



820 First Street, NE, Suite 510, Washington, DC 20002  
Tel: 202-408-1080 Fax: 202-408-1056 center@cbpp.org www.cbpp.org

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## **THE TROUBLING MEDICARE LEGISLATION**

by Edwin Park, Melanie Nathanson, Robert Greenstein, and John Springer

The final Medicare drug bill that the President will sign into law today will cost an estimated \$395 billion over ten years, and much larger amounts in succeeding decades as drug prices continue to rise. (It will cost more than \$1 trillion in the second decade it is in effect, according to the Congressional Budget Office.) Because the legislation is not “paid for,” it will substantially worsen the nation’s long-term fiscal problems, which already threaten to be the most serious in the nation’s history.

This raises a fundamental question: is the legislation sound enough policy to justify substantially worsening an already grim long-term fiscal outlook? Examination of the legislation strongly suggests the answer is no. The legislation contains a number of features that do not represent sound policy, either because they would change Medicare in troubling ways or because they fail to incorporate measures to curtail spiraling drug costs that ought to be an essential part of any legislation to establish a Medicare drug benefit.

Of particular concern on the fiscal front is the legislation’s failure to include true cost-containment provisions that would moderate the escalating cost of drugs to both the federal Treasury and American consumers. The legislation could have used Medicare’s enormous purchasing power to negotiate significantly lower prices for drugs (as, for example, the Department of Veterans Affairs and the Medicaid program do). Instead, at the apparent behest of the pharmaceutical industry, the legislation prohibits Medicare from playing this role. The legislation also fails to include a meaningful provision to facilitate the reimportation of drugs at reduced prices from Canada and contains only a weak provision to make generic drugs more widely available.

Given that the legislation will cover less than one-quarter of the prescription drug costs of elderly and disabled people, the failure to include meaningful cost-containment measures will not only swell the costs that the legislation will impose on a federal budget already deep in deficit, but also will cause consumers to pay more for drugs than would have been the case under better-designed legislation.

In addition, while bypassing true cost containment, the legislation contains a so-called cost-containment measure that could lead to increases in premiums, deductibles, co-payments and payroll taxes in the name of controlling Medicare costs and that would be triggered even if Medicare costs rise *more slowly* than projected and Medicare drug costs turn out to be lower than projected. This so-called cost control mechanism is designed in a regressive fashion. Increases in premiums and payroll taxes — which would heavily affect low- and middle-income

households — could be used to moderate Medicare cost increases, but increases in progressive income taxes could not be.

Another shortcoming of the legislation is that despite the expenditure of very large sums, the legislation will make several million of the nation's poorest elderly and disabled citizens *worse off*, requiring them to pay more for drugs than they do today and possibly to lose access to some drugs they now receive. (The legislation also is projected to cause more than two million retirees to lose retiree drug coverage they now have.) One reason the legislation will have this effect is that provisions injurious to low-income elderly and disabled people who receive both Medicare and Medicaid were added in conference to generate savings that apparently were used to help finance the large subsidies the final bill contains for private, for-profit health plans to provide Medicare benefits. These subsidies are doubly troubling; they cause insufficient resources to be available for other aspects of the legislation, and they exacerbate an already unlevel playing field in which heavily subsidized private managed care plans (that generally limit patients' choices of doctors) would be given an unfair advantage in providing Medicare benefits over traditional fee-for-service, leaving many beneficiaries no choice but to leave traditional Medicare and switch to private plans if they want to have a larger share of their drug costs covered.

Finally and of particular concern, the legislation contains a major new health-insurance related tax shelter that could cause premium charges for employer-based comprehensive health insurance to rise substantially over time by providing major tax incentives for healthier, more affluent workers to switch from comprehensive health insurance to the high-deductible health insurance policies that would be packaged with the lucrative new tax shelters. This would cause the pool of employees remaining in comprehensive employer-based coverage to become older and sicker, on average — and hence more costly to insure — which would necessitate increases in premiums for comprehensive employer-based coverage.

In short, the legislation is likely to lead to major problems and adverse outcomes on a number of fronts. It is difficult to justify sharply worsening the nation's long-term fiscal outlook in enacting this legislation.

A discussion of five troubling aspects of the Medicare drug legislation follows.

- 1. Private plans:** Under the Medicare program, beneficiaries can elect to receive all of their Medicare benefits from private managed care plans (primarily HMOs) rather than through traditional fee-for-service. According to the Medicare Payment Advisory Commission, a nonpartisan organization established by Congress to analyze Medicare payment policies, Medicare already pays these private managed care plans at rates that are 19 percent higher than traditional Medicare pays. (This differential is the result both of provisions in the Medicare statute that require higher payments to private managed care plans in certain geographic areas and of the fact that Medicare beneficiaries who enroll in the managed care plans tend to be healthier — and hence to have lower average health care costs — than beneficiaries who enroll in traditional Medicare fee-for-service.) The new Medicare legislation exacerbates this disparity in payments; it increases payments to these private plans (both HMOs and new Preferred Provider Organizations) by another \$14 billion over the next

ten years. This will result in the private plans being paid approximately 25 percent more than Medicare fee-for-service pays for comparable services to comparable beneficiaries. As explained below, this disparity has significant implications for inducing more Medicare beneficiaries to leave fee-for-service Medicare for private plans.

