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## Issue Brief

# How Beneficiaries Fare Under the New Medicare Drug Bill

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**ABSTRACT:** The Medicare Prescription Drug Improvement and Modernization Act (MMA) provides the largest benefit expansion in Medicare's history while enacting major changes to the program's structure. Offering \$410 billion in new drug benefits will certainly help many beneficiaries now struggling with the costs of prescriptions, particularly those with low incomes. It is difficult to determine, however, whether beneficiaries will be better off in the long run. The drug benefits will not grow with the needs of beneficiaries, and other changes that prove to be unworkable or that place some beneficiaries at risk will create added costs. In the meantime, favorable treatment of private plans will create new inequities. Additional legislation and carefully crafted regulations could mitigate a number of these issues; in the meantime, they will require close scrutiny.

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The Medicare Prescription Drug Improvement and Modernization Act (MMA), signed into law by President Bush on December 10, 2003, provides the largest benefit expansion in Medicare's history while enacting major changes to the program's structure. This issue brief examines the new Medicare law with respect to the following: 1) the adequacy of the drug benefit; 2) the benefit's structure; 3) the impact of greater privatization on Medicare outlays; and 4) additional issues affecting beneficiaries, including problems related to the benefit's complexity, stability of plan participation, and means-testing the Medicare premium.

As passed, the MMA is expected to increase federal spending by \$395 billion between 2004 and 2013. The drug benefit itself is expected to cost slightly more—\$410 billion over 10 years.<sup>1</sup> Even at this level of spending, funding constraints have resulted in a standard benefit package that contains a gap in coverage for people whose spending on prescription drugs falls within the middle range.<sup>2</sup> This gap will have important consequences

for certain groups of beneficiaries, including those with chronic conditions and relatively high drug expenditures. And while the low-income provisions in the final legislation represent a substantial improvement over the House and Senate bills, a number of Medicare beneficiaries who need help will still lack adequate financial protection. States, meanwhile, retain the substantial burden of helping to fund benefits for low-income beneficiaries.

The details of the drug benefit's structure—including the reliance on private standalone plans, consumer protections if private drug plans don't develop, and beneficiaries' preclusion from buying supplemental insurance to fill in coverage gaps—will likely create problems for beneficiaries. In many cases, these different components will determine how well the new legislation operates in practice for beneficiaries.

The MMA also contains provisions that, its supporters claim, will help reduce the rate of Medicare spending growth over time. In effect, the new law promotes the expansion of private plan options for providing Medicare benefits, based on the belief that competition within the private sector will achieve long-term savings for the program. In addition to retaining a role for the Medicare+Choice managed care plans, the new law will encourage participation of preferred provider organizations (PPOs), combining both into a new option called Medicare Advantage. Strong financial incentives are created to attract new private plans to the program. In 2010, Medicare will undertake a demonstration program in six regions in an effort to move toward a “defined contribution” approach, under which traditional Medicare will change substantially so that it operates as simply another plan option.<sup>3</sup> Although traditional, fee-for-service Medicare (in which the government bears the financial risk and individuals are free to go to most health care providers) will basically be left as is, the implicit goal is eventually limiting, or even replacing, participation in it.

## ADEQUACY OF THE DRUG BENEFIT

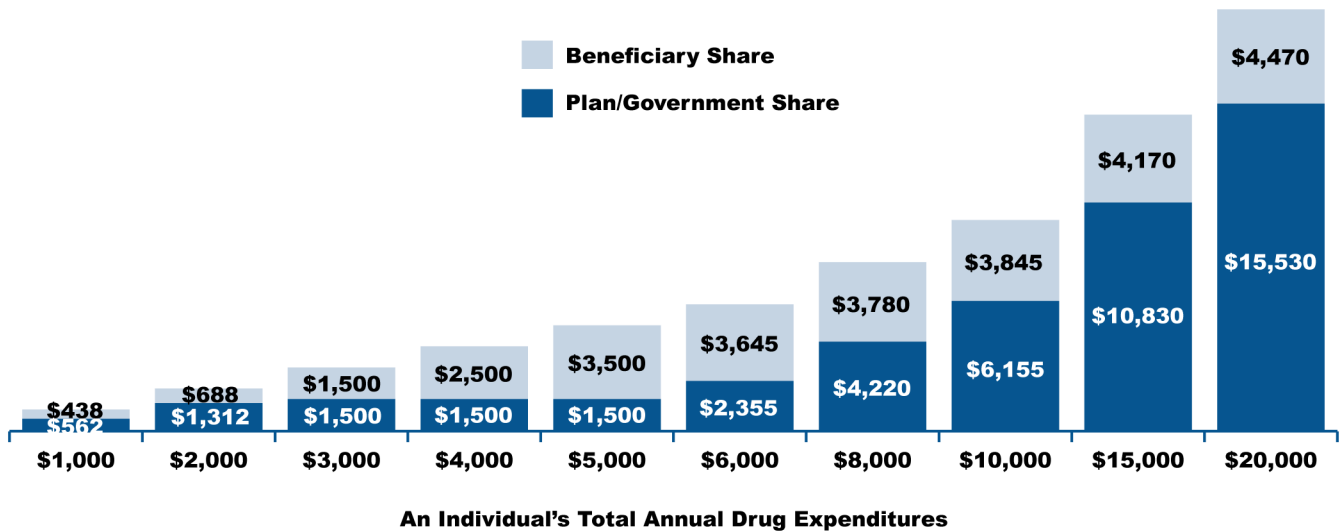
The scope of the new prescription drug benefit was determined largely by budget constraints and by its supporters' desire for a voluntary benefit. To attract enough Medicare beneficiaries to a voluntary program, some enticements had to be offered to those with low levels of drug spending. Another critical component was protection from catastrophic expenses for beneficiaries with high levels of spending. But limited federal funds led lawmakers to design a benefit with a “donut hole”—a gap in coverage whereby coverage stops once beneficiaries exceed a low level of spending and does not resume until their expenses reach a very high level. Protections for individuals with low incomes also were limited by budget constraints, although nearly half of the law's expenditures on drugs will go to lower-income beneficiaries.

