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## **Despite Critics' Predictions, Early Milestones Point to Success for Medicare's Prescription-Drug Benefit**

### *Executive Summary*

- The Medicare prescription-drug benefit has been the subject of much scrutiny since it became law in 2003.
- Critics have questioned the viability of the program, charging that few private-sector insurers would participate. However, many more companies than anticipated are participating.
- Due to competition among participating insurers, beneficiaries will save more than expected.
- Critics have argued that the new drug benefit would give further impetus to employers to discontinue their prescription-drug coverage for their Medicare-eligible retirees. That, too, has not held true due to the law's significant incentives for employers to maintain coverage for retirees.
- Some also charged the government with stalling tactics, suggesting that the program ought to be implemented in less than two years. Yet, an analysis by the Congressional Budget Office shows that this program's implementation timeline has been reasonable.
- Critics have also labeled as overly harsh the penalty that the law imposes on eligible beneficiaries who don't enroll when they first become eligible. Yet, this type of penalty is intended to provide seniors with an incentive to enroll early, rather than wait until their drug costs rise; meanwhile, a similar penalty has long been in place for Medicare Part B.
- Others have pointed to the benefit's gap in coverage as being unfair, but the gap will affect only about one-quarter of all beneficiaries. And those affected by the gap still may get assistance from their plans or from state resources that will help pay the out-of-pocket expenses.
- Some critics charge that prices could be reduced if the Secretary of Health and Human Services would enter into price negotiations with the drug providers. However, studies have shown that market forces, not government interference, will lead to lower drug prices.
- A prescription drug benefit that is completely cost-effective and perfect for every beneficiary is an impossibility, but Congress created a comprehensive, affordable, and generous benefit structure that will help modernize Medicare and provide beneficiaries with the drug coverage that they need. It deserves support.

## Introduction

The Medicare Prescription Drug, Modernization, and Improvement Act of 2003 (MMA) represents the most sweeping reform of the Medicare program since its inception in 1965. The MMA created a prescription-drug benefit within the Medicare program that will enable approximately 43 million seniors and younger Americans who suffer from disabilities to better afford the medications prescribed by their physicians.

Even before the new program has been given a chance to work, Members of Congress and others have been quick to heap criticisms upon it. The charges have been broadly made, covering issues ranging from the program's affordability for seniors to its price tag for taxpayers, and from the program's likely viability to the time lag in its implementation.<sup>1</sup> Yet, despite the scorn and skepticism, early milestones indicate the program will prove to be a success.

This paper first will provide a detailed overview of the new benefit, and then (beginning on page 6), it will address several of the criticisms and contradictions being voiced by opponents of the new benefit, concluding that the benefit is generous, significant, and timely.

## Overview of the New Medicare Prescription-Drug Benefit

For the first time in Medicare's 40-year history, seniors and disabled individuals will be able to obtain their prescription drugs through this federal program. Beginning November 15, 2005, all Medicare beneficiaries will be able to join a voluntary prescription-drug plan in order to receive prescription-drug coverage through the Medicare program. Additionally, all Medicaid beneficiaries will now have their prescription-drug costs covered under the Medicare program (although they will continue to receive other medical services under Medicaid). Detailed information about the plans approved by Medicare to provide prescription-drug coverage in their communities is now available to all those who are eligible. The plan information, along with additional information on the new benefit, is being mailed to individuals' homes as part of the *Medicare & You 2006* handbook, an annual publication which describes for beneficiaries all of the benefits covered under the Medicare program.

### When Coverage Begins

Medicare prescription-drug coverage is insurance provided by private companies that have been approved by Medicare. For those who join one of these plans prior to December 31, 2005, coverage will begin on January 1, 2006. For those who join a plan after January 1, coverage will begin the first day of the following month.

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<sup>1</sup>See, Senator Debbie Stabenow, "Bad Deal for Seniors . . . Bad Deal for Medicare," available at <http://stabenow.senate.gov/infocus/progress/medicare01.htm>. See also, Statement of Senator John Kerry, November 24, 2003 (regarding cloture vote on Medicare conference report), available at <http://kerry.senate.gov/text/cfm/record.cfm?id=215482>. See also, Democratic Policy Committee, "Medicare Conference Proposal Falls Short: A Bad Deal For America's Seniors," November 20, 2003, available at [http://democrats.senate.gov/dpc/dpc-pf.cfm?doc\\_name=tp-108-1-403](http://democrats.senate.gov/dpc/dpc-pf.cfm?doc_name=tp-108-1-403).

