EXPLAINER | CONGRESSIONAL PROGRESSIVE CAUCUS CENTER

Medicare Provisions in Build Back Better

Last Updated September 30, 2021

The Medicare program provides 63.1 million Americans with coverage for medical services, hospitalizations, and physician care. Despite the significance of preventative care for older adults, many seniors do not have comprehensive coverage for dental, vision, and hearing benefits, which leads to lack of access to the critical care needed to allow seniors to live healthy lives. As Congress considers adding coverage for these services along with proposals to reduce rising prescription drug costs in the Build Back Better package, lawmakers have a unique opportunity to make historic investments in improving access to care. Extending health coverage in the Medicare program could also mean that broader Medicare expansion efforts, like Medicare for All, have a brighter path forward.

Brief History of Medicare

In 1965, President Lyndon B. Johnson signed the Social Security Act Amendments into law, which created two national health insurance programs--Medicare and Medicaid. The Medicare program was a basic insurance plan for seniors to protect against the costs of hospital care and physician-related services. Prior to its implementation, only about half of those aged 65 and over had some type of health insurance, and private insurance companies frequently terminated health policies for elderly persons in the high risk category to drive down costs.[1] In the first year of establishment, Medicare consisted of two primary health insurance options--a hospital insurance plan (known as Part A) and a medical insurance plan for physician services (known as Part B). In 1997, optional Medicare coverage was expanded to the private market through Medicare Part C (known as Medicare Advantage), which allowed enrollees to access additional benefits like prescription drug coverage. In 2003, a stand-alone optional prescription drug benefit was added (Part D), expanding prescription coverage through private insurance companies.

Unlike traditional Medicare, which is administered by the Centers for Medicare and Medicaid Services (CMS), both part C and part D are administered through private insurers who contract with the federal government. This leads to a number of issues in the delivery of services to seniors. Medicare Advantage plans have restrictive provider networks, frequently issue inappropriate coverage denials and prior authorization barriers, and deceitfully "upcode" services to increase reimbursement. The use of private insurers to deliver prescription drug coverage in Medicare Part D also drives up costs and produces limited savings on drug prices.[2]

---

[1] Social Security Administration. *Social Security History* https://www.ssa.gov/history/ssa/lbjmedicare1.html
[2] Way, W. L. & Mayer, F. S. (2008). *Failures of Medicare Part D Delivery and Recommendations for Improvement* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2730081/

When Medicare Part D was initially implemented, there was a built-in gap in coverage referred to as the "donut hole." This coverage gap meant that after drug costs exceeded the initial coverage limit, seniors had to pay the full cost of their prescription drugs until their total costs qualified them for catastrophic coverage, resulting in some seniors splitting pills or skipping doses. With the enactment of the Affordable Care Act and changes made by the Bipartisan Budget Act of 2018, the coverage gap was phased out (though not entirely eliminated) for both brand-name and generic drugs. Nevertheless, medication affordability still remains an issue for Medicare beneficiaries, along with gaps in supplemental coverage. To address these issues, in 2019 House Democrats passed the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), which aimed to rein in Part D drug costs and allow the federal government to negotiate drug prices. Additionally, H.R. 3 made Medicare-negotiated drug prices available to commercial and individual marketplace insurance plans. The measure also made a number of improvements to Medicare programs for lower income individuals and expanded dental, vision, and hearing benefits. H.R. 3 passed the House by a vote of 230 - 192 and with unanimous support of Democrats participating in the vote, yet was not taken up by the Senate. As budget reconciliation negotiations continue, it will be important for lawmakers to address long-standing issues in Medicare coverage and prescription drug affordability by building off of H.R. 3 in the Build Back Better package.

Congressional State of Play

Covering Dental, Vision, and Hearing

Traditional Medicare coverage provides limited dental, vision, and hearing services. Those who are enrolled in private Medicare Advantage (MA) plans may receive these services as supplementary benefits or beneficiaries can purchase standalone coverage, which can be costly. In fact, a number of MA enrollees with supplemental coverage pay extremely high out of pocket costs--65% vision, 76% dental, and 79% hearing cost sharing obligations.[3] The absence of this coverage for all beneficiaries has direct implications for the overall health and wellbeing of seniors, who are often more likely to experience serious health complications as a result of foregoing preventative services. To address this issue, Democratic lawmakers have included coverage for all three benefit programs in the reconciliation package, to be administered under Medicare Part B.

