to fit into the beneficiary's budget and so retain an incentive to pass the benefit of rebates or price reductions to the beneficiary rather than the government.

Another option would be to spend more on developing better tools for beneficiaries to find the best policy for them as individuals given their age, health history, prior pharmaceutical use, and other personal factors. Such a software package could sort through the hundreds of plans available to the beneficiaries and determine the right plan and the right premium to pay given the beneficiaries' expected income, health costs, preferences for formularies, and availability of cheap alternative drugs. This step would seek to assure that beneficiaries would at least be paying the correct price for drug insurance even if their ability to pay the whole tab were increasingly challenged by the quirks of the incredible shrinking Part D benefit. Medicare might even benefit by paying a few thousand beneficiaries to be highly active shoppers, acting methodically to reward insurers who keep costs down.

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