### The Donut Hole

The standard prescription benefit established by the MMA creates a gap in drug coverage between \$2,250 and \$5,100 in a beneficiary's total spending. This gap is reached after the beneficiary pays a \$250 deductible and then 25 percent of the next \$2,000 in total spending. At that point, the beneficiary will have spent \$750 out-of-pocket. Before catastrophic coverage can begin, the legislation requires each individual to pay \$3,600 out-of-pocket. Thus, the next \$2,850 in spending on prescription drugs is the sole responsibility of the beneficiary and his or her family.<sup>4</sup> When that requirement is met, at \$5,100 in total drug spending, the benefit will then cover 95 percent of any additional spending. Consequently, the average amount paid by the government will depend on beneficiaries' total drug costs (Figure 1, Table 1). The share of spending covered by the drug benefit reaches a high point at \$2,250, declines until \$5,100, and then rises.

Figure 2 displays the share of Medicare beneficiaries whose total spending on drugs falls into each of the spending levels that are subject to different cost-sharing rules. About 27 percent of

**Figure 1. Beneficiary and Government Share of Spending in 2006, at Individual Expenditure Levels, Under the New Medicare Drug Benefit**



Source: Adapted from Congressional Budget Office.

the full Medicare population will have spending in the area of the “donut hole.” Moreover, the 15 percent with spending above \$5,100 also are affected by the donut hole, since they would have no coverage between \$2,251 and \$5,100 in total spending.<sup>5</sup>

The donut hole will reduce protection against drug expenses just as many of those Medicare beneficiaries who are most in need are expecting financial relief. Chronic health conditions are strongly correlated to high spending on prescription drugs, with expenses ranging from \$3,000 to \$5,000 per year. Moreover, a large proportion of Medicare beneficiaries have two or more chronic conditions, which can require taking several drugs every day, at a cost of \$1,000 or more per year for each medication (Figure 3).<sup>6</sup> The coverage gap for the basic drug benefit thus arises right at the point when the chronically ill experience growth in their drug spending. It is exactly in this spending range where better coverage of drugs could ultimately help to lower health care spending elsewhere. Ironically, the government’s share of costs for someone with \$5,000 in spending is 32 percent—much lower than the share paid for someone with just \$2,000 in drug expenditures (65%).

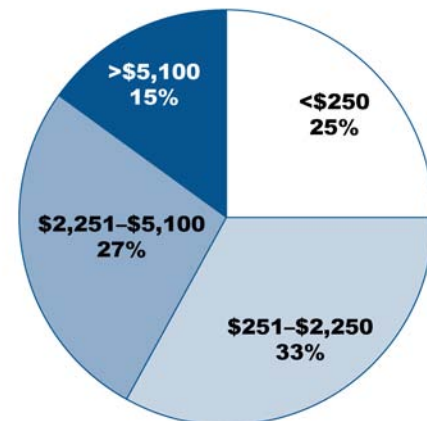
**Table 1. Individual Share of Basic Drug Benefit Based on Mean Spending Level in 2006**

Mean spending level in 2006*	\$3,167
Beneficiary pays	
\$250 deductible	250
25% of next \$2,000 in spending	500
100% of spending between \$2,250 and \$3,167	917
Subtotal (as share of spending: 53%)	1,667
Plus premium	418
<b>Total</b>	<b>\$2,085</b>

\* CBO estimate.

Source: Adapted from Congressional Budget Office.

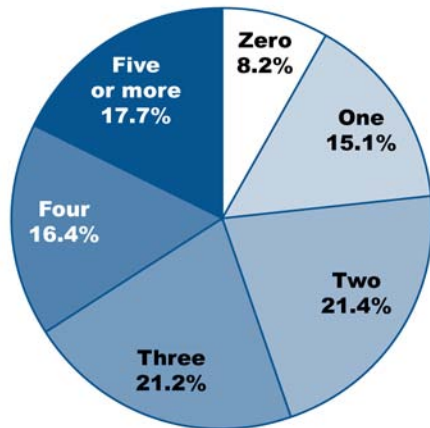
**Figure 2. Medicare Population by Level of Prescription Drug Spending in 2006**



Note: These figures represent the spending distribution for all beneficiaries. The distribution for those who participate in the program or who receive low-income subsidies may vary.

Source: Congressional Budget Office estimates.

**Figure 3. Distribution of Medicare Beneficiaries, by Number of Chronic Conditions, 1999**



Note: Excludes beneficiaries residing in nursing homes.

Source: Urban Institute analysis of the 1999 Medicare Current Beneficiary Survey (MCBS).

Many of the discussions about the donut hole have characterized it as being much smaller than it actually is. This is because the new Medicare law's rules for coverage are established on two different bases. Initially, the deductible and coinsurance are tied to total spending. But eligibility for catastrophic protection is linked to out-of-pocket spending. Why does this matter? Essentially, these rules restrict the ability of any health plan to fill in the benefit's gap: only contributions from the individual, his or her family, or a state pharmaceutical assistance program are allowed to count toward the out-of-pocket spending requirement. Supplemental policies for non-drug expenses work much differently, in that Medicare does not have any stake in who pays the deductibles and copayments.