Both the House Energy and Commerce proposal and the Ways and Means proposal outline a process for adding a dental benefit to Medicare. Beginning January 1, 2028, Medicare would provide coverage for preventive and screening services as well as basic services up to 80%. "Preventive and screening services" would include: oral exams, dental cleanings, dental x-rays, and fluoride treatments. Basic treatments would include: tooth restorations, basic periodontal services, tooth extractions, and oral disease management services. For major restorative

[3] Katch, H., & Van De Water, P. (2020) M*edicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits*
https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits#_ftn2

services, Medicare would cover 10% of costs for the first year, increasing annually each year until benefit coverage fully phases in, reaching 50% in 2032. “Major treatments” would be defined as major tooth restorations, major periodontal services, bridges, crowns, and root canals. Medicare would also cover two dental cleanings annually as well as a full or partial set of dentures once every five years.

For hearing coverage, Democrats’ proposal would extend this benefit under Medicare Part B beginning October 1, 2023. Medicare would provide payment for seniors with “severe or profound” hearing loss in one or both ears once every five years.

Proposals in Congress to expand the vision benefit would aim to establish coverage beginning October 1, 2022. Upon this date, Medicare would begin to cover one routine eye exam annually as well as one eyeglass or contact fitting service every two years. Beneficiaries would be responsible for 20% of the cost-sharing from these services. Medicare would also cover either one pair of eyeglasses and lenses or contact lenses up to $85 every two years. Expanding Medicare vision coverage could help seniors like Diane gain access to affordable eye exams and eyeglasses.

Build Back Better Spotlight: Diane's Story

Lowering Drug Costs

Under the Medicare Part D program, Medicare contracts with private plans to provide a prescription drug benefit to beneficiaries. When the Medicare Modernization Act establishing Part D coverage went into effect in 2006, it included a “noninterference” clause, prohibiting the Health and Human Services (HHS) Secretary from negotiating the price of drugs in Medicare. This approach directly contrasts with that of other federal drug programs, which use rebate models (Medicaid) and minimum discounts and ceiling prices (Department of Veterans Affairs).[4] As drug prices for seniors continue to outpace inflation, lawmakers have begun to take a direct look at ways in which prescription costs can be reduced.

House Ways and Means Committee

Building off of drug spending provisions in H.R. 3, the House Ways and Means proposal establishes a “Fair Negotiation Program” that would begin in 2025. This program would authorize the HHS Secretary to identify the 125 single-source covered Part D drugs which account for the greatest Part C and Part D net spending and the 125 single-source drugs which account for the greatest net spending in the United States and allow for direct negotiations of at least 25 drugs from this list in the first year, and 50 drugs in the years following.[5] The Secretary

---

[4] Cubanski, J., Neuman T., & Freed, M. (2021) *What’s the Latest on Medicare Drug Price Negotiations?* https://www.kff.org/medicare/issue-brief/whats-the-latest-on-medicare-drug-price-negotiations/

[5] In addition to these categories of negotiation-eligible drugs which may be selected for negotiation, the Secretary is also required to select for negotiations insulin products and “new-entrant negotiation-eligible drugs”, which are new to the market and do not yet have sales data but projected to be

would be required to negotiate with manufacturers to determine the “maximum fair price,” or upper limit based on international reference pricing. Specifically, the legislation would set drug costs to no more than 120% of the average international market price (AIM) for the same drug offered in a reference group of six countries: Australia, Canada, France, Germany, Japan, and the United Kingdom. US drug prices are nearly four times the average price in comparator countries.[6] To ensure compliance with the negotiation process, drug manufacturers would be subject to an escalating tax on the sale of the drug in question. Once a maximum fair price is established through negotiations, drug corporations failing to provide a price that is no greater than that amount to eligible payers and beneficiaries would face a civil money penalty worth 10 times the amount in excess of the maximum fair price.