In addition, starting in 2010, a six-year “demonstration project” to test the “premium support” approach will operate in six metropolitan areas. Medicare recipients in the demonstration areas will choose between traditional Medicare and private health plans from which to receive their Medicare benefits. If the average cost per beneficiary for the form of coverage that a beneficiary selects exceeds a benchmark level established for the area, the beneficiaries enrolled in the type of coverage with the “excess” costs will be required to pay added premiums to cover the difference. This is likely to result in increases in premiums for traditional Medicare fee-for-service; the cost of traditional Medicare is likely to exceed the benchmarks because many of the healthier beneficiaries will have been siphoned off into the private plans, causing the people left in traditional Medicare to constitute a group that is sicker on average and hence has higher average health care costs. The likely result will be that older and sicker beneficiaries who remain in traditional Medicare in the demonstration areas will be charged substantially higher premiums for Medicare coverage over time.

- **The generous subsidies provided to the private managed care plans will create an unlevel playing field, which is likely to leave many beneficiaries with little choice but to switch to private plans for their Medicare benefits if they wish to receive less skimpy drug coverage.** Under the new legislation, the Medicare drug benefit will provide no coverage whatsoever for a beneficiary’s total drug spending in excess of \$2,250 a year, until the beneficiary’s out-of-pocket drug costs reach \$3,600, at which point the drug benefit will cover 95 percent of further costs. Furthermore, as a result of a provision buried in the bill (that apparently may not have been well understood when the bill was voted on), the legislation *prohibits* the sale of “Medigap” policies that cover prescription drug costs in this coverage “hole.” Most Medicare beneficiaries in fee-for-service (except for those who have retiree coverage through their former employer) will have only one way to secure help with drug costs in this large coverage hole — by giving up their choice of doctors and enrolling in a private managed care plan that provides some additional coverage for drug costs in the coverage hole.

Private managed care plans generally will be able to offer drug coverage in the coverage hole and lower beneficiary cost-sharing (as well as extra benefits in other areas) because of the billions of dollars of extra federal subsidies they will receive. The legislation thus tilts the playing field in favor of the private managed care plans. By so doing, it will essentially force many beneficiaries who otherwise want to remain in traditional Medicare so they can retain their choice of doctors to switch to managed care plans in order to secure the broader drug coverage and other expanded benefits that the private plans can offer, as a result of the large subsidies they receive.

For these reasons, in analyzing the House version of the Medicare legislation, the actuaries at the Centers for Medicare and Medicaid Services previously estimated that the proportion of Medicare beneficiaries who enroll in private managed care plans instead of

traditional Medicare will rise from less than 15 percent of beneficiaries today to over 40 percent by 2010.

In short, while the idea of introducing more competition into Medicare through the expanded use of private plans has been promoted as a “reform” that can restrain rising Medicare costs, the reality is that the legislation *increases* Medicare costs by overpaying private plans in order to induce more beneficiaries to enroll in them. Examination of the details of the legislation indicates that the ideological goal of privatizing more of Medicare trumped the stated goal of using “competition” to restrain the rate of growth in Medicare costs.

- **The premium support demonstration is considerably larger than is needed for a demonstration project and is likely to cause a substantial increase in premiums for traditional Medicare coverage for beneficiaries in demonstration areas.** Data from the Department of Health and Human Services show that the premium support demonstration could cover several million beneficiaries. While this is a much smaller number than would have been covered under earlier proposed versions of this demonstration project, it still substantially surpasses what is needed to conduct a valid demonstration.

The two analysts who developed the premium support concept in the mid-1990s — Henry Aaron of Brookings and Bob Reischauer of the Urban Institute — have long noted that premium support poses serious dangers unless it is accompanied by regulatory and other measures to assure that the private plans do not “cherry-pick” the healthier beneficiaries, leaving traditional Medicare with the sicker ones. If these safeguards are not included and the private plans are able to serve a healthier clientele, premium support is likely to lead to increases in premiums that could become quite large for the less healthy beneficiaries who remain in traditional Medicare.