While the new law will allow plans the flexibility to vary the deductible and copay structure, the \$3,600 out-of-pocket requirement remains the same. If a private insurance plan covers spending above \$2,250, the gap would not be reduced; rather, it would just begin at a higher spending level. For example, if a private insurance company sold a policy to pay 100 percent of the spending between \$2,250 and \$4,250, then the catastrophic protection would not begin until \$7,100 in total

spending—the point at which the individual would have spent \$3,600 out-of-pocket.

Private plans do have the flexibility to change some of the coverage features. But since the new benefit is voluntary, private plans that make coverage more generous for those who spend a lot on prescription drugs and decrease it for those who spend less would result in adverse selection. That is, such a plan would attract enrollees with high costs, raising the costs of insuring this group, and discouraging those who rely less on prescription drugs from enrolling. Until or unless the government establishes an effective risk-adjustment mechanism, plans may be reluctant to experiment in this way. The government offers plans some degree of protection from risk, but only time will tell whether it will be sufficient to encourage plans to take a risk by changing their basic benefit structure.

Congress's rationale for strongly discouraging beneficiaries from filling gaps in drug coverage is that if individuals purchased more comprehensive supplemental benefits, the cost of the catastrophic protections would rise. In other words, more people would "make it" to the catastrophic spending level (\$5,100) if they had supplemental coverage. The implications can be viewed two ways: people will be discouraged from unnecessary use of drugs, or people in need of help—who limit drug use since they cannot afford it—may never spend enough out-of-pocket to reach the catastrophic level. In practice, both of these outcomes, to a certain extent, will likely occur.

The new benefit's donut hole will likely anger many beneficiaries once they understand these rules. And indeed, it seems unfair to provide better protection, as a share of their spending burden, to those with \$2,000 in spending than to those with \$5,000 in spending. Filling the gap, however, would be very expensive—perhaps as much as \$70 billion over 10 years—since over 40 percent of all beneficiaries in 2006 will have expenditures greater than \$2,250.

Instead, the federal government is more likely to respond to beneficiary concerns by allowing drug plans to relax the \$3,600 out-of-pocket requirement. This still might not be enough, however, to encourage plans to step in and fill the gap in coverage, since insurance companies will likely remain fearful of adverse selection. Rather, there might need to be some further subsidy or protection for insurers who move in this direction.

**Low-Income Provisions**

For Medicare beneficiaries with low incomes, the legislation will generally result in an improvement in drug coverage. Beneficiaries with income up to 135 percent of poverty will pay no premium and be subject only to small copayments of \$2 per generic drug and \$5 per brand-name drug.<sup>7</sup> These provisions will be less generous for individuals covered by Medicaid in the approximately 16 states that provide comprehensive benefits and lower copayments or none at all. But many beneficiaries potentially would become newly eligible for drug benefits: the standard eligibility level for Medicaid is 74 percent of the poverty level, and only 17 states cover Medicare-eligible adults up to

100 percent of poverty.<sup>8</sup> Between 135 and 150 percent of the poverty level, the benefits begin to phase out as a sliding-scale premium is charged, a \$50 deductible is added, and copayments are increased. The Congressional Budget Office (CBO) has estimated that of the 14.7 million Medicare beneficiaries who would be eligible for the low-income subsidies, 6.4 million are “dual eligibles” (i.e., eligible for both Medicare and Medicaid) (Table 2). Thus, over half of the 14.7 million will become newly eligible for a drug benefit.<sup>9</sup>

The drug benefit is the same for everyone above 150 percent of poverty. Anyone with an income just slightly above this level will find it difficult to pay the benefit’s premium and required cost-sharing. Someone spending \$3,000 on drugs, for example, would pay about 12 percent of his or her annual income out-of-pocket for drugs even if they purchased the coverage.<sup>10</sup> Other beneficiaries who are above the 150 percent cutoff may end up being no better off than they currently are if they decide they cannot afford the premiums. Many of the people in this group who underuse drugs they need will likely continue doing so.

**Table 2. Eligibility of Medicare Beneficiaries in 2006 for Low-Income Subsidies**

	Income (% Federal Poverty Level)				Total
	100% and Below	101%–135%	136%–150%	151% and Above	
Number of Eligible Beneficiaries (millions)					
Subsidy A					
Dual eligibles	4.4	1.1	0.2	0.6	6.4
All other beneficiaries	2.7	3.1	0.0	0.0	5.8
Subsidy B	0.2	0.5	1.2	0.0	1.9
Not eligible for low-income subsidies	0.4	0.9	0.5	23.7	25.4
<b>Total Medicare beneficiaries</b>	<b>7.7</b>	<b>5.6</b>	<b>1.8</b>	<b>24.2</b>	<b>39.4</b>

Note: Components may not sum to totals due to rounding.

**Eligibility and benefits under Subsidy A:**

1. Individuals would qualify if they have incomes below 135 percent of the Federal Poverty Level and countable assets of less than \$6,000 for an individual or \$9,000 for a couple. Those amounts would be adjusted for inflation in later years. Dual eligibles would also qualify, regardless of their income or assets.
2. Eligible individuals would receive a full premium subsidy and pay only nominal cost-sharing up to the catastrophic level; cost-sharing for dual eligibles in nursing homes or with incomes below the Federal Poverty Level would be further reduced or eliminated. Individuals would pay no cost-sharing above the catastrophic level.