This drug proposal also establishes mandatory rebate rules under Medicare Part B and D should a drug manufacturer raise prices beyond the rate of inflation. An analysis into the share of drugs that accounted for Medicare Part B and Part D spending in 2019 found that the top-selling 250 drugs in Medicare Part D without competition accounted for 60% of net total Part D spending. Similarly, the top 50 drugs covered under Medicare Part B accounted for 80% of total Part B drug spending.[7] Other major provisions included in the legislation would establish an out-of-pocket maximum of $2,000 for Part D enrollees, and a permanent roll back of a Trump-era rebate rule that Congress temporarily delayed, which the Congressional Budget Office (CBO) found would cost Medicare and Medicaid nearly $180 billion. The proposed measure outlines that negotiation and rebates would be extended to the commercial market for individual and group health plans as well, which provide coverage to about 69% of the US population.

---

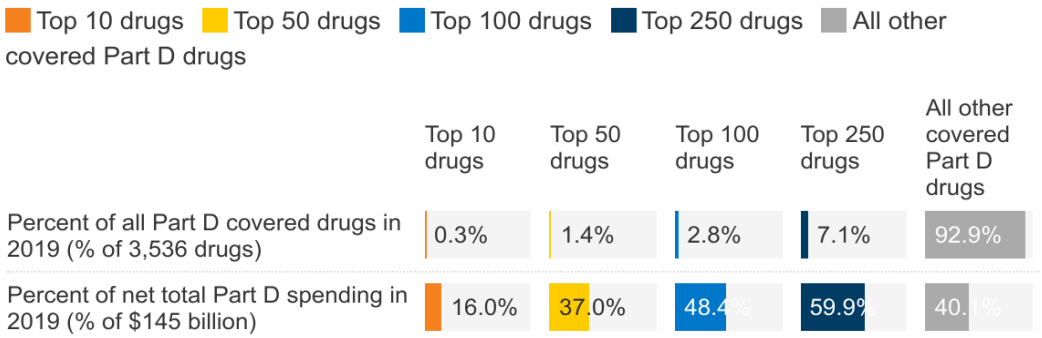
negotiation-eligible drugs once such data is available. Products from both categories do not count towards the 25 and 50 “Selected Drug” totals.

[6] Ways and Means Committee Staff. (2019) *US vs International Prescription Drug Prices* https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/U.S.%20vs.%20International%20Prescription%20Drug%20Prices_0.pdf

[7] Cubanski, J. & Neuman, T. (2021) Relatively Few Drugs Account for a Large Share of Medicare Prescription Drug Spending https://www.kff.org/medicare/issue-brief/relatively-few-drugs-account-for-a-large-share-of-medicare-prescription-drug-spending/

Figure 2

The 10 Top-Selling Part D Drugs - Less than 1% of Covered Drugs - Accounted for 16% of Net Total Part D Spending in 2019



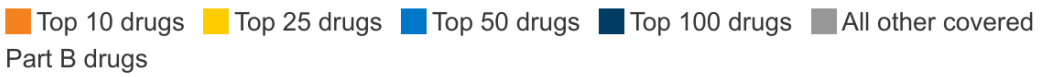
	Top 10 drugs	Top 50 drugs	Top 100 drugs	Top 250 drugs	All other covered Part D drugs
Percent of all Part D covered drugs in 2019 (% of 3,536 drugs)	0.3%	1.4%	2.8%	7.1%	92.9%
Percent of net total Part D spending in 2019 (% of $145 billion)	16.0%	37.0%	48.4%	59.9%	40.1%

NOTE: The top 250 drugs includes drugs with one manufacturer and no generic or biosimilar competitors, ranked by net total Part D spending, taking into account estimated rebates from Congressional Budget Office analysis of Part D spending data. The 2020 release of the Part D drug spending dashboard includes a total of 3,536 drugs in 2019, of which 2,458 have one manufacturer.
SOURCE: KFF analysis of 2019 data from the CMS Medicare Part D Drug Spending Dashboard, 2020 release.

KFF

Figure 3

The Top 50 Part B Drugs - Less Than 10% of Covered Drugs - Accounted for 80% of Total Part B Drug Spending in 2019



	Top 10 drugs	Top 25 drugs	Top 50 drugs	Top 100 drugs	All other covered Part B drugs
Percent of all Part B covered drugs in 2019 (% of 585 drugs)	1.7%	4.3%	8.5%	17.1%	82.9%
Percent of total Part B drug spending in 2019 (% of $37 billion)	43.0%	62.9%	79.7%	92.6%	7.4%

NOTE: The top 100 drugs are ranked by total Part B drug spending. The 2020 release of the Part B dashboard includes a total of 585 drugs in 2019.
SOURCE: KFF analysis of 2019 data from the CMS Medicare Part B Drug Spending Dashboard, 2020 release.

