

Assessing the New Medicare Prescription Drug Law

Robert B. Doherty, BA

The Medicare Modernization Act (MMA) is the product of a political compromise to attract moderate Republicans and enough Democrats without losing Republican conservatives. The compromise offered more private health plans to beneficiaries while maintaining and improving traditional Medicare's benefits. This compromise did not settle the debate over the legislation, which is a major issue in the 2004 elections. Voters poorly understand the law because of its complexity. In this paper, I explain how the policy decisions made by the U.S. Congress have contributed to the law's complexity and controversy. I examine the new private health plan options that will be offered to beneficiaries, improvements made to traditional Medicare, and the impact of introducing income-based determinations into Medicare. I also discuss the

impact of the drug benefit on beneficiaries in different income and assets categories and Congress's decision to prohibit the federal government from directly negotiating prices with drug manufacturers. I conclude by assessing the major claims made by critics and proponents. Both might be more circumspect in their assessments of the law's impact, since it is impossible to predict how a law of such complexity, with so many human variables, will work out in the end. The MMA is a worthwhile but imperfect effort to extend drug coverage to seniors who are most in need. It deserves neither condemnation nor indiscriminate praise but instead a commitment to help it succeed.

Ann Intern Med. 2004;141:391-395.

www.annals.org

For author affiliation, see end of text.

Is the Medicare Modernization Act (MMA) "a victory for all of America's seniors" (1) or a "sweetheart deal for Insurance companies . . . and pharmaceutical firms and a travesty for senior citizens" (2)?

The rhetoric about the legislation, which President George W. Bush signed into law on 8 December 2003, reflects the ideological divide that almost led to its defeat. Liberals believe that the benefit is too skimpy and that private insurers will skim off the healthier beneficiaries, driving up the costs of traditional Medicare and undermining it over time; on the other hand, conservatives do not like the establishment of a big new entitlement program (3). To bridge this gap, Congressional leaders designed a bill to attract enough votes from Democrats and moderate Republicans in the Senate without losing the support of too many Republican conservatives in the House of Representatives. They bridged the ideological gap by allowing beneficiaries to keep traditional Medicare with improved benefits, while offering them more choices of private plans.

The compromise did not end the debate, and the MMA is a major issue in the 2004 elections. With polls showing that voters do not understand the law, both political parties are trying to exploit the issue. One poll of elderly persons found that 53% said that they understood the law "not too well" or "not well at all" and only 14% understood the new law "very well" (4).

The public's difficulty in understanding the legislation is not surprising. It is complex, largely because of 4 decisions made by Congress:

1. By offering beneficiaries a choice of enrolling in private plans or in traditional Medicare with new preventive benefits, Congress adds complexity to the decision-making process for beneficiaries.

2. By insisting that the benefit stay within a \$400 billion expenditure limit over 10 years, Congress had to create a confusing cost-sharing structure to keep costs down.

3. By departing from Medicare's policy of providing

the same benefits at the same cost to all beneficiaries, Congress introduced complex determinations for assets and income.

4. By prohibiting direct price negotiation between the federal government and drug companies and instead relying on private insurers to negotiate discounts, Congress assures that drug costs and formularies will vary from plan to plan and locality to locality.

MORE PRIVATE PLANS

Effective 1 January 2006, beneficiaries can choose to remain in traditional Medicare and decline drug coverage, stay in traditional Medicare and purchase a "stand-alone" prescription drug policy, or opt out of traditional Medicare and enroll in a government-approved managed care plan that offers not only comprehensive medical care benefits at least comparable to traditional Medicare but also prescription drugs. Beneficiaries will be able to select coverage from health maintenance organizations or preferred-provider organizations. The health plan choices, called Medicare Advantage, replace the Medicare + Choice program created by the Balanced Budget Act of 1997. Medicare Advantage plans are allowed to provide benefits excluded from coverage under traditional Medicare, such as many preventive services, "well adult" physical examinations, and vision care.

The law increases payments to participating health plans, with an average increase of 6.6% scheduled for 2005. Although critics describe this as a health maintenance organization industry "pay-off," the higher payments are designed to prevent a repeat of the troubled history of the Medicare + Choice program, which was hampered by disruptive withdrawals of health plans from the market. According to Medicare officials, 4.6 million beneficiaries participate in Medicare Advantage, out of a total eligible pool of 36 million. Officials believe enrollment will increase as beneficiaries learn more about Medicare Advan-

tage. Other observers believe that the administration's expectations of increased enrollment in private plans are overly optimistic, given the advantages that traditional Medicare offers beneficiaries.

