The Heritage Foundation
Backgrounder
Executive Summary

No. 1293 June 16, 1999

How to Provide Prescription Drug Coverage Under Medicare

James Frogue

Congress is under considerable pressure to address the absence of outpatient prescription drug coverage in Medicare, the huge and financially troubled program that covers almost 40 million elderly and disabled Americans. Several bills before Congress would attempt to do this. For example, S. 841, sponsored by Senator Edward Kennedy (D–MA), and its companion bill, H.R. 1495, sponsored by Representative Pete Stark (D–CA), would require the Secretary of the U.S. Department of Health and Human Services (HHS) to contract with benefit managers, retail pharmacies, insurers, and others to provide a prescription drug benefit to Medicare's beneficiaries.

The real task before Congress, however, is not so much whether to provide prescription drug coverage to Medicare beneficiaries, but rather how to assist those seniors who really need help in obtaining prescription drugs, and how to finance it—considering the enormous potential cost of such coverage and the poor track record of previous attempts to add it. There is concern that congressional "remedies" could lead to a disruption of the prescription drug market and undermine the quality and availability of the very benefit lawmakers hope to provide. Members of Congress should recognize that:

- Medicare is already in financial trouble, and the addition of a costly new benefit, especially if done poorly, could make its financial condition worse;
- A new prescription drug benefit would likely increase Medicare costs dramatically; and
- Seniors could see their Medicare premiums double, and could find themselves with duplicate coverage.

Before providing a prescription drug benefit to Medicare beneficiaries, Congress should determine how many senior citizens are experiencing difficulty in obtaining prescription drugs. Although nearly 9 out of 10 Medicare beneficiaries use prescription drugs, according to Bureau of Labor Statistics data for 1997, the average senior spent $637 annually on both prescription and non-prescription drugs—

Produced by
The Domestic Policy Studies Department

Published by
The Heritage Foundation
214 Massachusetts Ave., N.E.
Washington, D.C.
20002–4999
(202) 546-4400
http://www.heritage.org

less than what the poorest seniors report spending in restaurants. A study for the National Academy of Social Insurance reports that only 10 percent of seniors have annual out-of-pocket expenditures for prescription drugs of $1,000 to $2,000, and only 4 percent report spending more than $2,000. The problem of affordability for a relatively small number of seniors is not a systemic crisis that necessitates a complete overhaul of the system.

Congress has considered adding a prescription drug benefit in the past. In 1988, with overwhelming support from the public and various interest groups, Congress enthusiastically passed the Medicare Catastrophic Coverage Act, adding a range of generous new benefits to the Medicare program that included coverage for outpatient prescription drugs. Within weeks, Congress was inundated with letters and calls from outraged seniors as they became aware of the ways in which this new law would impact their pocketbooks. Within one year, the Congressional Budget Office's estimates for the cost of the prescription drug benefit skyrocketed from $5.7 billion to $11.8 billion. By late 1989, under a powerful backlash from seniors, Congress was forced to repeal major elements of the law.

One of the proposals before Congress, S. 841 (H.R. 1495) requires the Department of HHS to contract with benefit managers, retail pharmacies, and insurers to provide a managed prescription drug benefit to Medicare beneficiaries. This approach, however, would jeopardize the supplemental drug coverage currently enjoyed by two-thirds of America's seniors, diminish the incentives seniors have to purchase Medigap or Medicare health maintenance organization policies, and make employers less likely to offer private health plans to their elderly employees. Not only is such a proposal bad policy, but its price tag of $20 billion, as estimated by Senator Kennedy when he introduced his bill, is likely to be a gross underestimate of the actual costs.

To assist lower-income seniors to obtain their prescription drugs, Congress should consider implementing the following steps:

1. **Establish a Medicare prescription drug benefit in Medicare managed care plans based on the procedure used in the Federal Employees Health Benefits Program (FEHBP).** Nearly all the plans offered federal employees in the FEHBP include a prescription drug benefit even without a mandate to do so.
2. **Create a "Benefits Board" to determine how to include a drug benefit in the Medicare fee-for-service program.** Congress then could vote straight up or down on the board's annual recommendations.
3. **Create an independent "Medicare Board" to negotiate on behalf of seniors for prescription drug benefits as well as other benefits.** This board should be modeled after the Office of Personnel Management, which negotiates with private insurance companies on behalf of federal workers for prescription drugs and other benefits in the FEHBP.
4. **Establish a voucher system to assist lower-income seniors to pay for prescription drugs.** The federal government gives the poor vouchers (food stamps) to purchase food of their choice in a freely functioning market. Medicare could provide similar vouchers for prescription drugs.
5. **Create a Medigap option exclusively for prescription drugs.** There currently are 10 types of Medigap policies available to seniors. Only three include prescription drug coverage, and none is for drugs alone. Congress should develop one or more new Medigap plans for prescription drugs.

