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Policy Brief

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Medicare Prescription Drug Legislation: How Would It Affect Beneficiaries?

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The probability that Medicare reform legislation will pass in 2003 seems as volatile as the stock market. After rapid passage of bills in the Senate and House in June, hopes that differences would be quickly reconciled have given way to concerns about the tough issues that still need to be resolved. Clearly, the commitment of \$400 billion for prescription drug coverage would be a major step forward for the Medicare program, especially as the budget deficit has grown and this represents a substantial share of new federal spending.

Even if a bill emerges from conference, however, it will include a number of contentious issues that will affect whether legislation is enacted this year. Three issues have dominated the discussion: the amount of new resources that will be devoted to a drug benefit, the details of the benefit, and the degree to which legislation would shift Medicare toward privatization. This period of uncertainty offers an opportunity to consider how these issues would affect Medicare beneficiaries.

The size of the drug benefit per se is not an issue in the conference discussion, since both the House and Senate have pledged \$400 billion over 10 years. Nonetheless, limiting it to \$400 billion has resulted in a number of provisions that cause concern, particularly the creation under both bills of a gap in coverage for persons in the middle range of spending and limits on protections for people with low incomes. An earlier paper examined how limited resources would constrain a prescription drug benefit.¹ Here, I focus on what this means for particular beneficiaries.

The details of the drug benefit and other reforms still leave much to be reconciled in conference. Although in many cases these issues seem to

be small pieces of the overall bills, these specific provisions will determine how well this new legislation would operate in practice.

The issue of tying a drug benefit to broader changes in Medicare is mainly a political and strategic concern. The controversy rests on whether a drug benefit will help to make other, less popular reforms more palatable to beneficiaries. The concept of reform in the House and Senate bills centers on an expanded role for the private sector, with the implicit goal of eventually replacing or limiting participation in the traditional Medicare option (in which the government bears the risk and individuals are free to go to most doctors, hospitals, and other care providers). In addition to retaining a role for the Medicare+Choice managed care plans, the bills would encourage preferred provider organizations (PPOs) to participate in a new option, called Medicare Advantage in the Senate and Enhanced Fee-for-Service in the House. These would give beneficiaries access to doctors and hospitals within broad networks, but require them to pay more if they choose providers out of the plan's network. The PPOs would cover traditional benefits as well as prescription drugs. For those who remain in traditional Medicare, the drug benefit would be offered as a stand-alone private insurance policy. In 2010, the House bill would move toward a defined contribution approach, requiring traditional Medicare to operate as simply another option. The risks and benefits of such an approach have been examined at length elsewhere.² For this paper, I focus on how provisions to increase Medicare privatization would affect beneficiaries.

I discuss these issues as they relate to four areas of concern: 1) the adequacy of the drug benefit for particular beneficiaries; 2) how the legislation would affect the complexity of the Medicare program; 3) whether some or all beneficiaries would be penalized by various aspects of the legislation; and 4) how greater privatization would affect them.