**Eligibility and benefits under Subsidy B:**

3. Individuals who do not qualify for Subsidy A would be eligible for Subsidy B if they have incomes below 150 percent of the Federal Poverty Level and countable assets of less than \$10,000 for an individual or \$20,000 for a couple. Those amounts would be adjusted for inflation in later years.
4. Eligible individuals would pay a lower deductible and reduced cost-sharing for spending below the catastrophic level. They would also receive a premium subsidy that would be phased out for individuals with incomes between 135 percent and 150 percent of the Federal Poverty Level.

Source: Adapted from Congressional Budget Office.



The MMA also relies on asset tests to limit eligibility for low-income protections.<sup>11</sup> For beneficiaries below 135 percent of poverty, the maximum total assets permitted are \$6,000 per single adult and \$9,000 per couple. Because of the stringency and complexity of the qualification process, many low-income beneficiaries are likely to be excluded from these programs. And while the asset limits are higher for individuals living between 135 and 150 percent of the poverty level (\$10,000 in assets for individuals and \$20,000 for couples), even these are quite stringent—especially considering that beneficiaries expect to stretch their modest savings over many years to supplement their incomes.<sup>12</sup> The CBO estimates that 1.8 million individuals who would be eligible for benefits based on their income would be excluded because of the asset test; and another 700,000 people would receive lower subsidies because they would not meet the lower asset test requirement (Table 3).

The combination of strict income and asset tests and the reluctance of many Medicare beneficiaries to identify themselves as “poor” is expected to hold down the number of beneficiaries participating in the subsidized drug benefit. In calculating the likely costs of the legislation, the CBO assumed that only 75 percent of those with incomes below 135 percent of poverty, and just 35 percent of those with incomes between 135 percent and 150 percent of poverty, would actually participate.<sup>13</sup> These participation levels are similar

to those found for the current Medicare Savings Programs.

Will states do more to fill in these gaps in low-income protections? While states are precluded from covering the copays required in the legislation from those with incomes below 135 percent of the poverty level, they are allowed to use funds from their pharmaceutical assistance programs to fill in the larger gaps in the basic benefit. Moreover, several of the larger state programs might continue to aid people above 150 percent of poverty, for example. But the new law also requires, through a provision referred to as the “clawback,” that states continue to pay a substantial amount of the existing costs of covering dual eligibles. This provision calls for states’ contribution to decline from 90 percent of what the expenses would have been without the Medicare drug benefit in 2006 to 75 percent of that level by 2015 and beyond. State contributions will also be adjusted upward to reflect increases in the number of dually eligible individuals.

### Indexation of the Benefit Structure

The various cutoff levels for the drug benefit, including the gap, will be indexed to the annual increase in the cost of the benefit itself. As a consequence, the \$3,600 gap is expected to rise to \$6,400 in 2013—a 78 percent increase (Table 4). Catastrophic protection in that year will not begin until an individual has spent \$9,066 on prescription

**Table 3. Annual Prescription Fills and Average Drug Spending, by Number of Chronic Conditions**

Number of Chronic Conditions	Prescription Fills	Average Drug Spending (2006 Dollars)	Percentage with More than \$2,000 in Drug Spending
0	8	\$1,346	18%
1	12	1,819	27
2	18	2,543	43
3	24	3,426	56
4	30	4,046	66
5 or more	40	5,673	75
<b>Total</b>	<b>23</b>	<b>\$3,320</b>	<b>51%</b>

Note: Excludes end-stage renal disease and beneficiaries living full-time in a nursing facility.

Source: Urban Institute analysis of 1999 Medicare Current Beneficiary Survey. Spending in 2006 adjusted for Congressional Budget Office estimates.

**Table 4. Standard Drug Benefit, 2006 and 2013**

	2006	2013
Annual deductible	\$250	\$445
Coinsurance to initial limit	25%	25%
Initial limit	\$2,250	\$4,000
Out-of-pocket threshold	\$3,600	\$6,400
Coverage gap	\$2,850	\$5,066
Coinsurance above OOP (greater of)	\$2/\$5 or 5%	\$3/\$8 or 5%

Source: Adapted from Congressional Budget Office.

drugs. At the same time, incomes of Medicare beneficiaries and their eligibility for low-income protection are expected to rise at a much smaller rate over this period—by only about half that amount. If that is indeed the case, beneficiaries' share of income devoted to prescription drugs will rise over time, even for those who choose to receive the drug benefit. So, for example, someone living above 150 percent of the poverty level in 2006 who spends 12 percent of her income on the benefit premium and out-of-pocket drug spending would be spending about 18 percent of her income on drugs by 2013.

### THE STRUCTURE OF THE DRUG BENEFIT

The new law allows prescription drug benefits to be offered only through private insurers (unless a fallback plan, explained below, is needed). This provision makes it more cumbersome for beneficiaries who choose to remain in the traditional, fee-for-service Medicare program to get drug coverage. Many beneficiaries would likely have to purchase two private supplemental policies—a Medigap plan and a drug plan. Those who currently have a Medigap plan that includes a drug benefit may retain their current plan if the company continues to provide such coverage, or they will need to enroll in a new plan without the drug coverage and buy a standalone drug policy. Since the new drug plans are subsidized, they will represent a better value than Medigap with drugs, although many beneficiaries will still likely be confused about exactly what to do. Each year, this

group will have to make tough decisions—perhaps switching to a less comprehensive Medigap policy if the costs of drug plans rise steeply, for example. Beneficiaries also will need to compare the costs of traditional Medicare, plus various options for two supplemental plans, against the more comprehensive, but potentially more expensive and/or restrictive, private options. Medicare beneficiaries with employer-subsidized retiree plans are also likely to be facing new decisions when employers change their plans.