KFF

Source: KFF analysis of 2019 data from the CMS Medicare Part B Drug Spending Dashboard, 2020

release

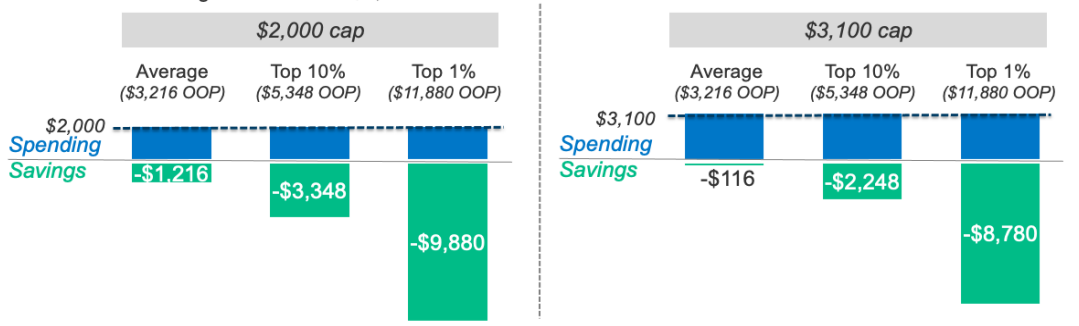
Alternative House Proposal

A separate bill introduced by a small group of Democrats would narrow the scope of price negotiations to non-retail drugs in Medicare Part B, which include injectables and infusions that must be administered in physician offices or hospital outpatient settings. The measure strictly outlines that only Part B drugs that no longer have exclusivity and have an expired patent would be subject to price negotiation. By excluding Medicare Part D, the largest prescription drug purchaser in the world, and by excluding drugs with unexpired patents and exclusivities, which account for the vast majority of drug spending and for which there is a gross excess in U.S. prices relative to those in the other wealthy countries, the centrist proposal deliberately ignores the primary sources of drug corporation price gouging. The proposal also ignores the government-granted monopolies on these costly drugs through regulatory exclusivities. The measure would not allow for negotiations in Medicare Part D, where 48 million Medicare beneficiaries receive retail drugs administered by pharmacies, and for which estimates show could yield $117 billion alone in savings.[8] Additionally, the measure contains a tiered yearly out-of-pocket maximum cap of $3,100 for Medicare Part D, higher than the Ways and Means package cap of $2,000. Previous estimates from a Republican-led proposal in 2019 which capped Part D out-of-pocket spending at $3,100, shows that potential savings would be less significant.

Figure 2

Estimated Cost Savings Under Proposed Medicare Part D Out-of-Pocket Spending Caps Could Be Substantial for Some Part D Enrollees with High Out-of-Pocket Costs

Estimated out-of-pocket spending and savings under proposed spending caps for the 1.2 million Part D enrollees with average costs above $2,000 in 2019



NOTE: Analysis excludes Part D enrollees receiving low-income subsidies (LIS). OOP is out-of-pocket. Estimated savings based on Part D enrollees with average out-of-pocket spending above $2,000 in 2019. The top 10% is 122,000 Part D enrollees and the top 1% is 12,000 enrollees.
SOURCE: KFF analysis of 2019 Medicare Part D claims data from the Centers for Medicare & Medicaid Services Chronic Conditions Data Warehouse.

KFF

Source: KFF analysis of 2019 Medicare Part D claims data from the Centers for Medicare and Medicaid

[8] Cubanski, J & Neuman, T. (2021) *How Would Drug Price Negotiation Affection Part D Premiums?* https://www.kff.org/medicare/issue-brief/how-would-drug-price-negotiation-affect-medicare-part-d-premiums/

Services

Hence, this far narrower drug pricing plan would not only generate fewer savings for Medicare beneficiaries, but presumably generate fewer offsets. This would likely necessitate that reductions be made elsewhere in the package. This type of proposal also ignores the rising material costs of retail drugs in Medicare Part D, and the effect that the lack of affordable drug access more generally has on health outcomes. It is estimated that 3 in 10 Americans ration their medication to cut costs.