## Costs and Savings

The Centers for Medicare and Medicaid Services (CMS) estimates that beneficiaries who do not currently have prescription drug coverage from another source (such as through a former employer) could save, on average, as much as 50 percent on their drug expenditures by joining one of the Medicare plans.<sup>2</sup> The amount that someone will pay under the new benefit, or how much they could save, will depend upon the plan in which that person enrolls. Plans will be available to beneficiaries based on where they live, and beneficiaries are guaranteed to have at least two plans from which to choose. In any area where there are not two participating plans, the MMA requires that CMS provide a “fallback,” or government-sponsored plan, to assure choices for prescription-drug coverage for beneficiaries.

The MMA mandates a standard minimum benefit package for participating drug plans; however, drug plan sponsors may elect to provide greater coverage than is required by the law. The law provides that the standard benefit is one that requires a beneficiary to pay a monthly premium of approximately \$35 (which, like Medicare Part B premiums, can be deducted directly from a beneficiary’s Social Security check), an annual deductible of \$250, and coinsurance of 25 percent up to an initial coverage limit of \$2,250. Beneficiaries whose annual pharmaceutical expenses exceed \$2,250 will be responsible for their additional prescription-drug expenses up to \$3,600. Once a beneficiary’s out-of-pocket spending exceeds \$3,600 in the calendar year, the beneficiary will only be responsible for small co-payments on his or her prescription drugs – Medicare will cover the rest.<sup>3</sup> This benefit is referred to as a “catastrophic” benefit because it protects beneficiaries against high out-of-pocket prescription-drug costs.

## Lower-Income Beneficiaries

Beneficiaries with lower incomes and limited resources will qualify for Medicare’s “extra help” in paying their prescription-drug costs. Those who fall below 135 percent of the federal poverty level (individuals with income under \$12,123 or couples with income under \$16,362) will pay no premiums and have no deductible. They will pay only small co-pays up to the out-of-pocket limit of \$3,600, after which all of their costs will be completely covered by Medicare. For those with slightly higher incomes, up to 150 percent of the federal poverty level (\$13,470 for individuals or \$18,180 for couples), monthly premiums would be determined using a sliding scale, and the beneficiary would pay only a \$50 deductible. These beneficiaries would be responsible for coinsurance of 15 percent, up to the out-of-pocket limit, after which they would pay only small co-payments.<sup>4</sup>

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<sup>2</sup>CMS, “Better Benefits – More Choices” The New Prescription Drug Benefit: General Overview,” CMS Fact Sheet, January 27, 2004.

<sup>3</sup>Out-of-pocket costs include the deductible, coinsurance, and costs not paid by a third party. Monthly premiums do not count against out-of-pocket costs. Co-payments will be \$2 for generic drugs and certain multiple source drugs. Co-payments for all other drugs will be \$5 or 5 percent of the discounted price, whichever is greater. Medicare will cover 95 percent of a beneficiary’s costs after out-of-pocket spending of \$3,600. Medicare beneficiaries who are eligible for full Medicaid benefits (known as “dual eligibles”) will pay smaller co-payments of \$1 and \$3, respectively.

<sup>4</sup>CMS, “Beneficiaries and True Out-of-Pocket Costs (TrOOP),” CMS Issue Paper #23, January 21, 2005. According to CMS, almost 11 million low-income beneficiaries are expected to apply for extra help, which features comprehensive coverage with no gap. Unlike standard plans, assistance received

## Covered Drugs

Under the MMA, prescription-drug plan sponsors have considerable flexibility in choosing which drugs they will cover. However, the law prohibits drug plan sponsors from covering certain drugs (particularly those deemed not to be medically necessary), and mandates that others be covered. For example, the law specifically excludes drugs used for anorexia, weight loss, or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth; cough and cold medications; vitamins and mineral products (except for prenatal vitamins or fluoride preparations); barbiturates; benzodiazepines (including drugs used to treat anxiety and insomnia); nonprescription drugs; drugs covered under Medicare Parts A or B; and outpatient drugs for which the manufacturer requires as a condition of sale that associated tests and monitoring devices be purchased exclusively from the manufacturer.<sup>5</sup> CMS has indicated that it expects drug plans to ensure access to drugs used by special needs populations (for example, those with mental illness or those living with HIV/AIDS) and, therefore, expects drug plans to cover all or substantially all drugs within six therapeutic classes: antidepressants, antipsychotics, antiretrovirals (for the treatment of HIV and AIDS), anticonvulsants, immunosuppressants, and antineoplastics (for the treatment of certain cancers).