ADEQUACY OF THE DRUG BENEFIT

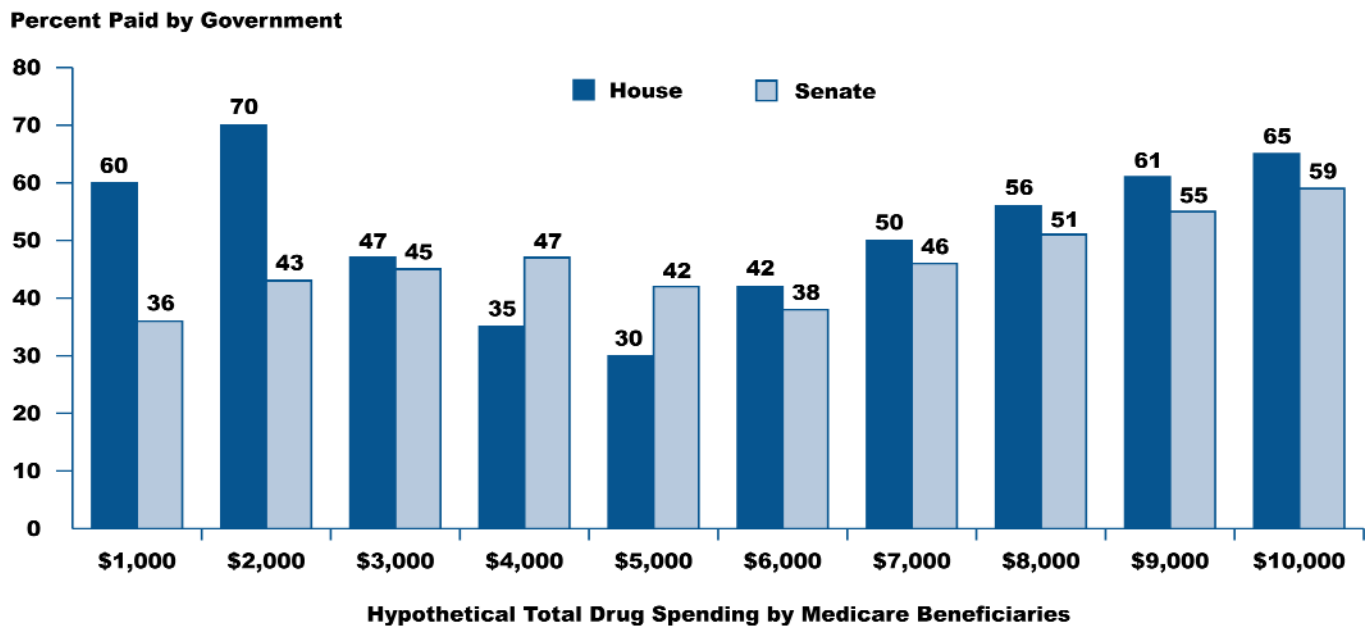
The prescription drug bills passed by the House and Senate were determined largely by budget constraints and by the voluntary nature of the benefit. To attract participants to a voluntary program, some benefits had to be offered to those with low levels of spending, including protection from catastrophic costs. But because dollars are limited, the money runs out before benefits at the bottom and the top of the spending scale can be extended to the middle ranges. Thus, the House and Senate create a gap, or “donut hole,” in coverage. In addition, limited spending has resulted in inadequate protections for persons with low incomes.

The Gap

The size of the gap varies considerably between the House and Senate bills. In 2006, the standard benefit in the House bill would initially be more generous than in the Senate version, offering a \$250 deductible and government contribution of 80 percent of drug spending from \$250 to \$2,000. The gap would begin at \$2,000 and extend to \$4,900, at which point the beneficiary would have spent \$3,500 out of pocket on drugs. The House bill then covers all expenses above \$4,900. The Senate version covers only 50 percent of costs above a \$275 deductible, up to \$4,500. Its gap is much smaller, extending from \$4,500 to \$5,813. Total spending by the beneficiary when the gap ends would be \$3,700. Above that cutoff, the Senate bill would cover 90 percent of the costs of drugs for beneficiaries. As a result, the average amount covered by the government would vary depending upon beneficiaries' total drug costs (Figure 1).

The gap reduces protection just as many of those who are most in need are expecting relief. Beneficiaries with chronic conditions are likely to have drug expenses in the range of \$3,000 to \$5,000. Many take several drugs every day, each of which can cost \$1,000 or more a year. This is

Figure 1. Medicare Prescription Drug Subsidy Paid by Government as a Share of Total Drug Spending by Beneficiaries



Source: Author's calculations, based on pending legislation.

where growth in spending on drugs is occurring, but these drugs may ultimately help to lower health care costs. Ironically, because of the gap, the government's share of the costs for someone with \$4,000 in spending would be lower than the share for someone with just \$2,000 in costs.

The House and Senate approaches are likely to have different supporters and detractors. For example, the House bill results in the widest swings in the share of benefits covered, and it puts those with chronic conditions at greater risk. On the other hand, those with only moderate spending are likely to favor the House bill because it is quite generous for those with lower costs. Yet, a flat-percentage contribution up to a catastrophic limit would be a fairer, simpler, and more straightforward way to structure a benefit. This approach could close the gap in the Senate bill at relatively low cost, both because this gap affects a narrower range of spending and because the bill would pay only 50 percent of drug costs before hitting the gap. In that case, an individual would have to pay all the costs up to the deductible of \$275. Above

that, the government would pick up half of all drug costs up to a limit of, say, \$5,000 in total spending. After that, the government would pay at least 90 percent of costs.