The majority of seniors does not experience problems in obtaining medication. Targeting those that do would cost taxpayers far less than providing 40 million Medicare beneficiaries with coverage that may duplicate their existing coverage. Members of Congress should allow senior citizens the same choices they themselves enjoy under the FEHBP and avoid mistakes Congress made in the past. In short, Members of Congress should not promise low-cost prescription drugs that they cannot deliver.

—James Frogue is Health Care Policy Analyst at The Heritage Foundation.

The Heritage Foundation
Backgrounder
214 Massachusetts Avenue, N.E. Washington, D.C. 20002-4999 • (202) 546-4400 • http://www.heritage.org

No. 1293 June 16, 1999

How to Provide Prescription Drug Coverage Under Medicare

James Frogue

Congress is under considerable pressure to address the absence of outpatient prescription drug coverage in Medicare, the huge and financially troubled government health care program that covers almost 40 million elderly and disabled Americans. Several bills in Congress seek to do this, including S. 841, sponsored by Senator Edward Kennedy (D–MA), and its companion bill in the House, H.R. 1495, sponsored by Representative Pete Stark (D–CA). This legislation would require the Secretary of the U.S. Department of Health and Human Services (HHS) to contract with benefit managers, retail pharmacies, insurers, and other entities to provide Medicare beneficiaries with a prescription drug benefit.[1] The Clinton Administration also is urging Congress to add a drug benefit to Medicare.[2]

The task before Congress, however, is not so much whether to provide prescription drug coverage to Medicare beneficiaries, but how to do it considering the enormous potential cost of the benefit and the poor track record of previous attempts to provide such coverage. There is concern that congressional "remedies" could lead to a disruption of the prescription drug market and undermine the quality and availability of the very benefit lawmakers hope to provide. Before Members of Congress consider providing a prescription drug benefit in Medicare, they should recognize three key facts:

- **Medicare is in financial trouble, and the addition of a costly new benefit, especially if not done properly, could make its financial condition even worse.** Despite Congress's extension of the life of Medicare's hospitalization trust fund, achieved mainly by juggling covered services between the

Produced by
The Domestic Policy Studies Department

Published by
The Heritage Foundation
214 Massachusetts Ave., N.E.
Washington, D.C.
20002–4999
(202) 546-4400
http://www.heritage.org

1. In addition, Representative Barney Frank (D–MA) sponsored H.R. 886, and Representative Eliot Engel (D–NY) introduced H.R. 1109.
2. See Robert Pear, "Clinton Will Seek a Medicare Change on Drug Coverage," *The New York Times*, June 8, 1999, p. Al.

program's two parts, the fiscal outlook for Medicare remains bleak. To propose a massive new benefit in a program that already is hurtling toward bankruptcy could turn a staggering problem into a financial disaster for taxpayers. Even worse, adding a prescription drug benefit could threaten existing Medicare coverage.

- **A new prescription drug benefit would be likely to increase Medicare costs dramatically.** A recent study by the National Academy of Social Insurance estimates that a new prescription drug benefit for Medicare would increase the program's costs by 7 percent to 13 percent over the next 10 years.[3] Similar findings are found in other studies.[4]
- **Seniors could see their Medicare premiums double, and many could find themselves with duplicate coverage.** Because details of the ways in which a drug benefit would be financed are unavailable, it is not clear who actually would pay the cost of this benefit, which could run as much as $40 billion annually.[5] If the full cost were to be borne by beneficiaries, premiums for Medicare Part B could more than double. Many Americans over age 65 would not react kindly to this large increase because two-thirds of seniors already have some kind of prescription drug coverage through Medicare's supplemental program, employer-sponsored policies, Medicare health maintenance organizations (HMOs), or Medicaid. Congress should recall that, when all seniors were required in 1988 to pay additional premiums for catastrophic coverage, drug coverage, and other benefits that many already had, a powerful political backlash caused the legislation to be repealed.