Aside from these specific guidelines, drug plan sponsors may design specific formularies (lists of drugs they have approved for coverage), provided that the drug is: available only by prescription; approved by the Food and Drug Administration; used and sold in the United States; and used for a medically accepted indication.<sup>6</sup> CMS will use guidelines issued by United States Pharmacopeia (USP), the official standards-setting authority for all prescription and over-the-counter medications manufactured and sold in the United States, to determine therapeutic classes for all drugs.<sup>7</sup> Plan sponsors will be required to cover at least two drugs in each therapeutic class, unless only one drug exists within that class. CMS will review formularies to ensure that they are adequate and do not discriminate against any group of beneficiaries by being under-inclusive. All plans are also required to use a Pharmacy and Therapeutic Committee (P&T), comprised primarily of practicing pharmacists and physicians, to develop and review their formularies.

## Provisions for Drugs Not Covered

CMS recognized that some Medicare beneficiaries are currently taking drugs that will not be on their new plan's formulary, and so it has made accommodations for that. Specifically, drug plan sponsors are required to provide an appropriate transition process for those beneficiaries whose conditions have been stabilized using a drug that is not included in the drug plan's formulary. Such a transition process may include patient counseling, during which the beneficiary and his physician can discuss alternative treatment options, or may include the plan providing coverage for a one-time transitional refill of the prescription until the beneficiary can make arrangements for coverage of

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through the extra help program will count toward out-of-pocket costs.

<sup>5</sup>Medicare Prescription Drug Benefit, 70 Fed. Reg. 4193, 4228 (Jan. 28, 2005) (to be codified at 42 C.F.R. pt. 423).

<sup>6</sup>70 Fed. Reg. 4228.

<sup>7</sup>Drugs are categorized into therapeutic classes based on their common effects on the body or the purpose for which they are used.

another drug that is on the plan's formulary, or the plan grants the beneficiary an exception for the drug. An exception may be granted when a non-formulary drug is considered to be medically necessary, meaning that use of another drug would either not be as effective in treating the individual, would have adverse consequences for the beneficiary, or both. Plans are required to provide beneficiaries with information about the process for obtaining an exception and for appealing exceptions and other coverage determinations.<sup>8</sup> Once granted, exceptions are valid until the end of the plan year. At the end of the year, the plan may make a new determination as to whether to continue to cover the drug for that beneficiary.

### **Provisions for Plans Dropping Coverage of a Drug**

MMA also addresses patient concerns about plans dropping coverage of drugs. Plan sponsors who wish to remove drugs from their formulary for reasons other than concerns about the safety of the drug (i.e., when a drug is pulled from the market by the FDA) must provide 60 days' notice to beneficiaries prior to removing a drug from the plan's formulary or must provide notice and cover a 60-day supply of the drug after the drug is removed in order to ease beneficiaries' transition to new drugs or permit time for requesting exceptions. Notice to beneficiaries must include the reason for removing the drug from the formulary, identify other formulary drugs available to the beneficiary in the same therapeutic class, and provide the beneficiary with information on the expected costs of alternative formulary drugs. Some plans may separate drugs into multiple cost "tiers," with generics or "preferred" drugs usually in the least-cost tier and other drugs in higher-cost tiers. Plans are also required to follow the notice procedures described above when shifting a drug from a lower-cost tier to a higher-cost tier.

### **Convenient Access to Pharmacies**

Medicare officials recognize that, in order for the new prescription-drug coverage to be successful, Medicare beneficiaries need convenient access to their prescription drugs. To ensure that this priority is met, a number of rules are in place to govern the plans' relationships with pharmacies. For example, plans must allow any pharmacy willing to abide by the conditions of MMA to join the plan network, and no plan may maintain a network that consists solely of mail-order pharmacies. In addition, plans must meet certain standards for the distance beneficiaries can be expected to travel to reach a pharmacy in their area.<sup>9</sup> A full 90 percent of a plan's urban beneficiaries must live within two miles of an in-network retail pharmacy, and 90 percent of suburban beneficiaries must live within five miles of an in-network retail pharmacy. For rural areas, 70 percent of a plan's beneficiaries must live within 15 miles of an in-network retail pharmacy.<sup>10</sup>

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<sup>8</sup>A coverage determination is a Medicare prescription-drug plan sponsor's decision about the coverage that a beneficiary will receive under the plan, including how much the beneficiary must pay for coverage. MMA provides that coverage determinations are subject to appeal and provides specific guidelines as to the different time periods within which plan sponsors must provide coverage determinations. Failure by a plan sponsor to provide timely coverage determinations is itself considered to be a coverage determination and is similarly subject to appeal.

<sup>9</sup>70 Fed. Reg. 4247.

<sup>10</sup>70 Fed. Reg. 4247.