Low-Income Provisions

Neither the House nor the Senate bill does a good job of providing comprehensive protection for low-income Medicare beneficiaries. The Senate cutoff of 160 percent of poverty is higher than that in the House bill (150 percent), but even at this level many would be left behind. A single person at 160 percent of poverty in 2003 would have an annual income of a little more than \$14,000. Beneficiaries with slightly higher incomes are unlikely to be able to pay a \$420 premium plus their share of drug expenditures. For a beneficiary with total expenditures of \$3,000, their costs would constitute about 14 percent of annual income.³ Under the House and Senate bills, such individuals are likely to be no better off than at present, cobbling together resources and under-using the drugs they need. In addition, both bills

would reduce benefits when a beneficiary's income as a share of poverty increases. Low-income benefits should extend to at least 200 percent of poverty (about \$18,000 annual income for an individual).

The House bill also relies on asset tests to limit eligibility for low-income protections.⁴ The proposed asset tests are quite stringent, especially considering that beneficiaries are likely to stretch these savings or lump sum pensions over many years to supplement their incomes.⁵ The Senate places a lower emphasis on asset tests and somewhat relaxes enrollment procedures. Yet, many low-income beneficiaries are likely to be excluded from these programs because of the complexity of the qualification process, just as more than half of those eligible have not enrolled in existing low-income health programs.

The Senate bill would require those with the lowest incomes to get their benefits from Medicaid. But one of Medicare's strengths is that it treats all beneficiaries the same, regardless of their income level. The 14 percent of beneficiaries who now receive both Medicaid and Medicare benefits should be at the top of the list of concerns for reform, rather than the bottom. The low-income benefits for those not on Medicaid are relatively generous under this bill.

The House bill also is inadequate in that low-income beneficiaries have the same gap in coverage as other beneficiaries. Coverage for low-income beneficiaries would end after they spend \$2,000 on drugs, making them responsible for 100 percent of the costs in the gap (up to about \$4,900). A low-income individual with \$4,500 in expenditures, for example, would pay \$3,040 out of pocket. Even for someone at 120 percent of poverty, this would be about 28 percent of income. Thus, in different ways, both the House and Senate bills limit low-income protection. It would be better to find savings elsewhere to fix these flaws.

COMPLEXITY

Both bills would offer drug benefits solely through private insurers, and thus create a more cumbersome system of coverage for beneficiaries who choose to remain in traditional Medicare. Neither bill would expand the traditional Medicare program, but instead would increase cost-sharing and pass greater burdens on to its beneficiaries. These beneficiaries would likely have to purchase two, private supplemental policies in addition to Medicare—a Medigap plan and a drug plan. Each year, they would have to make tough decisions, perhaps buying a less comprehensive Medigap policy if the costs of the drug plans rise steeply, for example. Beneficiaries also would need to compare the costs of traditional Medicare plus two supplemental plans with the more comprehensive but potentially more expensive and/or restrictive private options.

Those who wish to shift their coverage to preferred provider organizations (PPOs) or remain in existing Medicare HMOs may have most of their needs met in one plan, but they will have to choose among varying benefit packages. In particular, the cost-sharing structures will differ from traditional Medicare and across various plans. The new PPOs promoted by this legislation would create in-network and out-of-network benefits, deductibles, and cost-sharing, essentially doubling the number of rules for beneficiaries to negotiate. In addition, different PPOs could have different networks of providers, affecting how easy it would be for beneficiaries to find health care services at a reasonable cost. Complicated benefit packages that vary from plan to plan make informed choice infeasible. To enable beneficiaries to make true comparisons, standardized benefit designs would be needed. But this would place limits on the degree of flexibility plans could offer.

One of the rationales for relying on a private approach is to allow variety in the types of coverage offered. For both the stand-alone drug plans and the PPOs, people could choose among

plans that offer comprehensive coverage with low cost-sharing and those that have more cost-sharing payments but lower premiums, for example.