TRADITIONAL MEDICARE IMPROVEMENTS

Traditional Medicare is a defined benefit program—the government guarantees that expenditures will keep pace with the rising costs of covered benefits. In addition, unlike managed care plans, which restrict patients to receiving care from a “network” of contracted providers, traditional Medicare gives beneficiaries complete control over which physicians they see.

Traditional Medicare has two distinct disadvantages compared to the Medicare Advantage plans: lack of coverage for most preventive services and higher average out-of-pocket expenses. The MMA begins to address some of the benefit shortcomings. Beginning in 2005, traditional Medicare benefits will include a one-time geriatric assessment for new beneficiaries and for diabetes and cardiovascular screening tests.

In addition, the MMA funds pilots and demonstration projects that could lead to better coverage under traditional Medicare of services relating to care of patients with chronic diseases. It creates a pilot program to reimburse health plans, physician groups, disease management companies, or other entities for effective management of patients with chronic illnesses. Participating organizations will receive coverage for coordination and management services that historically could not be reimbursed under Medicare and will receive higher payments if they manage costs well. In return, they will be expected to measure and report their effectiveness according to accepted clinical performance measures and accept the financial risk of not achieving the desired savings. The MMA allows the results of these pilot programs to be incorporated into permanent changes in benefits and reimbursement under traditional Medicare.

The MMA authorizes another demonstration project to encourage physicians in traditional Medicare to measure and report effectiveness in meeting clinical performance measures for 6 chronic diseases and 3 preventive services to state-level quality improvement organizations. These organizations will help participating physicians redesign their offices to take advantage of the benefits of electronic medical records and other health information technologies and provide yet-to-be-defined incentives to encourage physicians to participate.

These studies are important because traditional Medicare is built on a fee-for-service, acute care model in which doctors are paid a set amount per procedure or visit for patients who show up with an acute medical problem, without regard to the effectiveness of the care rendered. The studies, if designed correctly and implemented successfully, could lead to permanent changes in the tradi-

tional program's benefits structure and reimbursement practices to reward physicians for effective management and coordination of care for patients with chronic diseases.

PAYMENT AND REGULATORY IMPROVEMENTS

The MMA makes improvements in Medicare payment and regulatory policies that benefit physicians and, indirectly, patients by making it more likely that physicians will continue to participate in the traditional program. Instead of a cut of 4.5% in 2004 and a similar projected cut in 2005 due to flaws in Medicare's payment update formula, the MMA stabilizes payments to physicians by guaranteeing minimum updates of 1.5% annually in 2004 and 2005. The MMA will substantially increase payments to rural physicians. Bonus payments for physician services provided in some designated areas of health profession shortages will be raised from 10% to 15%. Due process improvements are made in Medicare's rules for recouping alleged “overpayments” from physicians for improperly billed services and in the program's rules for documenting office visits.

HIGHER-INCOME BENEFICIARIES PAY MORE

Medicare patients—especially those with higher incomes—will begin to pay more for traditional Medicare. The deductible and premiums for Medicare Part B, which covers physician services, will be indexed to inflation; beneficiaries with substantial means will pay an increased share of the program's costs through income-based Part B premiums.

Out-of-pocket expenses for the drug benefit vary by income and assets. Beneficiaries with incomes above 150% of the federal poverty level (FPL) will pay more for drug coverage and will be exposed to a “doughnut hole”—or coverage gap—in their drug benefit, while less well-off beneficiaries who satisfy income and assets eligibility criteria will pay little for the benefit and will be protected from the doughnut hole.

STANDARD DRUG BENEFIT

Beneficiaries with incomes above 150% of the FPL will be able to purchase a “standard” prescription drug benefit for about \$35 per month, or \$420 per year, with a \$250 deductible. After the deductible, the Medicare-approved plan will pay 75% of the share of drug costs until total drug costs reach a limit of \$2250. The standard drug plan then pays nothing until a limit of \$5100 in total costs, or \$3600 in out-of-pocket expenses, is reached, after which beneficiaries will pay 5% of total costs.

This doughnut hole—the gap between \$2250 and \$5100 per year—has been described by one liberal consumer group as a “bizarre and sparse drug benefit” (5). Indexing provisions in the law may add to middle-class dissatisfaction with the benefit. The deductible will in-

Table. Drug Benefit Based on Beneficiaries' Incomes and Assets*

Variable	Dual-Eligible† <100% of FPL: No Assets Test‡	<135% of FPL: Assets, \$6000/\$9000‡	<135% of FPL: Assets, \$10 000/\$20 000‡	135%–150% of FPL: Assets, \$10 000/\$20 000‡
Eligible persons, <i>n</i>	4.4 million	6.9 million	0.7 million	1.4 million
Deductible	No	No	\$50	\$50
Premium	No	No	No	Sliding scale
Cost-sharing§	\$1/\$3 copay	\$2/\$5 copay	15% co-insurance to \$3600, then \$2/\$5 copay	15% co-insurance to \$3600, then \$2/\$5 copay
Doughnut hole	No	No	No	No

* FPL = federal poverty level. Estimated federal poverty level for 2006 is \$9600 for an individual and \$13 000 for a couple. Data obtained from reference 7.