### Fallback Plans

In part because of geographic variations in spending on prescription drugs, some regions of the country may not be attractive to private drug plans. In these areas, fallback provisions will be critical to ensure that beneficiaries in traditional Medicare have access to drug coverage. The new legislation will create a federally run drug plan in areas where less than two private plans participate (only one of which must be a standalone drug benefit plan). The government will bear the insurance risk for the fallback plan and contract with a pharmacy benefit management company or another entity to process claims and administer the program. The fallback plan will remain in place only until new private plans enter the market.

The fallback option, however, will not be triggered as long as a given market has one plan offering a standalone drug benefit, as well as one Medicare Advantage plan. Such a minimal requirement could lead to a number of problems for beneficiaries. Those who live in such a market but wish to remain in traditional Medicare will not have any choice of drug plan, despite what many of the legislation's supporters have claimed.

Competition among plans was intended to ensure that enrollees' premiums and quality of coverage are reasonable. But in the absence of competition, the sole standalone plan participating in a given region could set its premium substantially higher than in other areas.<sup>14</sup> The new law does not provide for the federal oversight necessary

to prevent such overcharging. Furthermore, over three years, beneficiaries potentially could be forced to participate in three different plans—the original private plan, the federal fallback option (following the original plan’s withdrawal), and a new private plan (once the market becomes attractive again)—each with its own rules and premiums.

Another shortcoming of the rules established for fallback plans is that the government is not allowed to take advantage of the lower administrative costs it would incur compared with a standalone drug plan. In fact, the MMA explicitly requires the government to use the average private plan administrative costs when setting the fallback premium.

A better way to deal with beneficiaries remaining in traditional Medicare is to let them choose a federally run plan if they wish. Doing so would also enable the government to negotiate for lower rates on behalf of beneficiaries wanting to enroll in a government plan.<sup>15</sup> At a minimum, keeping the fallback option in place for several years would give beneficiaries a stable base. And if the government manages to operate the plan inexpensively, it should be allowed to pass savings on to beneficiaries.

### **Delayed Sign-Up**

Beneficiaries who delay enrollment past the initial period will be assessed substantial financial penalties under the MMA, with premiums rising by at least 1 percent for each month of delay. The increase, however, could be higher if the Secretary of Health and Human Services certifies that actuarial costs are greater. How actuarial costs are to be determined is not clear. For example, will health status be taken into account? If so, this would be the equivalent of underwriting and could preclude people with substantial health care needs from obtaining reasonably priced coverage. In addition, if someone loses creditable coverage during the year and does not qualify for a special enrollment period, the government could assess a late penalty. For these reasons, it will be important to monitor

the regulations formulated for this part of the legislation.

In order to protect beneficiaries, especially in the drug benefit’s early years, plans will need to balance mechanisms used to encourage people to sign up against penalties for individuals who may be skeptical or confused about the benefits. The legislation could be improved by creating a longer initial sign-up period before late penalties are assessed.

### **Formularies**

Formularies, which specify the drugs covered by a plan, will likely serve as a major source of cost-containment efforts. For example, for a therapeutic class of drugs aimed at meeting specific needs (such as lowering cholesterol), plans could limit the number of drugs covered to just two. Plans could also specify levels of copayments by type of drug, differentiating between those that are preferred and others within a therapeutic category. In addition, plans could promote the use of generic drugs over brand-name ones.

These tools can be used to reduce the costs of drugs, which can in turn lower beneficiaries’ premiums. But they also add to beneficiaries’ confusion. Moreover, the rules can change during the course of the year, and they do not have to be disclosed before people enroll. A formulary need be disclosed only at the time of enrollment—and even then, beneficiaries may only be given a Web site address or phone number to obtain that information. This makes it very difficult to compare plans—presumably the reason for offering multiple plans.

Generally, the way in which pharmacy benefit managers or other entities that might offer plans achieve savings is to steer patients to those drugs for which the manufacturer has offered the biggest discount. Such an approach, however, may not be the best one from a health perspective. Without adequate information about the comparative effectiveness of related drugs and the presence of side effects, the formulary may not steer patients



to the drug that would best meet their overall health needs. The Veterans Administration and a number of states have begun to modify their formularies in cases where such data are available. With the investment of additional resources, Medicare could further advance the state of knowledge with regard to comparative drug efficacy and safety.<sup>16</sup> Funds were not appropriated for this purpose, however.

### **Standalone 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 opt to stay in traditional Medicare, drug benefits would be provided by a separate, standalone drug plan. Many experts in both the private and public sectors have expressed doubts about insurers' ability to offer standalone benefits.<sup>17</sup> One concern is that risk adjustment will not be as effective for a standalone benefit as it would for an integrated benefit package, because individuals who know that they have high drug expenses are likely to congregate in more comprehensive plans to a greater degree than risk adjustment models assume. Another is that standalone plans will require their own administrative structures. For these reasons, they will likely be more expensive to operate than integrated benefit plans—and could saddle beneficiaries remaining in traditional Medicare with higher costs.

### **GREATER PRIVATIZATION IN MEDICARE**

The new PPO option added by the MMA provides Medicare Advantage plans with special subsidies to encourage private insurers' participation in Medicare. Privatization has been touted by its supporters as the means to achieve slower rates of growth in Medicare spending over time. These supporters also claim that traditional Medicare will not be harmed in any way by the new law. Skepticism about both claims is at the heart of criticism leveled at the legislation.