Drug plans also could vary in terms of the controls they establish on use of specific drugs. For example, within a therapeutic class of drugs aimed at meeting particular needs (such as lowering cholesterol), plans could establish a limited number of drugs that either would be the only ones covered or would be offered to patients at lower copayments. Premiums charged to the beneficiaries would then vary across plans, based on their cost-sharing structure and the stringency of controls on drugs. All of these variations add to the complexity of the proposed legislation. Polls indicate that people are attracted to the general principle of “choice,” but that they do not wish to spend a great deal of time sorting through complex options.⁶ The bills do have some requirements to protect consumers, but insurers would still have a great deal of flexibility in setting up their plans.

To ensure protections for beneficiaries and avoid some of the problems detailed below, the legislations should be simplified.

Information and Support for Decision-Making

Even well-educated consumers struggle to understand Medicare, and many seniors have less than a high school education or are of advanced age, likely resulting in lower health literacy skills.⁷ What’s more, nearly a quarter of Medicare beneficiaries have health problems such as hearing or cognitive declines that make it difficult for them to make informed choices about their care.

The current level of funding at the Centers for Medicare and Medicaid Services (CMS) for beneficiary education is insufficient to deal with the existing system, much less to meet the greater needs that will arise in the proposed system. Yet, neither bill provides sufficient resources to help beneficiaries make informed choices. Leaving this task to private plans runs the risk of misleading advertising. Beneficiaries require an independent

source of information, such as the State Health Insurance Programs (SHIPs).

Both bills would create a new agency to run the drug program and private plan options. Thus, Medicare beneficiaries may need to deal with two bureaucracies. If lines of oversight are not drawn carefully, someone enrolled in traditional Medicare may have to interact with CMS about those benefits and with the new agency about drug benefits. This, too, would create unnecessary complexity for beneficiaries.

Opportunities for Gaming the System

Complexity in the rules, flexibility of coverage, and other details create opportunities for private plans and providers to game the system. For example, in the current Medicare+Choice system, HMOs have sometimes denied services to beneficiaries that clearly are covered by statute. Although knowledgeable case workers can straighten out such issues, the same problem often recurs in the same HMO.⁸ At present, there is no way for CMS to learn about recurrent problems of this type, since most of the aid provided by SHIPs and other groups have no automatic feedback loop to correct such problems. Opportunities for activities such as denial of benefits, arbitrary shifting of drugs on or off the preferred list, and manipulation of payments to out-of-network providers would expand considerably under the program envisioned in both bills. The Senate does a somewhat better job of establishing tools for appeals and oversight, but both bills essentially rely on patients to know their rights and exercise them aggressively. Substantial resources would need to be devoted to ensure patient protections in this area.

Disruptions over Time

In both bills, requirements on private plans (for stand-alone drug benefits and broader private options) are for one-year commitments. This may create a hardship for beneficiaries, for whom a stable source of treatment helps to reduce confusion and ensure quality of care. If plans are permitted to

come in and out of markets, beneficiaries will be faced with the same problems that have caused so much dissatisfaction in Medicare+Choice. In this program, insurers have withdrawn entirely from certain regions. Beneficiaries frequently have to change physicians when joining a new plan, only to repeat the process if it later pulls up stakes. This can happen even if plans do not withdraw, but instead raise premiums or cut benefits, thus putting pressure on beneficiaries to look for a new plan. Evidence from California suggests that some beneficiaries stay in inadequate, expensive plans.⁹ More stability in contracts with private plans ought to be considered, including limitations on how fast premiums can rise and how quickly details of the plan can change. Fall-back provisions for when private plans fail to materialize also are important, as discussed below.

DETAILS LIKELY TO PENALIZE BENEFICIARIES

Though not much discussed, many details in the proposed legislation will have significant impacts on beneficiaries. Some of these provisions, such as late enrollment penalties, are designed with specific goals in mind, but may have unintended negative consequences. In addition, many details vary between the House and the Senate bills.

Fall-Back Plans

In part because of the geographic variations in spending on prescription drugs, some regions may not be attractive to private drug plans. In that case, fall-back provisions are critical to ensure that beneficiaries in traditional Medicare have access to drug coverage. The House bill seeks to do so by offering additional federal subsidies in areas where stand-alone drug plans are reluctant to participate. This approach adds an incentive for private plans to hold out in negotiations for better arrangements and would likely result in higher premiums for beneficiaries in those areas.