Adding prescription drug coverage as a benefit in Medicare should be done within the context of overall Medicare reform. The model for reform, as anticipated by the National Bipartisan Commission on the Future of Medicare, is based on the successful record of the popular and effective Federal Employees Health Benefits Program (FEHBP), a consumer-driven system that serves 9 million federal workers, including Members of Congress, their staffs, and their dependents. Congress should create a Medicare Board that would negotiate prescription drug coverage and a Benefits Board that would propose the drug benefit and other modifications of the Medicare benefits package in the fee-for-service program. It also should create a voucher system to assist lower-income seniors to obtain prescription drugs. It should allow consumers and seniors groups to offer health plans to their members and to negotiate better deals for coverage; and it should create a Medigap option for prescription drugs that would permit the marketing of a drug-only supplemental policy to seniors.

LEARNING FROM PREVIOUS REFORM ATTEMPTS

Before Members of Congress debate the many bills that are being introduced on a prescription drug benefit for Medicare, they should recall the lessons learned in 1988 and 1989, after Congress passed the Medicare Catastrophic Coverage Act with overwhelming support from the public and various interest groups. The House passed the law by a vote of 302 to 127 and the Senate by a vote of 86 to 11, adding many generous new benefits to the Medicare program. Among the benefits were unlimited annual hospital coverage for catastrophic illness, 150 days of skilled nursing care, 38 days of home health care, and unlimited hospice care, which were provided even as Congress capped Medicare Part B (hospitalization) expenses at $1,370 per beneficiary in 1988 dollars. The law also covered outpatient prescription drugs.

3. Michael E. Gluck "A Medicare Prescription Drug Benefit," National Academy of Social Insurance *Medicare Brief* No. 1, April, 1999.
4. Laurie McGinley, "With Drug Benefit, Costs of Medicare to Rise 7% to 13%," *The Wall Street Journal,* April 14, 1999.
5. Merrill Matthews, "Making Prescription Drugs a Right" *Investor's Business Daily,* March 8, 1999.

Sticker Shock

The snag in implementing this law was the high cost of these popular benefits. To assist with the financing, the law required states to pay Medicare premiums plus deductibles and coinsurance for millions of low-income elderly and disabled individuals. Individual Medicare beneficiaries who were not classified as low-income or disabled were subject to new premiums and taxes. First, there was an additional monthly premium of $4 for catastrophic coverage. Second, Congress imposed an income-dependent, sliding-scale tax of up to $800 annually per person or $1,600 per couple. And third, seniors were to pay a flat monthly drug premium of $1.94, a deductible of $550 for the benefit, and a copayment of 50 percent.[6]

Within weeks of the bill's passage, it became clear to seniors just what this meant for their pocketbooks. Many became outraged, and broad public and congressional support for the measure began to drop precipitously. The National Committee to Preserve Social Security and Medicare, an activist liberal interest group, informed senior citizens that a far greater number of them would be subject to higher "supplemental premiums" than Congress had estimated.[7] According to the committee:

> The Congressional Budget Office (CBO) underestimates the number by 24 percent. The widespread tax consequences affect almost half of all seniors in 1989. In addition, 30 percent to 40 percent of Medicare enrollees—most of the seniors paying the surtax—will suffer out-of-pocket costs for Medicare covered services. This is true even after taking into consideration all the new benefits and the reductions in Medigap premiums.[8]

Underestimating Costs

In June 1988, when Congress passed the Medicare Catastrophic Coverage Act, the Congressional Budget Office (CBO) estimated the prescription drug benefit to cost $5.7 billion over five years. One year later, however, that estimate rose to $11.8 billion. Other provisions of this legislation saw even greater upward revisions.[9]

Representative Marilyn Lloyd (D–TX) echoed the sentiments of many of her colleagues when she stated on September 29, 1988, that seniors would be "taken to the cleaners" by the new legislation. The very next day, Representative William Archer (R–TX), along with 32 cosponsors, introduced H.R. 5426 to delay implementation of the recently passed law. Congressional staff handled a constant barrage of letters and calls from outraged seniors, and eventually Congress found it had no choice but to repeal major elements of the legislation.[10]