### **The Likelihood of Savings from Relying on Market Forces**

Those opposed to Medicare relying on private plans point to evidence suggesting that these plans are unlikely to slow cost growth over time. They also cite practical concerns about whether new features, such as standalone prescription drug plans, will work at all. To date, the evidence indicates that privatization will not achieve savings for Medicare.<sup>18</sup> Certainly, the claim that privatization is essential for holding down Medicare's costs is on shaky ground: recent experience with Medicare+Choice managed care plans suggests that year after year, beneficiaries are paying more and getting less value in return.<sup>19</sup> Moreover, spending growth in Medicare over the last 30 years has been lower than that in both private insurance and the Federal Employees Health Benefits Program.<sup>20</sup>

Serving mainly healthier, and less costly, Medicare beneficiaries, private plans appear more efficient than they actually are. While plans have offered enrollees additional benefits with the excess payments they receive, plans have not saved money for the federal government. It is simply difficult for private plans to compete with Medicare. While managed care has been able to hold down costs by obtaining discounts from hospitals, doctors, and other care providers, few plans can do as well as Medicare, with its enormous purchasing power. Furthermore, administrative costs for private plans are quite high. The only other avenue for plans to save money is to truly manage care by reducing use of goods and services or creating networks of providers with less costly practice "styles." But most private plans have thus far not created any new or innovative care delivery systems that generate substantial savings over time while keeping consumers satisfied.

Private plans have been able to succeed largely where they have attracted healthier-than-average enrollees and hence implicitly have been overpaid by Medicare. Risk adjustment has been such that the health status of enrollees of one private

plan is compared only to that of enrollees of another private plan; health status of beneficiaries in traditional Medicare is not even taken into account.

Under the MMA, payments to private plans are likely to continue to exceed the cost of providing benefits through the traditional Medicare program. The CBO estimated that between 2005 and 2013, private plans would add \$14 billion to the cost of the legislation in bonus payments. The subsidies would be made directly, through explicitly higher payments to plans, and indirectly, since an implicit subsidy would be included in the monthly payment to plans to help support medical education and care for indigent hospital patients. These items add to traditional Medicare's costs but are not usually an expense to private plans.<sup>21</sup> 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. The CMS Office of the Actuary estimates that the bonus payments will enable plans to offer more benefits and attract more beneficiaries. Because of this, they assume greater enrollment in private plans and greater privatization will cost the program \$46 billion rather than the \$14 billion extra.<sup>22</sup> Experimenting with new private plans for Medicare makes sense, but private 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 simply to increase the share of beneficiaries enrolling in private plans.

If plans must be paid more than it costs to serve beneficiaries in traditional Medicare, how is it possible to assume that they will save money for the program over time? In the case of PPOs, savings arise from enrolling "efficient" health care providers—those who are less likely to order tests and procedures—in their networks. But savings also derive from paying very low amounts on services used outside the network, through higher copayments and by setting payments for such services at a very low level. This creates a conundrum

for Medicare: by limiting how much beneficiaries must pay for using out-of-network services, the legislation effectively eliminates a major cost-saving tool for PPOs. There will likely be pressure on Congress to give PPOs more flexibility in paying for out-of-network services in order to keep PPOs in the program.

Another limitation on plans' ability to generate price competition, and thus increased savings, is the emphasis on consumer choice. If plans can vary in the benefits they offer, they may rely on marketing and benefit structure, rather than lower premiums, to attract customers. For this reason, some proponents of competition say that cost savings will be determined in part on the extent to which price is emphasized, which in turn will depend on minimal variance in plans' benefits.<sup>23</sup> Ironically, one of the selling points of private plans—that people can get precisely the benefits they want rather than being limited by a "one-size-fits-all" approach—may be at odds with holding down the costs of health coverage.

Why should beneficiaries care about the rate of spending growth? First, there likely will be greater pressure to achieve savings by allowing, for example, PPO plans to limit what they pay out-of-network providers and providers, in turn, to pass on higher costs to beneficiaries. Second, lower-priced plans, even ones of questionable quality, may be promoted, putting traditional Medicare or higher-priced plans at a disadvantage. Although finding new ways to pay plans is the focus of the 2010 "demonstration," higher-than-anticipated growth rates may speed up that process and encourage supporters to skip the experimental period altogether. This approach is expected to put traditional Medicare at a disadvantage. Finally, subsidies to private plans are likely to create an unequal playing field that will penalize beneficiaries enrolled in traditional Medicare even before 2010.

### **A Level Playing Field for Medicare?**

Thanks to higher payments to private plans, Medicare Advantage insurers that provide all

Medicare benefits will be able to offer improved benefits. Traditional Medicare, meanwhile, will not be allowed to improve its currently inadequate benefit package. The approach, in effect, favors the healthy over the sick. That is because individuals who remain in traditional Medicare are likely to be sicker than the average beneficiary and unwilling to take a chance on a new insurance option.<sup>24</sup> According to the Centers for Medicare and Medicaid Services (CMS), traditional Medicare enrollees are more costly than Medicare+Choice enrollees because of adverse risk selection.<sup>25</sup> But the application of risk adjustment does not take into account differences in risk between beneficiaries in traditional Medicare and those in private plans. It will only affect payment levels across private plans. Further, Medicare Advantage plans will have some additional flexibility in coordinating drug benefits with other coverage to create more generous benefits.

People wishing to remain in traditional Medicare are also at a disadvantage because they must purchase two separate supplemental policies to obtain comprehensive coverage. Doing so entails added administrative costs and complexity for these beneficiaries, further tilting the playing field in favor of private plans.

In describing the new PPO options, their supporters often suggest that these plans are just like traditional Medicare in terms of having a choice of any doctor or hospital. But PPO enrollees, in truth, will incur substantially higher costs if they have to go out-of-network to get the doctors of their choosing. Nonetheless, if “educational” materials oversell these new plans, beneficiaries may enroll in them with false hopes. Large shifts of beneficiaries into the new PPO options may not be a valid test, under these conditions, of private plans versus traditional Medicare.