Alternatively, the Senate would create a federal government-run drug plan in areas where less than two private plans participate. The government

would bear the risk and contract with pharmacy benefit management companies or some other entity to process claims and administer the program. This latter approach would be a more reliable system and provide better protection for beneficiaries. Yet, it would remain in place only until new private plans enter the market. This could mean that, over three years, beneficiaries could have to participate in three different plans, each with its own rules and premiums. If private drug plans withdrew after the first year, a federal fall-back plan would be activated in the second. If in the third year new private plans entered, the fall-back plan would be eliminated, forcing individuals to once again change plans. Creating a permanent fall-back drug plan run by the government would do the most to protect beneficiaries. Alternatively, keeping the fall-back in place for several years would give beneficiaries a stable base.

Delayed Sign-Up

Both the House and Senate bills would allow drug plans to impose financial penalties on beneficiaries who delay enrollment past the initial period. If applied fairly, this tool could encourage beneficiaries to participate in the drug benefit as soon as possible—when their expenses are likely to be lowest—rather than waiting until they need several medications. Part B of Medicare, for example, increases the premium by 10 percent each year that an individual delays enrollment. Instead of this approach, the House bill allows plans to vary the penalty for late applicants based on their estimated actuarial risk. This underwriting practice (used by many Medigap insurers) may result in extremely high financial penalties that could effectively eliminate some individuals' access to drug coverage. The Senate plan takes a more equitable approach to the imposition of penalties. It calls for standardized penalties for all enrollees, based on a specified amount per year of delayed enrollment.

In order to protect beneficiaries, plans need to balance mechanisms used to encourage people

to sign up against penalties for those who may be skeptical or confused about the benefits, especially in the early years. The final bill could be improved by creating a longer initial sign-up period and by establishing more predictable penalties for late enrollment.

Geographic Concerns

Spending on prescription drugs varies widely across the United States because of several factors, including regional differences in health care use, needs, costs, and how health care is practiced by physicians.¹⁰ Although the Congressional Budget Office estimates that, on average, beneficiaries will face \$35 premiums for basic coverage in stand-alone drug plans under both the House and Senate bills, actual premiums and benefits would likely vary considerably by geographic area.

If payments to plans reflect geographic differences in spending, the discrepancies can become quite visible and contentious, as currently seen in the Medicare+Choice program. It is likely that there would be regional differences among benefit packages as well. Under the current Medicare+Choice system, beneficiaries who live in areas with high per-person health spending (e.g., urban areas) are offered plans with extra benefits, while in rural areas enrollees are much less likely to be offered extra benefits or must pay substantially higher out-of-pocket costs for them.

Similar concerns could arise in regard to the 2003 Senate bill, in which premium subsidies to stand-alone drug plans would be adjusted by geographic differences in prices of drugs, and possibly by differences in drug use. With these adjusters, beneficiaries in rural areas may find themselves in less generous plans than their urban counterparts, since rural plans would receive starkly lower federal subsidies. Accordingly, rural beneficiaries could face higher premiums, more restrictive formularies, and higher cost-sharing than urban beneficiaries.

But if Medicare's payments to plans per beneficiary were the same across the country, benefici-

aries in urban areas would likely be offered less generous benefits than their rural counterparts. This may become a problem for the stand-alone drug plans proposed under the House bill, which would standardize premium subsidies across the nation (although adjusting them for enrollees' health status).

For private plans that cover Medicare Part A and B benefits as well as drugs, both the House and Senate bills address geographic variations in spending, to some degree, by establishing a regional competitive bidding process. But competitive bidding for a comprehensive package of Medicare services is untested.

Stand-Alone Plans and Traditional Medicare

For beneficiaries who choose to get all their benefits from private plans, the proposed drug benefit would be integrated into an overall package. But for those who choose to stay in traditional Medicare, drug benefits would be provided by a separate, stand-alone drug plan. Many private and public sector experts have expressed doubts about insurers' ability to offer stand-alone benefits.¹¹ For example, risk adjustment is likely to work better for an integrated benefit package than for a stand-alone benefit. In addition, such a benefit would require its own administrative structure. For these reasons, stand-alone plans likely would be more expensive than integrated benefits for insurers to provide. This could saddle those who remain in traditional Medicare with higher costs.