The new Medicare legislation lacks such safeguards. As a result, it poses dangers to older and sicker beneficiaries in the demonstration areas. Traditional Medicare almost certainly will cost more per enrolled beneficiary than the private plans, both because it will be serving a sicker population, on average, and because of the billions of dollars in added subsidies the legislation provides to the private plans. (These subsidies are not counted when comparing the per-beneficiary costs under the private plans and traditional Medicare.) In the demonstration areas, the resulting differences in per beneficiary costs may cause the premiums that retirees left in traditional Medicare must pay to rise substantially.

2. **Health Savings Accounts:** Tax-advantaged savings accounts to pay out-of-pocket medical expenses, which exist today only under a limited demonstration project, will be made universally available. These accounts will be available to people with high-deductible health insurance policies; the accounts cannot be used in conjunction with the comprehensive health insurance coverage that employers have traditionally offered. Holders of these accounts will be able to make tax-deductible deposits in them, watch the earnings compound tax-free, and pay no tax upon withdrawal as long as the funds are used for medical expenses.

- **This establishes a new, unprecedented and extremely lucrative type of tax shelter.** All existing tax-advantaged savings or retirement accounts provide a tax break when funds are deposited *or* when they are withdrawn, *but not both*. If a precedent of providing both “front end” and “back end” tax breaks is established, the political pressure to do the same for other types of savings and retirement accounts could become irresistible. A proliferation of tax-free accounts of this type would send federal deficits to much higher levels.
- **It could undermine comprehensive health insurance.** Healthy, affluent workers would have a strong incentive to opt out of comprehensive health insurance plans in favor of the new accounts: they would receive a large tax break, and they would not be much affected by switching to a high-deductible health policy since they generally use fewer health services. If large numbers of such workers opt out of comprehensive plans, the pool of people left in comprehensive plans would be older and sicker, causing premiums for comprehensive insurance to rise significantly. Premiums for comprehensive, employer-based coverage could *more than double* if such accounts became widespread, according to major studies conducted in the past by RAND, the Urban Institute, and the American Academy of Actuaries.

That, in turn, would drive still more healthy workers out of comprehensive insurance, making those that remain even more costly to insure and adding pressure on employers to stop offering comprehensive coverage. Older and sicker workers could wind up paying more for health coverage or losing it altogether and becoming uninsured.

3. **Effects on Low-income Elderly and Disabled People Covered by both Medicare and Medicaid:** Currently, if a benefit is covered by Medicare and Medicaid alike, the low-income elderly and disabled people who are eligible for both programs receive the benefit through Medicare and also receive any additional assistance that Medicaid may provide, such as a lower co-payment for the covered services. The final Medicare legislation takes the unprecedented step of eliminating this Medicaid “wrap-around” coverage with respect to the new drug benefit. That will have adverse consequences for several million poor elderly and disabled people.

- **Many low-income Medicare beneficiaries will end up worse off than under current law and eventually may have difficulty affording their drugs.** Low-income elderly and disabled people who qualify for Medicaid now receive drugs through Medicaid free of charge or pay nominal charges. (In most states, they receive drugs without charge or pay \$1 or \$2 per month per prescription.) Under the new legislation, such beneficiaries will be required to begin paying \$3 per month per brand-name prescription and \$1 per month per generic-prescription if they have incomes below the poverty line, and \$5 per month per brand-name prescription and \$2 per month per generic-drug prescription if they are modestly above the poverty line. This could pose problems for seriously ill people who have a large number of medications.

Of particular concern, the \$5 and \$2 co-payment amounts that Medicare beneficiaries, who are also on Medicaid and have incomes modestly above the poverty line (now \$8,980 for a single individual), will be charged will be increased each year at the rate that

drug costs rise per Medicare beneficiary. The Congressional Budget Office has projected these costs will increase *at least 10 percent per year*. Yet low-income elderly and disabled beneficiaries generally live on fixed incomes such as small Social Security checks that rise with the general inflation rate, or *only 2 percent to 3 percent per year*. With the co-payment charges being increased each year at a rate three or four times greater than the rate at which Social Security checks will increase, prescription drugs are likely to become increasingly unaffordable over time for many near-poor elderly and disabled people who have a large number of prescriptions. Those who will be most sharply affected — elderly and disabled people modestly above the poverty line who qualify for Medicaid as well as Medicare — are generally people who have significant medical conditions and qualify for Medicaid because they already incur such high out-of-pocket health care costs that their *disposable* incomes, after these health care costs are taken into account, leave them below the poverty line. For a sick widow enrolled in Medicaid who has gross income of \$10,000 and incurs substantial out-of-pocket medical costs, the increased charges that she will have to pay for prescription drugs under the new Medicare legislation may present a significant hardship.