### **Penalty for Late Enrollment**

CMS is strongly encouraging Medicare-eligible individuals to join a plan during the initial enrollment period, which runs from November 15, 2005, until May 15, 2006. By joining a plan early, seniors and disabled individuals can guarantee that they will pay the lowest possible monthly premiums. For those who choose not to join at the outset and do not currently have prescription-drug coverage at least as good as the standard Medicare benefit, Medicare will impose a penalty equal to 1 percent of the monthly premium for each month that a beneficiary was eligible and did not join. For example, if an individual waits 12 months to sign up for a plan, that individual will pay a penalty each month equal to 12 percent of his monthly premium. This penalty, like other penalties assessed by insurers, is payable as long as the individual maintains the prescription-drug coverage. The rationale for this penalty is to encourage people to join a plan before their drug costs become very high, such as they would after the onset of a serious illness. Statistically, the likelihood of such a situation increases markedly over time, so beneficiaries take a real risk in waiting.

### **Flexibility in Plan Selection**

Medicare beneficiaries should be pleased with the fact that they are not signing up for an inflexible, long-term commitment that may not meet their future needs. Rather, enrollment in Medicare prescription-drug coverage lasts for only the calendar year, and beneficiaries can change to a different plan during the annual enrollment period from November 15 through December 31 of every year. Beneficiaries also will be permitted to change plans at other times, depending on the circumstances.<sup>11</sup> Full-benefit dual eligibles (those who have Medicare and full coverage under Medicaid) can change their plans at any time.

## **What Critics Are Saying (and Why They Are Wrong)**

Under the new Medicare prescription-drug benefit, every Medicare beneficiary will, for the first time, have the opportunity to obtain help from Medicare in paying for his or her prescription drugs. Despite this unprecedented coverage and the extensive efforts to assist beneficiaries in understanding their options and making informed choices, some observers have focused their efforts on criticizing the new benefit rather than helping seniors and the disabled make informed choices about how they can get the most out of the program – even before it has had a chance to work.

To counter this, President Bush, Secretary of Health and Human Services (HHS) Michael Leavitt, CMS Administrator Mark McClellan, and a host of others have been traveling the country to educate people about the details of the benefit. They stress the importance of educating not only those who are eligible for the benefit but also the family and friends of those who are eligible. This is to help assure that beneficiaries have a support network to help them decide which plan best meets their needs.

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<sup>11</sup>70 Fed. Reg. 4529-4530.

Some of the most common questions and misconceptions about the program encountered by the President and other officials during their recent travels revolve around the issues of plan participation, affordability, employer coverage, and gaps in coverage.

### **Will Enough Private Plans Participate?**

Critics have argued that the program's use of private plans to deliver the benefit means the federal government cannot guarantee that all geographic areas (particularly rural ones) will receive adequate response from potential plan sponsors, potentially leaving beneficiaries without coverage (or at least without choices). Some cite early stumbles in the Medicare + Choice program as an example of how private entities do not belong (and will not participate) in the Medicare program. During debate about prescription drug legislation, one group critical of private-sector participation issued a statement saying that "the insurance companies that are expected to offer this coverage have already said they won't participate in a program they believe can't work."<sup>12</sup>

This charge, as it turns out, was a rush to judgment. Insurance companies, for their part, have demonstrated that they *do* believe the program can work and that they are more than willing to participate. Earlier this year, the *New York Times* reported that the Medicare drug benefit "passed a major milestone . . . as a substantial number of big insurance companies said they would offer prescription drug coverage to Medicare beneficiaries next year, defying the predictions of many industry experts."<sup>13</sup>

The MMA promised beneficiaries that they would be able to choose between at least two Medicare prescription-drug plans. In the event that two plan sponsors could not be approved for a particular area, Medicare would offer a government "fallback" plan that offered the standard Medicare prescription-drug benefit. Yet, as an indication of the program's success, this "fallback" will not be necessary in 2006.<sup>14</sup> CMS recently indicated that the number of approved plans is *in the double-digits* in every area of the country.<sup>15</sup>

### **Are the Plans Affordable or Not?**

Some beneficiaries are concerned about critics' charges that the new Medicare prescription-drug benefit simply isn't affordable. This criticism is unfounded. In fact, more plans than originally anticipated have signed up to offer coverage, which has resulted in increased competition – and increased savings for participants.

Because of the large number of insurers that submitted bids to participate, CMS recently announced that premiums for Medicare prescription-drug coverage will be lower than originally

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<sup>12</sup>Statement of John J. Sweeney, President, AFL-CIO, June 19, 2002, available at <http://www.aflcio.org/mediacenter/prsptm/pr06192002.cfm>.