The failure of Washington, to estimate the high cost of the new health benefits also proved fatal to the Clinton Plan in 1993 and 1994. During the debate over the Clinton health care plan, *Newsweek* columnist Robert J. Samuelson observed that,

> Five outside groups re-estimated the Clinton "basic package" of insurance benefits. All found higher costs than the White House did.[11]

Clearly, the federal government's cost estimates can turn out to be inaccurate—and especially so for open-ended benefits like prescription drug

6. In 1988 dollars. See Robert E. Moffit, Ph.D., "The Last Time Congress Reformed Health Care: A Lawmaker's Guide to the Medicare Catastrophic Debacle," Heritage Foundation *Backgrounder* No. 996, August 4, 1994.
7. National Committee to Preserve Social Security and Medicare, "Medicare Catastrophic Coverage Act: More Out-of-Pocket Costs, Little or No Benefit," *Research Report,* February 1989.
8. Moffit, "The Last Time Congress Reformed Health Care."
9. *Ibid.*
10. *Ibid.*
11. Robert J. Samuelson, "Congress Should Simply Start Over," *The Washington Post,* July 13, 1994, p. A17.

coverage. There are two main reasons for this. First, there is every political incentive for sponsors and backers to lowball costs in order to gain support. Second, when any good or service appears very cheap or even free to a consumer, there is no incentive to limit its use.

TREADING CAREFULLY WITH DRUG COVERAGE

Some Members of Congress point to the escalating costs of prescription drugs (and the potentially high cost of a Medicare drug benefit) as evidence that something must be done. According to a leading pharmaceutical industry publication, total prescription drug spending went up 15.7 percent in 1998.[12] Between 1992 and 1998, spending on pharmaceuticals in the United States nearly doubled. Such figures often are cited as evidence that costs have gotten out of control and government needs to become involved. According to the 1999 industry profile, however, the 15.7 percent spending increase in 1998 was due largely to a 12.5 percent increase in the volume of purchases. The remaining 3.2 percent was the result of actual price increases.[13] This dramatic increase in the volume of purchases speaks to the quality and effectiveness of the available drugs.

Although it is true that spending on prescription drugs consumes a larger share of the health care pie, this trend is due in large part to the huge development costs of pharmaceuticals as well as the success and cost-effectiveness of these drugs in treating patients. Consider, for example, the Veterans Administration's recent decision to cover the $12,000 to $15,000 annual cost of providing a patient with a new drug to combat hepatitis C.[14] Although it is expensive, taking this drug can eliminate the need for more costly treatments in the future, including a liver transplant that could cost hundreds of thousands of dollars. This makes the high cost of the drug a sensible investment from a financial as well as a medical point of view. Similarly, ulcer surgery is declining because new "H2 antagonist drugs," which cost $900 per year, make the physical and financial ordeal of the $28,000 surgery unnecessary.[15] And blood-thinning anticoagulants, which prevent the recurrence of a stroke, cost over $1,000 a year, compared with a total lifetime costs for a debilitating stroke of $100,000. Examples like these abound, and public pressure to generate such drugs is the driving force behind the rising drug expenditures.[16]

Avoiding Overreaction and Double-Charging

Congress first should determine whether a significant majority of America's senior population experiences consistent trouble in obtaining prescription drugs. If it does not, then the level and range of government intervention into the drug market that is being contemplated today would be unnecessary, and ultimately it could hurt more people than it would help.

Nearly 9 out of 10 Medicare beneficiaries use prescription drugs.[17] Between two-thirds and three-quarters of these seniors also have some drug benefit coverage through Medicare HMOs, private health plans, the Veterans Administration, Medigap policies, or Medicaid (a program that provides medications).[18] In 1997, almost 60 percent of Medicare beneficiaries with incomes

12. Pharmaceutical Research and Manufacturers of America, *1999 Pharmaceutical Industry Profile,* Washington, D.C, March 1999, p. 49.

13. *Ibid*.

14. Bill McAllister, "VA to Offer New Hepatitis C Drugs: Costly Treatment Program Targets a Disease Far More Common in Veterans," *The Washington Post,* January 27, 1999, p. A19.