Increased Cost-Sharing Requirements in Traditional Medicare

While the bills provide some help to beneficiaries to reduce the costs of prescription drugs, both would increase cost-sharing requirements for other services. The House bill would add cost-sharing requirements for home health services. Cost-sharing for home health would fall most heavily on the very old and those with chronic conditions—groups who generally have lower incomes than other beneficiaries and are therefore least able to

pay. The cost-sharing liability for persons age 80 and over already is about twice that for beneficiaries ages 65 to 74. Finally, now that there is a home health prospective payment system based on episodes of care, many analysts are concerned that agencies may skimp on offering needed services.

The Senate bill would add cost-sharing for laboratory services. Cost-sharing was eliminated for those services a number of years ago on the grounds that individuals have little control over what tests are ordered on their behalf. This has not changed. Labs agreed to receive lower overall reimbursement in exchange for not having to seek payments from beneficiaries. Thus, this option and home health cost-sharing would not improve the structure of Medicare cost-sharing but instead would pass more costs on to beneficiaries.

An increase in the Part B deductible has been discussed frequently as a means of saving federal dollars. Both bills would index the Part B deductible, causing it to rise over time. The current \$100 deductible is low relative to other insurance plans for workers. But other areas of cost-sharing are much higher under Medicare, so that Part B deductible increases are often discussed as a way to pay for cost-sharing reductions elsewhere in the benefit package. The Part B deductible increase does make sense as a structural change, but it would be better to make this change and at the same time reduce cost-sharing in other areas.

Means-Testing Catastrophic Coverage

The House bill would make beneficiaries with annual incomes above \$60,000 subject to a higher cap before catastrophic benefits apply. This would create a situation in which benefits vary by income—for the first time in Medicare's history. (Previous proposals would tie premium levels, rather than benefits, to income.) Means-testing catastrophic coverage raises a number of red flags, affecting Medicare's traditional role and generating substantial practical difficulties as well.

The fact that Medicare treats all seniors and

persons with disabilities who pay into the program alike certainly contributes to its popularity. But it also recognizes that high-income beneficiaries contribute substantially to the program. The payroll taxes that make up about half of Medicare's financing are charged on all wages, no matter how high. As a result, individuals with very high incomes already contribute far more than it costs to serve them. Since the drug benefit is paid out of general revenues, persons with substantial incomes who become Medicare beneficiaries will continue to contribute even after retirement.

Further, the House proposal to reduce benefits for people with incomes over \$60,000 poses practical problems. Even though \$60,000 is lower than the usual cutoff for describing high-income individuals, few Medicare beneficiaries reach that level. Only about 5 percent of single beneficiaries have incomes of \$60,000 or more and less than 0.2 percent of all beneficiaries would both hit the catastrophic limit and have incomes above \$60,000. To find them, new mechanisms are needed to determine incomes, adding to administrative costs.

GREATER PRIVATIZATION IN MEDICARE

The House and Senate bills include subsidies to serve as incentives to expand participation in private plans, for both stand-alone drug plans and full benefit options. Are such subsidies a wise use of resources, particularly given the inadequate nature of the drug benefit? Will they lead to slower rates of growth in Medicare spending over time? In 2010, the House bill would put Medicare on track to become a defined contribution plan with no special protections for the traditional Medicare option. Forcing traditional Medicare into competition would put many of the most vulnerable beneficiaries at risk.¹² The problems of risk selection are unlikely to have been resolved and thus premiums would likely rise substantially for traditional Medicare. These disadvantages should be weighed against the probability that privatization would generate real savings for Medicare over time.

Savings from Market Forces

Some of the opposition to a private approach is driven by skepticism about what extra value the private sector would bring to Medicare since the evidence suggests that it would not lower costs, and some rests on practical concerns about whether new features, such as stand-alone prescription drug plans, will work. To date, the evidence shows that privatization will achieve few if any savings for Medicare.¹³ Certainly the claim that privatization is essential to holding down costs is on shaky ground. Recent experience with Medicare+Choice plans suggests that beneficiaries are paying more and getting less value in return.¹⁴

Because they serve mainly healthy beneficiaries, private plans appear at first more viable than they turn out to be once the effects of risk selection are taken into account. Thus far, private plans have not created new and innovative delivery systems that generate substantial savings over time.