<sup>13</sup>*The New York Times*, "Defying Experts, Insurers Join Medicare Drug Plan," March 6, 2005.

<sup>14</sup>CMS, August 30, 2005.

<sup>15</sup>HHS News Release, "Medicare Drug Plans Offer Premiums of \$20 per Month or Less – Lower Deductibles, Enhanced Coverage Also Available," August 29, 2005, available at <http://www.hhs.gov/news/press/2005pres/20050829.html>.

expected. While CMS had initially estimated that beneficiaries would pay monthly premiums averaging about \$37, it was able to revise its estimate to an average of about \$32 once insurers began submitting bids for participation in the new benefit. CMS has also announced that, in all areas of the country, beneficiaries will be able to choose from among multiple plans that offer premiums *significantly below* \$32. And, in every area except Alaska, beneficiaries will have access to at least one plan with premiums below \$20 per month, with some areas having plans whose monthly premiums are *significantly below* \$20.<sup>16</sup> Some premiums will be as low as \$1.87 per month for a standard Medicare prescription-drug plan. In general, plans offering the standard prescription-drug benefit will have lower monthly premiums than those offering more comprehensive coverage. Beneficiaries will be able to choose both the level of coverage that is right for them and how much they are willing to pay for that coverage.

Much like an employer subsidizes a portion of its employees' health insurance premiums, the federal government will subsidize a significant portion of beneficiaries' premium amounts. As such, savings of \$5 by a beneficiary results in a monthly savings to the government of approximately \$15. The resulting savings to taxpayers will amount to billions of dollars in the first year of the program alone.<sup>17</sup>

### **Will Beneficiaries Lose Employer-Provided Coverage?**

Some critics contend that beneficiaries who currently receive prescription-drug benefits through their employer will be forced from their employer's coverage as a result of the new federal benefit.<sup>18</sup> This simply isn't true.

In November 2003, the Congressional Budget Office (CBO) issued a statement that critics continue to point to as evidence of their charge. At that time, CBO estimated that, "Of the projected 11.7 million nonfederal retirees, . . . 32 percent, or 3.8 million individuals, would have their coverage reduced to (or replaced by) the [Medicare prescription-drug benefit]."<sup>19</sup> In CBO's opinion, "Enactment of the new [benefit] would prompt some employers to cease providing supplemental drug coverage for retirees."<sup>20</sup> It is important to recognize that nothing in the MMA directs employers to reduce the coverage they provide. In fact, during consideration of MMA, Congress was concerned about the trend it was seeing of employers reducing or eliminating retiree benefits as a means of cutting their

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<sup>16</sup>HHS News Release, August 29, 2005.

<sup>17</sup>Medicare Fact Sheet, "Medicare Drug Premiums Will Be Lower Than Expected – Consumer Choice, Competition Will Help Beneficiaries," August 9, 2005, available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1530>.

<sup>18</sup>See, for example, "Statement of U.S. Senator Russ Feingold on the Medicare Conference Report," available at <http://feingold.senate.gov/statements/03/11/2003B24739.html>. See also, "Remarks by Senator Patty Murray on the Medicare Prescription Drug Bill," November 23, 2003, available at <http://murray.senate.gov/news.cfm?id=215570>. See also, Senator Harry Reid, "Statement on Final Passage of the Medicare Conference Report," November 23, 2003, available at <http://reid.senate.gov/pdfs/medicarefloorstatement112303.pdf>.

<sup>19</sup>Douglas Holtz-Eakin, CBO Director, in a letter to Congressman Bill Thomas, Chairman of the House Committee on Ways & Means, November 14, 2003.

<sup>20</sup>Holtz-Eakin, November 14, 2003.

operational costs. Those who crafted the MMA did not want employers to use enactment of a Medicare prescription-drug benefit as an excuse to reduce or eliminate the coverage that they provide to Medicare-eligible retirees.<sup>21</sup> And so, they included in the law significant incentives for employers to maintain coverage for retirees.

The MMA requires the Secretary of HHS to make special subsidy payments to employers or unions that offer prescription-drug coverage that is at least as good as that offered under the standard Medicare benefit. Early indications are that “most employers and unions currently offering drug benefits to retirees will elect the subsidy for 2006.”<sup>22</sup> In 2006, subsidy payments will equal 28 percent of a retiree’s gross drug costs between \$250 and \$5,000 and would not be subject to federal tax. As CMS has commented, “The Medicare retiree drug subsidy represents a particularly important strengthening of health care coverage for Medicare-eligible retirees, given the continuing erosion in the availability and generosity of employment-based retiree drug coverage *that has already been taking place.*”<sup>23</sup>

MMA also provides additional options for employers and unions that choose not to take the subsidy. Under these options, the retiree is encouraged to sign up for the new Medicare prescription-drug coverage, and the employer or union will provide additional financial assistance. Some of these options include: employer payment of Medicare prescription-drug premiums; supplemental or “wrap-around” coverage; purchase of an enhanced prescription-drug benefit through an existing provider; and the retiree plan itself applying to become an approved Medicare prescription-drug plan.