† Dual-eligibles are defined as Medicare beneficiaries who are fully eligible for Medicaid benefits.

‡ Allowed assets are per individual (lower number) or per couple (higher number).

§ Copays are listed for preferred/generic drugs (lower number) and nonpreferred drugs (higher number).

crease from \$250 to \$445 in 2013, and the point at which seniors will get help with catastrophic drug costs rises from \$3600 in out-of-pocket spending in 2006 to \$6400 in 2013 (6).

Why did Congress create such an unusual coverage gap? Without the doughnut hole, the Congressional Budget Office, which independently estimates the costs of proposed bills for Congress, would have placed the costs of the bill as being much higher than the \$400 billion over 10 years Congress was willing to spend.

LOW-INCOME SUBSIDIES

Medicare beneficiaries who qualify for full Medicaid coverage (“full-benefit dual-eligibles”) will pay no premium or deductible, have no doughnut hole, and pay only nominal copayments, without regard to their assets. Beneficiaries who are not eligible for Medicaid but who have incomes no higher than 150% of the FPL and who meet an assets test will qualify for subsidized coverage (zero or reduced premiums and deductibles, and lower cost-sharing compared to the standard benefit) and will not be affected by the doughnut hole. (The assets test includes liquid assets such as savings but generally excludes primary residences and automobiles.) The Congressional Budget Office estimates that over 13 million low-income beneficiaries, or 36% of the Medicare population, will be eligible for the subsidies (6). The Table shows the effect of the drug benefit for beneficiaries who are eligible for subsidized coverage and the number who will benefit.

The decision to link Medicare’s cost-sharing requirements to income represents a departure from Medicare’s historical promise of providing the same benefits to all regardless of income and status. Such changes may be justifiable on the basis of fairness—requiring wealthier beneficiaries to pay more is one way to provide better coverage for poor persons without exceeding budgetary limits—but critics argue that they will undermine support for the program among middle-class voters.

PROHIBITING PRICE NEGOTIATIONS

In a very controversial decision, Congress prohibited the federal government from directly negotiating drug

prices with manufacturers. This decision adds complexity to the program because instead of a single, government-negotiated price schedule and formulary, each Medicare-approved prescription drug plan will negotiate the prices for covered drugs and decide on its own which drugs will be on the “preferred” formularies, subject to federal guidelines. The out-of-pocket expenses of beneficiaries will depend on whether their health plan’s preferred list includes the drugs they most commonly use, since they will pay more for drugs that are not preferred. Health plans must consult with pharmacy and therapeutics committees that include practicing physicians in developing their formularies, and the formularies must include at least one drug for each disease category.

Why did Congress prohibit direct price negotiations? Most Republican members of Congress oppose government price-setting and believe that the private sector can do a better job. By prohibiting direct price negotiation, Congress also could forestall opposition from drug manufacturers that might have sunk the bill.

A BALANCED ASSESSMENT

The preceding analysis explains why Congress designed the legislation to meet political and policy considerations required to get the legislation passed, even though their decisions made the legislation more complex and controversial.

Some criticisms of the MMA have merit, but the record does not support the view that the law represents an abandonment of traditional Medicare and the “sell out” to drug manufacturers, as charged by the act’s fiercest critics.

Instead of privatizing Medicare, the MMA improves traditional Medicare while offering more private plans to beneficiaries. It funds studies on better ways of paying for care of patients with chronic diseases, which could lead to long-term improvements in benefits and reimbursement. It stabilizes payments and eases regulations for physicians who participate in the traditional program. It does this while providing a low-cost drug benefit to low-income beneficiaries.

Critics of the prohibition on drug price negotiations by the federal government dismiss the evidence that private

health plans may be as effective as or more effective than the federal government in negotiating discounted prices (8). The Congressional Budget Office concluded that striking this prohibition would have a negligible effect on federal spending because 1) the private plans can achieve substantial savings and 2) there is no reason to believe that the federal government would be able to negotiate prices that further reduce federal spending significantly (8). Even if one accepts the argument that the government could do a better job, we would do well to remember that the architects of the original Medicare law promised doctors and hospitals that the government would not regulate their prices. The legislation avoided shifting costs to other payers or did not seek discounts beyond what the program's private contractors might have secured for their own population. The strategy behind the design of the original Medicare program was to make it difficult for opponents to attack and make it likely to pick up critical support (9). (Years later, Congress reversed course and put price controls on doctors and hospitals.) Why should critics judge the current Congress and administration more harshly for making the political calculations necessary to pick up critical support for the MMA?