Further, the emphasis on consumer choice can undermine plans' ability to generate price competition, and thus savings. If plans can vary in the benefits they offer, they may use marketing and benefit structure, rather than lower premiums, to attract customers. For this reason, some proponents of competition emphasize that cost savings also will depend on the extent to which the emphasis is on price, and hence the need to ensure that plans vary little in terms of what they offer to consumers.¹⁵ Ironically, one of the selling points for relying on private plans—that people can get precisely the benefits they want rather than being put into a “one-size-fits-all” structure—may be at odds with holding down the costs of drug coverage.

Subsidies for Private Plans

Both bills would subsidize the comprehensive private plans. These payments are likely to exceed what it would cost to provide drug benefits through the traditional Medicare program. The Congressional Budget Office estimates that the House bill would add \$7.5 billion between 2006

and 2013 to Medicare's spending and the Senate bill would add \$18 billion between 2005 and 2013.¹⁶ The subsidies would be direct, through explicitly higher payments to plans, and indirect, since they would include support for medical education and care of indigent hospital patients. These items add to traditional Medicare's costs but are not usually an expense to private plans.¹⁷ Presumably, these higher payments are intended to jumpstart a competitive system, but it is reasonable to ask when such subsidies would pay returns, if ever. Experimenting with new private plans for Medicare makes sense, but these plans should add value either through savings or through new and innovative approaches to care. Otherwise, it is difficult to justify spending scarce public dollars on such an effort. Neither the House nor the Senate holds plans accountable for innovation beyond a vague requirement to experiment with disease management approaches.

For beneficiaries, these subsidies would create an uneven playing field: thanks to subsidies, insurers that provide all Medicare benefits could eventually offer improved benefits, while traditional Medicare may have to place limits on its benefit package. Since individuals who are unwilling to take a chance on a new insurance option and who thus stay in traditional Medicare are likely to be sicker than average, this approach favors the healthy over the sick.¹⁸

Reducing Risk to Private Plans

This legislation would attempt to attract private, stand-alone drug plans by paying a share of insurers' expenses above a certain level. In the Senate bill, the sharing of risk would start when the catastrophic protection begins, limiting government contributions for this purpose. But the House bill would go much further, beginning to share costs with plans once an individual spends more than \$1,000. In this case, risk may be reduced to such a degree that plans become less conscious of achieving savings and negotiating lower prices.

The impact of this response on beneficiaries may be to keep the stand-alone drug plans from creating restrictive formularies. This could help beneficiaries in terms of access to drugs, but it also may result in more rapid premium and cost-sharing increases over time.

Moreover, since the House bill precludes government intervention in drug pricing, the government may become liable for substantial spending over which it has little control. More attention is needed to determine the appropriate level of risk protection to offer participating plans.

Further Privatization in 2010

The House bill establishes changes to Medicare in 2010 that would effectively move the system to a defined contribution approach. That is, federal payments to all options under Medicare, including the traditional part of the program, would be based on a share of the average of the premiums in all Medicare options. This would place a cap on government's contribution to the cost of premiums. As a result, any plan with a higher-than-average premium bid would have to charge substantially higher amounts from beneficiaries. This could potentially divide Medicare beneficiaries on the basis of ability to pay higher premiums. Moreover, it will not always be the case that these higher premiums will reflect true differences in benefits or quality of care. Plans that attract a higher-than-average percentage of unhealthy beneficiaries (which will likely include traditional Medicare) will have to charge higher premiums, unless a very good risk adjustment mechanism is developed by 2010. As yet, there is no reason to believe that such an adjuster will be available by that time. The House bill would thus enact as policy a major untested experiment with a population that is particularly vulnerable to the high costs of health care.

CONCLUSION

Offering \$400 billion in new benefits could certainly help many beneficiaries now struggling with the costs of prescription drugs. Nonetheless, it is

difficult to determine whether beneficiaries would be better off under this legislation without resolution of important details. Enacting changes that prove to be either unworkable or that place some beneficiaries at risk would not move Medicare in the right direction. The conference committee work certainly can and should mitigate the problems discussed here. But any final bill needs to be carefully explained to the American public, including a thorough discussion of its strengths and weaknesses. In particular, the emphasis on facilitating private sector participation at the expense of beneficiaries should be examined head-on.