Meanwhile, a key point to keep in mind is that beneficiaries’ participation in the new Medicare prescription-drug benefit is *completely voluntary*. If an employer opts to continue providing coverage, and a beneficiary’s existing coverage through his employer is better than that provided by the Medicare plans offered in his area, that individual can choose to continue coverage through his employer rather than opting into a Medicare plan. He is also free to enroll in a Medicare plan during the next annual open enrollment period.

### **Has the Program’s Implementation Been Delayed Due to Politics?**

Despite labeling the benefit as “a bad deal for seniors,” critics argue that it isn’t being implemented soon enough. Some questioned whether the time between the enactment of MMA in December of 2003 and the implementation of the benefit in 2006 amounts to political maneuvering.<sup>24</sup>

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<sup>21</sup>Congressional Research Service (CRS), “Medicare Drug Benefit: Retiree Provisions,” August 19, 2005.

<sup>22</sup>CRS.

<sup>23</sup>CMS, “Overview of Retiree Drug Subsidy Option,” available at <http://www.cms.hhs.gov/medicarereform/pdbma/overviewoftheretireedrugs subsidy.pdf>.

<sup>24</sup>See, for example, press release from Senator Bill Nelson, “Senator Nelson Unveils Plan to Fix Major Flaw in New Medicare Bill by Lowering Drug Prices,” November 26, 2003, available at [http://billnelson.senate.gov/news.cfm?mr=112603\\_hlth](http://billnelson.senate.gov/news.cfm?mr=112603_hlth).

They charged that the delay was leaving beneficiaries without drug coverage for an inordinate amount of time.<sup>25</sup>

Such charges are specious. A benefit as comprehensive as the new Medicare prescription-drug benefit – one that provides prescription-drug coverage for over 43 million Medicare and Medicaid beneficiaries across the country – is unavoidably complex and cannot be crafted and implemented overnight. In October 2002, CBO issued a report entitled “Issues in Designing a Prescription Drug Benefit for Medicare,” which examined a broad array of issues related to the creation of Medicare prescription-drug benefit. In the report, CBO concluded that 2005 would be “the earliest year that Medicare could probably begin implementing a drug benefit that was enacted in 2002.”<sup>26</sup> Based on that, a January 2006 implementation date is very reasonable with respect to a benefit signed into law in December 2003.

Meanwhile, no one has been denied anything. Beneficiaries have never before had prescription-drug coverage under Medicare. Those beneficiaries who have coverage from other sources can retain that coverage, and those who do not are currently benefitting from the prescription-drug discount card program that was implemented in June 2004. CMS reports that the discount card has helped beneficiaries “obtain discounted prices that are about 12 to 21 percent less than the national average prices . . . for commonly used brand name drugs at retail pharmacies.”<sup>27</sup> In some instances, cardholders have been able to save as much as 34 percent, even when compared to purchases made through mail-order pharmacies, which typically offer discounted prices.<sup>28</sup>

### ***Is the Penalty for Late Enrollment Unfair?***

Critics point to the late-enrollment penalty as a flaw in the program. As previously detailed, a penalty is imposed on those who do not join a plan when they first become eligible or who do not maintain coverage from another source that is at least as good as the standard Medicare benefit.

It is likely that some beneficiaries who currently do not have high prescription-drug costs will opt not to participate in the program. If there were no penalty in place, this would make good economic sense for those individuals.<sup>29</sup> However, the penalty is meant to provide seniors with an incentive to enroll in the benefit when they first become eligible, rather than waiting until an illness causes their drug costs to rise (which, of course, also causes the taxpayers’ costs to rise). Medicare

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<sup>25</sup>See, for example, press release from Senator Frank Lautenberg, “Senator Lautenberg Questions Why Bush Medicare Plan Doesn’t Go Into Effect Until 2006,” November 24, 2003, available at <http://lautenberg.senate.gov/~lautenberg/press/2003/01/2003B24D38.html>.

<sup>26</sup>CBO, “Issues in Designing a Prescription Drug Benefit for Medicare,” October 2002, p. 11, available at <http://www.cbo.gov/ftpdocs/39xx/doc3960/10-30-prescriptiondrug.pdf>.