15. Betsy McCaughey Ross, "Make Senior Prescriptions Affordable," *Times Union (* Albany, N.Y.), February 28, 1999.

16. *Ibid*.

17. "Pharmaceuticals Balk, While AARP Supports Expanding Program to Cover Prescriptions," BNA *Daily Report for Executives* No. 16, January 26, 1999.

below the federal poverty line were eligible for Medicaid, although not all took advantage of their eligibility.[19]

According to the Bureau of Labor Statistics, the average senior spent $637 in 1997 on prescription and non-prescription drugs—less than 3 percent of the average senior's total spending that year of $24,413. Even the poorest seniors report spending less on drugs than they do in restaurants.[20] So it would appear that, although some seniors have trouble purchasing prescription drugs, most find paying for prescription drugs not overly burdensome. In fact, according to the National Academy of Social Insurance, only 10 percent of seniors report out-of-pocket expenditures totaling $1,000 to $2,000 per year, and only 4 percent spent more than $2,000.[21]

The real issue for Congress, then, is how to assist those who cannot afford adequate coverage. For some seniors, certain high-priced drug therapies are the only answer, and government can make it easier for them to obtain necessary treatments. But the problem of affordability for a few is not a systemic crisis that demands a complete overhaul of a system; neither is it one that justifies the exorbitant costs involved that would affect taxpayers and the pharmaceutical industry as well as senior citizens.

PROBLEMS WITH THE PROPOSALS

Proposals before Congress, such as S. 841 and H.R. 1495, which would require the Secretary of HHS to contract with benefit managers for large companies, retail pharmacies, insurers, and other entities to provide a managed prescription drug benefit to Medicare beneficiaries, take the wrong approach. Contrary to their proponents' claims, the S. 841 proposal is not a plan oriented toward the "private sector." It would give new powers to the Health Care Financing Administration (HCFA)—the powerful bureaucracy that runs the Medicare and Medicaid programs—to regulate pharmacies, insurers, and pharmaceutical manufacturers.

This subsidized benefit approach would have serious repercussions. It would jeopardize that prescription drug coverage already enjoyed by seniors who have supplemental coverage, and it would carry a large potential cost to taxpayers. The reason: If Medicare offered prescription drug coverage with taxpayer subsidies, then the incentive seniors would have to purchase Medigap or Medicare HMO coverage would diminish. Moreover, employers could become less inclined to offer private health plans to their elderly employees. (If drugs already were covered by someone else, why would employers spend the extra money?) This new subsidized benefit would crowd out the more efficient private market from the drug market. In addition, the price controls embodied in this approach would stifle incentives for innovative pharmaceutical companies to develop new medicines—an enterprise that is so crucial in combating today's debilitating diseases and improving the quality of life for senior citizens.[22]

Financing the Benefit

A key problem with S. 841 is its financing. Even its sponsor, Senator Kennedy, estimates that its drug benefit would cost taxpayers $20 billion per year.[23] Unfortunately, government officials routinely underestimate the cost of health care.

18. Merrill Matthews, "A Prescription for Medicare Disaster," National Center for Policy Analysis *Brief* No. 288, April 19, 1999.
19. Robert M. Goldberg, "An Unnecessary Prescription," *The Weekly Standard*, March 22, 1999, p. 18.
20. U.S. Department of Labor, Bureau of Labor Statistics, *Consumer Expenditure Survey,* December 1998, at *http://www.bls.gov/sahome.html.* According to the *Consumer Expenditure Survey,* seniors over age 65 reported spending an average of $1,193 on "Food Away From Home" in 1997. See also Matthews, "A Prescription for Medicare Disaster."
21. Gluck, "A Medicare Prescription Drug Benefit."
22. See James Frogue, "Why Price Controls on Prescription Drugs Would Harm Seniors," Heritage Foundation *Executive Memorandum* No. 595, May 4, 1999.

Even more problematic than the high potential cost is the question of how such a benefit would be financed. Senator Kennedy has suggested using tobacco tax money to finance the plan.[24] Smoking, however, is on the decline and thus would be unlikely to provide a revenue stream sufficient to cover the ever-expanding cost of prescription drugs. To the extent that taxation discourages tobacco use, there would be a corresponding shortfall in necessary revenue. Such a shortfall would have to be made up either in higher premiums and copayments for seniors or a drawdown on general revenues from the Treasury. It is not clear how the program would be funded if it turned out to exceed estimates. Thus, it simply would be unwise to make the financing of prescription drugs dependent on taxes paid by smokers.