### **Further Privatization in 2010**

If it is eventually adopted as a permanent policy, the demonstration slated to begin in 2010 would effectively move the Medicare system toward a defined contribution approach. Federal payments

to all options under Medicare, including the fee-for-service component, would be based on a share of the average of all premiums. This would place a cap on the government’s contribution toward the cost of premiums. As a result, any plan wishing to charge a higher-than-average premium would have to charge enrollees a substantially greater share—potentially dividing Medicare beneficiaries on the basis of ability to pay. Moreover, it will not always be the case that higher premiums reflect true differences in benefits or quality of care. Plans that attract a higher-than-average percentage of sick beneficiaries (which will likely include traditional Medicare) will have to charge higher premiums, unless a highly effective risk adjuster is developed by 2010 and applied across all plans, including traditional Medicare.

While this undertaking is only a demonstration, individuals living within its targeted areas will have no choice but to take part. If they are in traditional Medicare and wish to remain there, they will likely face higher premiums over time than will beneficiaries in traditional Medicare living outside the demonstration areas. As in the past, it will likely prove very difficult to undertake this demonstration, since it will potentially harm some beneficiaries relative to others. Nevertheless, the temptation may well be to move toward full implementation of a defined contribution approach. Limiting payments to private plans, while shifting higher costs onto beneficiaries, may turn out to be the only way to ensure that privatization “saves” money.

## **OTHER ISSUES RAISED BY THE LEGISLATION**

### **Problems Arising from Complexity**

Medicare beneficiaries who wish to shift their coverage to PPOs or remain in existing Medicare HMOs may have most of their needs met in one plan, but they will still have to choose among various benefit packages. The new PPOs promoted by the MMA will create in-network and out-of-network benefits, deductibles, and cost sharing,

essentially doubling the number of rules that beneficiaries must negotiate. In addition, different PPOs could have different networks of providers, which could affect beneficiaries' ability to find health care services at a reasonable cost. Complicated benefit packages that vary from plan to plan will make informed choice difficult for most beneficiaries. To help people make true comparisons, standardized benefit designs would be needed. However, standardization necessarily places limits on the flexibility plans will be able to offer.

### **Information and Support for Decision-Making**

Even well-educated consumers currently struggle to understand Medicare. What's more, nearly a quarter of Medicare beneficiaries have health problems, such as declines in sight or cognitive skills, that make it difficult to make an informed choice about their care.<sup>26</sup>

The current level of CMS funding for beneficiary information and education is insufficient to deal with the existing system, much less meet the greater needs that will arise under the new one. Yet, the MMA sets aside only \$1 billion in new funding to cover all aspects of implementation. Even if half of those resources were devoted to beneficiary education, that would mean an average of only \$12 per enrollee, and the amount will likely be much lower than that. Leaving the task of informing beneficiaries about the new system to private plans may lead to misleading advertising. Beneficiaries require independent sources of information, such as State Health Insurance Assistance Programs (SHIPs). And groups providing this assistance require substantial funding to meet the likely surge of beneficiaries needing help.

### **Opportunities for Gaming the System**

The complexity of 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 caseworkers can straighten out these issues, the same problem often recurs in the same HMO.<sup>27</sup> 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 is not linked to an automatic feedback mechanism to help correct such problems. Opportunities for denial of benefits to beneficiaries, arbitrary shifting of drugs on or off the preferred list, and manipulation of payments to out-of-network providers will expand considerably under the new legislation, with its new PPOs, standalone drug plans, and bonus program. Again, substantial resources would need to be devoted to ensure that consumers are protected from such activities.

### **Disruptions over Time**

Private plans wishing to provide either the standalone drug benefit or the broader private options are required to participate for only one year. Such a short commitment may create a hardship for beneficiaries, who need a stable source of treatment to reduce confusion and ensure quality of care. If plans are permitted to enter and leave markets with such frequency, beneficiaries will be faced with problems similar to those that have caused so much dissatisfaction with Medicare+Choice. In that program, insurers have withdrawn entirely from certain regions of the country. 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. Consequently, beneficiaries are forced to look for a new plan or, as evidence from California suggests, stay in inadequate, expensive plans.<sup>28</sup> Longer terms for the government's 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. And, as discussed above, improvements are needed to the fallback provisions for the drug benefit.

## Higher Part B Deductible in Traditional Medicare

An increase in the Part B deductible (for physician services, outpatient hospital treatment, and home health care) has been discussed frequently as a means of saving federal dollars. The Part B deductible, currently \$100, will rise to \$110 in 2005 and then will increase by the same percentage as the Part B premium. Although the current deductible is low relative to employer insurance plans, other areas of cost-sharing are much higher under Medicare. The Part B deductible increase does make sense as a structural change, but it would be better to make this change while also reducing beneficiary cost-sharing where it is too high.

## Means-Testing the Part B Premium

The MMA institutes a higher Part B premium starting with individuals whose annual incomes exceed \$80,000 and couples whose incomes exceed \$160,000. This requirement keeps the income test on the revenue side—an important improvement over a requirement originally offered in the House of Representatives version of the drug bill. As a consequence, people at higher income levels will have to pay more but the principle of giving everyone the same benefit remains intact. The CBO estimates that when this provision begins in 2007, it will affect only 3 percent of beneficiaries; the share of beneficiaries subject to the income-related premium is expected to rise to 6 percent by 2013.<sup>29</sup>

The payroll taxes that make up about half of Medicare's financing are charged on all wages, no matter how high. Individuals with very high incomes therefore already contribute far more than it costs to serve them. Since the drug benefit is paid out of general revenues, people with substantial incomes who become Medicare beneficiaries will continue to contribute even after retirement. This new requirement builds on an existing financing system that asks higher-income beneficiaries to pay more. Nonetheless, it remains a controversial provision to many supporters of social

insurance, who see this as a first step toward breaking down the universality of the benefit.