<sup>27</sup>CMS, “CMS Studies Confirm Significant Savings Through Medicare-Approved Drug Discount Cards,” CMS Fact Sheet, October 12, 2004, available at <http://www.cms.hhs.gov/medicarereform/drugcard/reports/cmsdrugcardanalysis.pdf>.

<sup>28</sup>CMS Fact Sheet, October 12, 2004.

<sup>29</sup>See, for example, *Chicago Tribune*, “Medicare Late-Signup Fee Already Bitter Pill for Some,” August 7, 2005.

prescription-drug coverage is not a drug subsidy program – CMS Administrator Mark McClellan emphasizes that the penalties are imposed because the Medicare prescription-drug plan operates like any other insurance plan. And, as with other plans, the prescription-drug coverage provided under Medicare requires participants to pay premiums to maintain coverage when they are well and not just when the beneficiary needs access to coverage due to illness. He noted that “the longer you wait to buy insurance, the more it costs. If you wait until your home is on fire to buy home insurance, the cost will be considerably higher.”<sup>30</sup>

Furthermore, this type of penalty already has a precedent within the Medicare program. Since its inception, Medicare Part B (Medicare’s voluntary program for medical insurance) has imposed a similar penalty. The cost of Part B could go up 10 percent for each full 12-month period that an eligible individual does not sign up for coverage, and the penalty is paid as long as the beneficiary receives coverage under Part B.<sup>31</sup>

### **Why Have the “Doughnut Hole”?**

Opponents of the MMA label the program’s out-of-pocket provision – the so-called “doughnut hole” – as unfair. As previously detailed, Medicare beneficiaries will be required to pay the full amount of their drug costs between \$2,250 and \$3,600, while beneficiary expenditures outside this range are at least partially subsidized.

First, it is important to recognize that the gap in coverage is estimated to affect only about one-quarter of all beneficiaries in 2006.<sup>32</sup> And even for those affected, some Medicare prescription-drug plans will provide coverage for generic drugs within the coverage gap.<sup>33</sup> Additionally, the affected beneficiaries would continue to have access to discounted drugs through their Medicare prescription-drug plan, which means that they would still be paying less than the full retail price for those drugs. Some of these beneficiaries are also likely to receive additional assistance through state pharmacy assistance programs (SPAPs), their former employers or unions, or other supplemental coverage arrangements. Finally, for beneficiaries willing to pay higher monthly premiums, the benefit could cover 100 percent of an individual’s costs.

While it will not even affect 75 percent of beneficiaries, this gap in coverage is economically defensible. It arises from the contention that prescription-drug coverage under Medicare was intended to serve primarily as a catastrophic benefit, ensuring that the benefit help those in dire need – specifically, beneficiaries with low incomes or high drug costs. However, the new benefit is more generous than that – it will cover a large percentage of most beneficiaries’ drug costs. It was never intended to cover 100 percent of costs for 100 percent of the beneficiaries. Clearly, that cost would have been overwhelming to taxpayers.

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<sup>30</sup>*San Francisco Chronicle*, “Medicare Rolls Out New Drug Plan – Push On to Enroll Subscribers Starting in November,” August 11, 2005.

<sup>31</sup>CMS, “Your Medicare Benefits,” page 5, available at <http://www.medicare.gov/publications/pubs/pdf/10116.pdf>.

<sup>32</sup>CMS.

<sup>33</sup>HHS News Release, August 29, 2005.

In criticizing the coverage gap, opponents are essentially calling for greater coverage and less personal financial responsibility on the part of the beneficiary. Yet these are often the same critics pointing to the program's high costs.

### **Why Not Require the Government to Negotiate Prices?**

Some critics argue that the benefit is fiscally irresponsible because it prohibits the Secretary of HHS from "using the purchasing power of 40 million beneficiaries" to negotiate with prescription-drug plans, which, they contend, would result in lower drug prices.<sup>34</sup>

Studies, however, have shown that competitive market forces, not interference by HHS, is what will lead to lower drug prices for seniors. In a letter to Majority Leader Bill Frist, CBO Director Douglas Holtz-Eakin noted that removing the "non-interference" provision from the MMA "would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree."<sup>35</sup> The Chief Actuary for CMS echoed this assessment, adding that "Medicare prescription-drug plans will have a strong incentive to negotiate effective price reductions."<sup>36</sup> CMS noted, too, that private negotiation between plan sponsors and drug manufacturers "will achieve comparable or better savings than direct negotiation between the government and manufacturers," and added that privately negotiated coverage options would better reflect beneficiary preferences.<sup>37</sup>