NOTES

- ¹ Marilyn Moon and Matthew Storeygard, *Stretching Federal Dollars: Policy Trade-Offs in Designing a Medicare Drug Benefit with Limited Resources* (New York: The Commonwealth Fund, Aug. 2002).
- ² See, for example, Sally Trude and Paul Ginsburg, *Are Defined Contributions a New Direction for Employer-Sponsored Coverage?* (Washington, D.C.: Center for Studying Health System Change, Issue Brief No. 32, Oct. 2000); Karen Davis, Cathy Schoen, Michelle Doty, and Katie Tenney, “Medicare Versus Private Insurance: Rhetoric and Reality,” *Health Affairs Web Exclusive* (Oct. 9, 2002): W311–W324; General Accounting Office, “Medicare+Choice: Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending” (Washington, D.C.: GAO/HEHS-00-161, Aug. 2000); and Marilyn Moon, *Restructuring Medicare: Impacts on Beneficiaries* (New York: The Commonwealth Fund, May 1999).
- ³ This calculation assumes an annual income of \$14,500 and includes the premium and cost-sharing (which at that income is similar between the two bills).
- ⁴ See Laura Summer and Robert Friedland, *The Role of the Asset Test in Targeting Benefits for Medicare Savings Programs* (New York: The Commonwealth Fund, Oct. 2002).
- ⁵ Marilyn Moon, Robert Friedland, and Lee Shirey, *Medicare Beneficiaries and Their Assets: Implications for Low-Income Programs* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, June 2002).
- ⁶ Marsha Gold and Natalie Justhe, “How Salient Is Choice to Medicare Beneficiaries?” (Washington, D.C.: Mathematica Policy Research, Inc., Fast Facts #5, Jan. 2001).
- ⁷ Patricia Neuman et al., “Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform,” *Journal of Aging and Social Policy* 10 (4–1999): 25–50.
- ⁸ Medicare Rights Center, *Systematic Problems with Medicare HMOs* (New York: MRC, Sept. 1998). Available at <http://www.MedicareRights.org>.
- ⁹ Tom Buchmueller, “The Health Plan Choices of Retirees Under Managed Competition,” *Health Services Research* 35 (Dec. 2000, Pt. 1): 949–76.
- ¹⁰ Fred Teitelbaum et al., *Drug Trend Report 2000* (St. Louis: Express Scripts, June 2001); Department of Health and Human Services, *Report to the President: Prescription Drug Coverage, Spending, Utilization, and Prices* (Washington, D.C.: DHHS, Apr. 2000).
- ¹¹ See, for example, Robert Pear and Walt Bogdanich, “Some Successful Models Ignored As Congress Works on Drug Bill,” *New York Times*, Sept. 4, 2003, pp. A1, C6. They quote Tom Scully, administrator of CMS, and Chip Kahn, formerly head of the Health Insurance Association of America, as indicating that stand-alone drug plans are unworkable.
- ¹² The House bill would make Medical Savings Accounts (MSAs) a permanent part of the Medicare program, eliminating its status as a demonstration. Since MSAs could result in major risk-selection problems, further study is needed to determine how successful they would be. This is a much broader issue and is not explored in detail here.
- ¹³ GAO, “Medicare+Choice: Payments,” 2000.
- ¹⁴ See, for example, Marsha Gold and Lori Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002* (New York: The Commonwealth Fund, Nov. 2002).
- ¹⁵ Comments by Robert Reischauer and Jeff Lemieux at Alliance for Health Reform meeting, 2003.
- ¹⁶ Congressional Budget Office, “Cost Estimate: H.R. 1 and S.1” (Washington, D.C.: CBO, July 22, 2003).
- ¹⁷ That is, Medicare makes direct payments to hospitals for these expenses and that amount is averaged over all beneficiaries as a Medicare cost. But, since private plans do not pay such subsidies to hospitals, they effectively receive an overpayment. These overpayments were taken out of payments to private plans in the Balanced Budget Act of 1997, but the current legislation would restore those amounts.
- ¹⁸ Patients relying on multiple doctors or who are in the middle of treatments are less likely to want to face the disruption of changing plans, for example.

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