The issue of greatest concern, however, is whether the resources that will be obtained through means testing will be substantial enough to justify the considerable new administrative costs and reporting requirements the government will engender. That is, the Social Security Administration will be required to obtain data from the Internal Revenue Service from the previous year's tax filings in order to calculate what premium to charge each Medicare beneficiary.

## CONCLUSION

Offering \$410 billion in new drug benefits will certainly help many beneficiaries now struggling with the costs of prescriptions, particularly those with low incomes. It is difficult to determine, however, whether beneficiaries will be better off in the long run under the new legislation. The drug benefits will not grow with the needs of beneficiaries, and other changes that prove to be unworkable or that place some beneficiaries at risk will create added costs. For example, if the payment system is changed to reflect a defined contribution premium-support approach, premiums for traditional Medicare could rise disproportionately if sicker beneficiaries remain in the traditional fee-for-service plan. In the meantime, favorable treatment of private plans will create new inequities. The ability to truly compare the viability of traditional Medicare with that of private plan options has been severely compromised.

Additional legislation and carefully crafted regulations could certainly mitigate a number of these issues. However, it may be difficult to engage in a constructive debate about the legislation's problems following the rancor in the debate over passage. Although it will be some time before many parts of the legislation go into effect, some provisions begin this year. These will need to be closely scrutinized before creating a new set of constituencies for this new status quo.<sup>30</sup>



## NOTES

- <sup>1</sup> Letter from the Congressional Budget Office to Congressman Bill Thomas, Chairman, Ways and Means Committee, Nov. 20, 2003.
- <sup>2</sup> 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).
- <sup>3</sup> 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).
- <sup>4</sup> The exception to this is that state pharmaceutical benefit programs will be allowed to fill in the gaps for people eligible for these benefits. At present, only four states have plans that provide benefits to substantial numbers of people above 150 percent of poverty. In addition, there is no penalty on employer-subsidized plans that are more comprehensive than the new benefit package. In fact, as long as the package provides coverage at least at the level of the basic plan, employers will qualify for a subsidy toward the costs of that benefit.
- <sup>5</sup> CBO private communication.
- <sup>6</sup> Fred Teitelbaum et al., 2002 Express Scripts Drug Trend Report, Express Scripts, Inc., June 2003.
- <sup>7</sup> Institutionalized individuals face no cost-sharing requirements and those with incomes below 100 percent of poverty who are dually eligible have slightly lower cost-sharing requirements.
- <sup>8</sup> Henry J. Kaiser Family Foundation, *State Health Facts Online*. Available at <http://www.statehealthfacts.org>.
- <sup>9</sup> Some of these individuals, however, might be enrolled in state-only pharmaceutical benefit plans. This estimate is contained in a Congressional Budget Office letter to Senator Don Nickles, Nov. 20, 2003.
- <sup>10</sup> This calculation assumes an annual income in 2006 of \$15,400 and includes the premium and cost-sharing required.
- <sup>11</sup> 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).
- <sup>12</sup> 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).
- <sup>13</sup> CBO letter to Senator Don Nickles, Senate Budget Committee, Nov. 20, 2003.
- <sup>14</sup> While many people believe that the \$35 premium was set as the amount that all individuals would pay, in practice it could vary substantially by area.
- <sup>15</sup> In fact, such an arrangement would most likely be necessary to satisfy those who would like to allow the government to negotiate prices. Price negotiations by the government would be alternative to the arrangements made by competing private plans.
- <sup>16</sup> This is discussed in more detail in another brief in this series: Marilyn Moon, “Formularies and Their Role in Cost Containment,” The Commonwealth Fund, forthcoming.
- <sup>17</sup> 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 standalone drug plans are unworkable.
- <sup>18</sup> GAO, “Medicare+Choice: Payments,” 2000.
- <sup>19</sup> 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).

- <sup>20</sup> Katharine Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, and the Health Accounts Team, “Health Spending Rebound Continues in 2002,” *Health Affairs* 23 (Jan./Feb. 2004): 147–59; Cristina Boccuti and Marilyn Moon, “Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades,” *Health Affairs* 22 (Mar./Apr. 2003): 230–37; and Karen Davis, Barbara S. Cooper, and Rose Capasso, *The Federal Employees Health Benefits Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003).
- <sup>21</sup> 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 will restore those amounts.
- <sup>22</sup> CMS, Office of the Actuary estimates, Feb. 2004.
- <sup>23</sup> Comments by Robert Reischauer and Jeff Lemieux at Alliance for Health Reform meeting, 2003.
- <sup>24</sup> 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.
- <sup>25</sup> Office of the Actuary, Centers for Medicare and Medicaid Services, “Note to Medicare Advantage Organizations and Other Interested Parties,” Jan. 16, 2004.
- <sup>26</sup> 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.
- <sup>27</sup> Medicare Rights Center, *Systematic Problems with Medicare HMOs* (New York: MRC, Sept. 1998). Available at <http://www.MedicareRights.org>.
- <sup>28</sup> Tom Buchmueller, “The Health Plan Choices of Retirees Under Managed Competition,” *Health Services Research* 35 (Dec. 2000, Pt. 1): 949–76.
- <sup>29</sup> CBO letter to Senator Max Baucus.
- <sup>30</sup> CBO letter to Senator Don Nickles, Senate Budget Committee, Nov. 20, 2003.

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