A Purchasing Cartel

Another problem is that S. 841's approach would establish, in effect, a Medicare cartel. If Medicare is the largest single purchaser of prescription drugs, then it is more or less free to pay whatever price it wants for the drugs it buys. A manufacturer, especially one with a new drug under patent, could not afford to ignore its largest purchaser, and conceivably the only purchaser of drugs for a particular class of patients. That manufacturer would be put in the position of having to sell to Medicare, even if the price Medicare paid were below what the company normally would obtain in a competitive market.

This raises, if indirectly, the issue of current law on prescription drug patents and the reason that Congress adopts such laws. The point of offering a patent is to allow a small number of successful products to pay the cost of thousands of failures. The patent allows a company to recoup the enormous expenses it incurred for basic research in developing that new drug. Members of Congress have agreed to this arrangement because it is the best way to encourage inventive scientific enterprise to pursue these results. The issuing and protecting of patents creates incentive for the kinds of drug research that lead to breakthroughs—the hallmark of modern medicine.

A purchasing cartel would undermine the rationale of this arrangement. If Medicare were to become the sole or dominant buyer of prescription drugs, it would undermine the patent concept and have the same effect as price controls—discouraging the level of investment in research that is necessary to develop new drugs. Less investment means reduced chances of finding a cure for cancer, heart disease, and the other ailments that plague America's rapidly aging society. There certainly are sound reasons to revisit current patent law governing prescription drugs. But if so, the reexamination should not be done in the politically charged atmosphere surrounding the debate over a Medicare prescription drug benefit.

WHAT CONGRESS SHOULD DO

Medicare, Medicaid, and today's employer-based, third-party payment system all share a common feature: They distort personal decision-making by hiding from patients the true costs of medical services and discouraging them from seeking value for their health care dollar. This, in turn, reduces the incentive for health care providers to find the best and most cost-effective way to satisfy consumers.

A better approach would be to empower individual consumers. In the case of Medicare, this could be accomplished by making more plans and benefits available to seniors through a comprehensive reform of the current program. Short of that, Congress should begin to allow innovative private-sector purchasing of prescription drugs by Medicare beneficiaries, coupled with an expanded use of targeted government assistance to assist needy seniors in offsetting the cost of medicines. Doing this would encourage competing plans to

23. "Democrats Introduce Bills to Provide Comprehensive Prescription Drug Coverage," BNA *Daily Report for Executives* No. 76, April 21, 1999.

24. *Ibid.*

determine the best way to offer the drug coverage. In addition, Congress needs to take steps to stimulate creative ways to provide coverage of drugs through the traditional fee-for-service program and the Medigap market.

When it was created in 1965, Medicare provided state-of-the-art health coverage to beneficiaries. But because all major benefit changes require an act of Congress, mere discussion of changes to its benefit structure necessarily have been bogged down in the political process. Actually making changes becomes next to impossible. Consequently, the benefits package available under Medicare is completely out of date compared with private-sector plans. For example, in 1999, one would be hard-pressed to find a large corporation that does not offer its workers a plan including at least some coverage for outpatient prescription drugs. Even the FEHBP provides drug coverage and other modern benefits to retired and active federal workers and their families.

Based on its experiences with Medicare reform in the past, there are several options from which Congress could choose to ensure seniors also have access to good prescription drug coverage:

1. **Establish a Medicare prescription drug benefit in Medicare managed care plans servicing seniors through the procedures used in the FEHBP.** In the FEHBP, Members of Congress and federal workers enjoy an array of choices in health plans. The competition among these plans results in quality service and keeps prices down. Nearly all the plans provide a prescription drug benefit because, in effect, competition has forced plans to include the benefit to retain customers. Other benefits have been introduced into plans merely by "jawboning" them to do so—without formal regulations or legislation. If Congress wanted to extend prescription drug coverage to seniors and control costs at the same time, it should model this reform after the way it provides its own prescription drug coverage.

   A bipartisan majority of members of the recently disbanded National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA) supported changing the current Medicare program to a new system based on "premium support," as in the FEHBP.