Congress has been consistent in its support for competition, rather than government negotiation of prices, for many years. A non-interference provision has been included in every Democratic and Republican Medicare prescription-drug proposal introduced since the 106<sup>th</sup> Congress (1999). In a July 2001 document titled "Democratic Principles for a New Medicare Prescription Drug Benefit," the Senate Democratic Policy Committee (DPC) outlined several principles with which "any new Medicare prescription drug benefit should be consistent." Among those principles, the DPC noted that "private organizations should negotiate prices with drug manufacturers and handle the day-to-day administrative responsibilities of the benefit," and that "discounts should be achieved through competition, not regulation or price controls."<sup>38</sup> Similarly, the U.S. Chamber of Commerce, in a "Key Vote Alert" to Congress, issued during debate of the FY 2006 budget resolution, "strongly urge[d]"

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<sup>34</sup>See, for example, Associated Press, "Democrats: Medicare Bill Doesn't Do Enough," November 29, 2003, available at <http://www.cnn.com/2003/ALLPOLITICS/11/29/dem.radio.address.ap>. See also, "Pryor Votes Against Flawed Medicare Bill – Says Bill Jeopardizes Medicare and Increases Drug Costs for Arkansans," November 25, 2003, available at <http://pryor.senate.gov/newsroom/details.cfm?id=216945&&>.

<sup>35</sup>Douglas Holtz-Eakin, CBO Director, in a letter to Senator Bill Frist, Senate Majority Leader, January 23, 2004.

<sup>36</sup>Richard Foster, CMS Chief Actuary, in a memo to CMS Administrator Mark McClellan, February 11, 2005.

<sup>37</sup>CMS, Medicare Drug Benefit Uses Price Negotiation to Get Best Possible Drug Prices," CMS Issue Paper #10, January 9, 2005.

<sup>38</sup>Democratic Policy Committee, "Democratic Principles for a New Medicare Prescription Drug Benefit," July 2001, available at <http://democrats.senate.gov/~dpc/pubs/107-1-215.html>.

Members to oppose modification or removal of the non-interference provision from the MMA. The Chamber noted that the provision protects the Medicare program “from government-imposed price controls on prescription drugs and ensures that seniors and the disabled have choices when selecting options that meet their needs.”<sup>39</sup>

### **Why Does the Benefit Have to Be So Complicated?**

Critics say that, because it is complex, the benefit will be detrimental to beneficiaries. If beneficiaries are confused, the critics say, they will simply not participate in a Medicare prescription-drug plan.

Granted, such a comprehensive benefit is complex. But so is almost any financial commitment that beneficiaries have been making throughout their lives, ranging from life insurance to legal contracts. In the case of this program, however, the Administration and several private entities have undertaken an extensive education campaign to help beneficiaries understand it and make wise choices for themselves. Extensive information about Medicare prescription-drug coverage and the participating plans is already being mailed to beneficiaries in their *Medicare & You* handbooks. In addition, President Bush and other officials from his Administration have been touring the country to answer questions from beneficiaries and provide them with more information about how the new Medicare prescription-drug coverage can benefit them. Advocacy groups (formed by organizations concerned with issues important to seniors, disabled individuals, and those who suffer from chronic diseases) have been airing television and radio advertisements to ensure that every eligible individual is made aware of the benefit and knows where to seek assistance in enrolling. Even private insurers are helping to promote the benefit. For example, one insurance company, Humana, has teamed up with Wal-Mart to staff information kiosks inside of stores across the country.

Educating beneficiaries and their friends and families about the new benefit can eliminate confusion and allay fears. To be most helpful to beneficiaries, opponents should work to explain the benefit and the signup process. The Secretary of Social and Health Services in one state admonished critics that, “Even if you have concerns with it, it’s our job to make this work.”<sup>40</sup> She characterized the new benefit as “an amazing opportunity” that is “long overdue.”

## **Conclusion**

Some have been quick to criticize the Medicare prescription-drug benefit, even before its implementation. However, for the sake of those it is designed to help, critics would be wiser to exercise prudence until the benefit is implemented and allowed to work. A prescription-drug benefit that is completely cost-effective and perfect for every beneficiary is an impossibility. After a great deal of negotiation and debate, Congress created a comprehensive, affordable, and generous benefit structure that will help modernize Medicare and provide seniors with the drug coverage that they need. It is in everyone’s best interest to work to ensure its success.

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<sup>39</sup>R. Bruce Josten, Executive Vice President, Government Affairs, U.S. Chamber of Commerce, in a letter to Members of the United States Senate, March 14, 2005.

<sup>40</sup>*Seattle Post-Intelligencer*, “Bush Cabinet Secretary Touts Prescription Drug Benefit,” August 15, 2005.