On the other hand, proponents of the MMA gloss over potential problems that need close watching. Access to new private plans could undermine traditional Medicare if large numbers of healthier patients leave the traditional program to enroll in a private plan. Experience provides little basis for confidence that competition between health plans will improve care and reduce costs, particularly in rural areas where little effective competition exists.

The introduction of income and assets tests represents a fundamental change that, even if justifiable on grounds of fairness, could lead middle-class voters to become disenchanted with Medicare. This, in turn, could undermine the broad political support required to keep the Medicare program adequately funded.

Complexity may be the MMA's Achilles heel. Proponents assume that beneficiaries will be able to weigh the different choices available to them, take into account their incomes and assets and medication needs, and make the decision that is best for them medically and financially. Given the complexity of the choices, no one knows whether beneficiaries will be able to choose the option that best meets their medical needs.

Prescription drug costs will probably strain the federal government's ability to fund the program while continuing to meet other urgent priorities. Faced with recent estimates from CMS that the legislation may cost as much as \$530 billion over 10 years instead of the \$400 billion estimated by the Congressional Budget Office, lawmakers are already talking about how to rein in costs. Voters should be asking how Congress will be able to meet its promises to current beneficiaries, fund other national priorities, and keep Medicare solvent for the baby-boomer generation. In this

election year, few politicians are willing to raise these issues.

Finally, critics and proponents alike should be more circumspect in their assessments of the new law. Robert M. Ball, who as Commissioner of Social Security during the Kennedy and Johnson administrations was the first person to administer the new Medicare program, had this to say about the country's experience with Medicare (9):

It is clear . . . from the Medicare experience that in such a program everything depends on the human factor, on how patients, physicians, hospital administrators, insurers and others behave. The program is not a mechanical model but a system that has all the messiness that arises when human beings are called on to run complicated, interrelated institutions that depend on human behavior. We should not be discouraged about further extensions of health insurance, but neither should we expect a smooth-running, purring machine.

The MMA too depends on so many human variables that it is impossible to predict how it will all work out in the end. The only certainty is that as problems arise—and they will—Congress will change the law. The MMA is an imperfect but worthwhile effort to extend drug coverage to seniors who are most in need. It deserves neither condemnation nor indiscriminate praise. It does deserve a constructive commitment by physicians, patients, legislators, and the executive branch to help it succeed.

From the American College of Physicians, Philadelphia, Pennsylvania.

Potential Financial Conflicts of Interest: None disclosed.

Requests for Single Reprints: Customer Service, American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.

References

1. Bush GW. Remarks by the President at the Signing of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. 8 December 2003. Accessed at www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/12-08-2003/0002071552&EDATE= on 26 May 2004.
2. Kennedy EM. Kennedy, Dingell announce their intention to introduce the defense of medicare and real medicare prescription drug act. Press release. 8 December 2003. Accessed at <http://kenedy.senate.gov> on 26 May 2004.
3. Altman DE. The new Medicare prescription-drug legislation. *N Engl J Med*. 2004;350:9-10. [PMID: 14702422]
4. March/April 2004 Kaiser Health Poll Report Survey— Selected Findings on Knowledge and Understanding of the New Medicare Rx Drug Program. Washington, DC: Kaiser Family Foundation; 2004. Accessed at www.kff.org/kaiserpolls/pomr041404pkg.cfm on 26 May 2004.
5. Anger among seniors contrasts with euphoria at White House as President signs Medicare Bill. Press release. Washington, DC: Families USA; 8 December 2003. Accessed at www.familiesusa.org/site/PageServer?pagename=Media_Statement_Anger_Among_Seniors on 26 May 2004.
6. Prescription Drug Coverage for Medicare Beneficiaries: An Overview of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Prepared by Health Policy Alternatives, Inc., for The Henry J. Kaiser Family Foundation. Washington, DC: Kaiser Family Foundation; 14 January 2004.

7. **AARP**. Medicare changes that could affect you. Accessed at www.aarp.org/bulletin/prescription/Articles/a2003-11-26-foryou.html on 28 May 2004.

8. **Holtz-Eakin D**. Letter to the Honorable William H. Frist, MD. Washington, DC: Congressional Budget Office; 23 January 2004. Accessed at www.cbo.gov

[/showdoc.cfm?index=4986&tsequence=0](#) on 28 May 2004.

9. **Ball RM**. Reflections on how Medicare came about. In: Reischauer RD, Butler S, Lave JR, eds. Medicare: Preparing for the Challenges of the 21st Century. Washington, DC: Brookings Institution Pr; 1997.