- **Low-income elderly and disabled Medicaid beneficiaries also are likely to lose access to some medically necessary drugs that they currently receive through Medicaid.** The new law allows the private insurance plans that will administer the new Medicare drug benefit for beneficiaries in fee-for-service (as well as the private managed care plans, if beneficiaries elect to receive all of their Medicare benefits including drug coverage through such plans) to cover as few as two drugs in each “therapeutic class.” Low-income elderly and disabled Medicaid beneficiaries who need a drug other than the drugs that their private plan elects to cover, and who currently are prescribed the drugs they need through Medicaid, stand to lose coverage for such drugs unless they file an appeal and emerge victorious in an appeals process. For poor, sick elderly and disabled people with depression, dementia, other mental or cognitive impairments, or physical ailments that limit their mobility, filing an appeal and negotiating the appeals process often will not be a viable alternative. (Moreover, in a departure from standard Medicare practice, the new legislation *prohibits* physicians from filing such appeals on behalf of their patients. If a physician believes a drug to be necessary for a patient but the private plan that delivers the drug benefit declines to cover the drug, the physician will not be able to file an appeal on behalf of the patient.)

The power that the legislation accords to private insurance plans administering the drug benefit to determine which drugs to cover will present a problem not only for low-income beneficiaries, but for all Medicare beneficiaries who cannot afford to purchase such drugs on their own. As noted above, beneficiaries who participate in the Medicare drug benefit will not be allowed to purchase Medigap policies that cover drugs the private plans elect not to include in the Medicare drug benefit. As Medicare expert Jeanne Lambrew has explained:

“The new law gives private insurers the authority to ration access to drugs funded by Medicare. Insurer-created committees decide what types of drugs to cover, which specific drugs to include on their formularies, and how high to set the beneficiary payment for each drug [except for the

payments that the low-income beneficiaries are charged]. It will be difficult and, in some cases, impossible to get drugs that are not included on an insurer's formulary. These restrictions, rarely seen in today's marketplace, mean that seniors who have drug coverage today could have less access to drugs under the plan."<sup>1</sup>

4. **Cost containment:** Each year the executive branch will project the share of overall Medicare costs that would be financed with general revenues. When that share is projected to exceed 45 percent within the coming seven years, the President will be required to submit legislation presumably to alter Medicare to bring the projected percentage back below 45 percent.
  - **Staying within the 45-percent threshold would entail making increasingly drastic changes in Medicare over time.** The share of Medicare costs covered by general revenues is rising, largely because of advances in medical practice that are permitting patients to have shorter hospital stays and that make wider use of outpatient services and prescription drugs instead. (Hospital stays are covered by Medicare Part A, which is funded by payroll taxes; outpatient services and prescription drugs are covered by Medicare Parts B and D, which are funded by general revenues.) General revenue costs are virtually certain to reach the 45-percent level in the second decade of this century and to keep rising above the 45-percent level after that, even if Medicare costs in general and Medicare drug cost in particular rise *more slowly* than projected. Adhering to a 45-percent limit will consequently entail making increasingly deep cuts in Medicare, such as lower provider reimbursement rates, reductions in benefits, or higher premiums and other forms of cost-sharing.
  - **The burden of financing Medicare could shift increasingly to working-poor families and middle-income families, as well as to Medicare beneficiaries.** The final Medicare legislation gives preferential treatment to income taxes over payroll taxes by setting a target for the maximum share of Medicare costs that may come from general revenues, and hence from income taxes. This preference favors higher-income people, since income taxes are progressive, while payroll taxes are regressive. By militating against general revenues as a source of added Medicare funding, the Medicare legislation makes increases in payroll taxes and/or higher premiums and co-payments for Medicare beneficiaries more likely. Both of these kinds of changes fall more heavily on people with low or middle incomes.
5. **Long-term effect on states:** State Medicaid programs face serious long-term budget pressures as a result of the impending retirement of the baby-boom generation. Rising drug costs for low-income Medicare beneficiaries who also qualify for Medicaid constitute a significant part of this problem, since drug coverage is the part of Medicaid that is growing most rapidly in cost, and drug costs are expected to grow still faster when the baby boomers retire in large numbers. The House version of the Medicare drug legislation would have phased out state financial responsibility for providing drug coverage to low-income Medicare beneficiaries. Such relief is likely to be essential if states are to be able to continue financing

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<sup>1</sup> Jeanne Lambrew, "Lost in the Fine Print: Ten Overlooked Policies that Harm Medicare and Its Beneficiaries," Center for American Progress, December 4, 2003.

their share of Medicare costs without instituting deep Medicaid cuts, once the baby boomers retire *en masse*.

The final Medicare legislation marks a major step backward from the House bill in this area; it removes most of the long-term fiscal relief the bill provided. Under the final legislation, states will remain responsible in perpetuity for 75 percent or more of the drug costs for low-income elderly and disabled people that states would have incurred if these beneficiaries had continued receiving drugs through Medicaid. Moreover, a sizeable share of the remaining savings will be consumed by new costs that the legislation imposes on states, such as the costs of determining eligibility for the new Medicare low-income drug subsidies.