Senate Finance Committee

In contrast to the House proposal, the Senate Finance Committee reportedly is considering a policy that would peg HHS drug pricing negotiations with a domestic reference pricing mechanism. This model would set a ceiling on price negotiations of a percentage of the Federal Ceiling Price, a metric used by other Federal health programs, rather than a percentage of the average price in a basket of reference countries similar to the United States. Due to the enactment of the Veterans Health Care Act, the VA has access to statutorily discounted drug prices and is allowed to negotiate prices as a single health system based on a set formulary, or list of covered drugs. The Government Accountability Office (GAO) found that in 2017, on average, the VA paid 54% less per unit for a sample of 399 brand name and prescription drugs as did Medicare Part D.[9] Other details of how the Senate plan may deviate from the House plan remain unclear and are in ongoing development, but may include excluding commercial plans from the benefits of price negotiations or price spike protections, incorporating the use of QALYs, limiting which drugs may be eligible for negotiations, or the number of drugs required or allowed to be negotiated.

Key Takeaways

The changes under consideration provide a critical opportunity to improve our nation's healthcare system by lowering drug costs and improving access to care. Polling results indicate that a number of Americans are becoming increasingly frustrated with a system that prioritizes profits over people. Polling shows that a full 88% of Americans want the government to negotiate drug prices for both Medicare and private insurance, as House Democrats' drug pricing proposal would do. Lawmakers can build on this widespread support by passing key healthcare provisions in the Build Back Better Act.

Drug pricing reform must remain a cornerstone of any healthcare proposals. Previous CBO estimates of savings from drug provisions outlined in H.R. 3 would lower spending by $456 billion. With the inclusion of a permanent rollback to the Trump Administration's rebate rule in the House package, additional savings could reach $180 billion. The revenue generated from these drug savings is critical to helping finance the $3.5 trillion reconciliation package.

---

[9] Government Accountability Office. (2021) *Department of Veterans Affairs Paid About Half as Much as Medicare Part D for Selected Drugs in 2017* https://www.gao.gov/products/gao-21-111

Claims that limiting pharmaceutical companies' unfettered access to price controls would stifle innovation are likely unfounded. The CBO reported that the outlined provisions in H.R. 3 would have only a modest impact on drug innovation--a reduction of 8 out of 300 new drugs entering the market over a 10 year period, and fewer than 30 drugs over the subsequent decade.[10] Research indicates that given the highly profitable industry of pharmaceutical manufacturing that accounts for 63% of the profits for the entire health sector, companies have the ability to trim costs without stifling innovation. Moreover, some of the largest brand-name drug manufacturers only spend about 10-20% of their revenue on research and development of new drugs, and taxpayer-funded public research plays a key role in financing research that has led to some of the most transformative drugs.[11]

Other concerns in the budget reconciliation package cannot be understated. The current House proposal to add dental benefits to Medicare Part B coverage would not go into effect until 2028. Additionally, benefit coverage for major restorative services would only cover an initial 10% of the cost for services until benefit coverage is fully phased in, upon which Medicare would pay 50% of costs. Both proposals present potential issues in that if dental benefits require considerable out-of-pocket spending and take several years to implement, the full benefits of an expanded Medicare program could be undermined. Doing so could also come at a cost to overall expansion efforts, where more seniors may be obliged to enroll in Medicare Advantage plans that overbill the government each year and compound Medicare spending.

To strengthen the current package, lawmakers could expand the number of drugs subject to negotiation and consider including a provision to lower the Medicare eligibility age to 60. In doing so, revenue from drug savings could be maximized and at least 23 million people would gain access to critical life-saving services through Medicare. As work continues between the House and the Senate to advance the Build Back Better Act, the inclusion of bold policies to address long-standing deficits in our healthcare system can be implemented to address issues of escalating costs and inadequate coverage.

---

[10] Congressional Budget Office. (2019) *Effects of Drug Price Negotiation Stemming From Title 1 of H.R. 3* https://www.cbo.gov/system/files/2019-10/hr3ltr.pdf

[11] Kesselheim, A. & Avorn, J. (2021) Letting the Government Negotiate Drug Prices Won't Hurt Innovation. https://www.washingtonpost.com/outlook/2021/09/22/drug-pricing-negotiation-biden-bill/