2. **Create a "Benefits Board" to determine ways in which to include a drug benefit in the benefits available to Medicare beneficiaries in the fee-for-service program and to propose subsequent additional improvements in the core benefits package.** Instead of having Congress or the Administration specify detailed Medicare benefits, Congress should create a Benefits Board to propose specific incremental changes in Medicare's core benefits. The Administration and Congress would select members of this independent board for specific terms. The board's annual recommendations to Congress would be subject to an up-or-down vote without amendment. This change would reduce political pressure on benefit decisions and remove lawmakers from the process of making medical decisions. Yet it would give Congress the final say in any benefit changes. The practical logic for establishing such a board is the same logic behind the Base Closing Commission created in the 1980s.

   The first task for a Benefits Board should be to determine the best way to introduce a drug benefit into Medicare's traditional fee-for-service program. Congress could instruct it to develop a modified benefits package that included drug coverage within a specified budget. The board could propose small changes in various features of the benefits package to develop a well-balanced package that achieved Congress's objectives. Should it fail to win approval in the up-or-down vote, the board would develop modified versions until an agreement was reached.

3. **Create an independent "Medicare Board" to negotiate on behalf of seniors for prescription drug benefits.** The Office of Personnel Management (OPM), which negotiates with private insurance companies on behalf of federal workers and retirees for prescription drugs and other benefits in the FEHBP, provides a

good model for an independent Medicare Board that would negotiate on behalf of senior citizens in Medicare. Such a board would assume the role of HCFA which currently negotiates with private plans that want to do business with Medicare's beneficiaries. HCFA then would be free to make the fee-for-service Medicare program more up-to-date and efficient. Creating a Medicare Board also would resolve the conflict of interest inherent in having HCFA write the rules of competition while operating one of the competing plans. By comparison, the OPM does not run a plan in the FEHBP.

The Medicare Board could make sure that competing plans offered a core of benefits guaranteed by law.[25] It could encourage or even require, as a condition of participation, that private plans offered a prescription drug benefit. The OPM does so on behalf of FEHBP beneficiaries. Private plans would agree to different combinations and levels of benefits that they determined would enable them to meet consumer demand for a drug benefit in the most efficient way possible in a competitive market. As a result of these negotiations, the board and the plans would enter into a contract, and plans would compete on the basis of that contract for consumer dollars, just as plans do in the FEHBP.

Under this arrangement, seniors would be free to choose from a number of plans that offer at least a standard core of minimum benefits specified by law. Plans would distinguish themselves on price, service, and different combinations of additional benefits, just as in the FEHBP today. For example, if a certain level of prescription drug coverage proved popular among seniors, plans would have to include it to remain competitive. The result would be more responsive and tailored drug insurance coverage for seniors who chose private plans.

4. **Establish a voucher system to assist lower-income seniors with obtaining prescription drugs.** The federal government, to assist those who cannot afford food, does not use price controls. Instead, it provides vouchers (food stamps) to the poor to allow them to purchase the food of their choice in a freely functioning market. Prescription drug coverage should be no different. For lower-income patients who did not have money readily available to buy medications, HCFA could deposit funds into an account for prescription drug costs only or to subsidize the core of a drug coverage plan. The value of the voucher could be means-tested. HCFA could consider using electronic debit cards; every time a senior citizen visited the nearby pharmacy, the balance on the card would be adjusted.

5. **Create a Medigap option for prescription drugs exclusively.** Under current rules, there are 10 types of Medigap policies available to Medicare beneficiaries. Only three (H, I, and J) include partial coverage for prescription drugs. They are the most comprehensive and therefore the most expensive plans. Drug coverage itself has high cost sharing for beneficiaries—a $250 deductible and a 50 percent copay up to $1,250 for plans H and I and up to $3,000 for plan J. Seniors who wished to purchase a Medigap policy that includes a drug benefit would be forced also to purchase coverage for (1) the Medicare Part A deductible; (2) skilled nursing facility care daily coinsurance; and (3) medically necessary emergency care in a foreign country (80 percent coverage after a $250 deductible).[26] The cost of a Medigap policy plan to cover prescription drugs exclusively would be significantly lower without the excess coverage listed above.

25. See Stuart M. Butler, Ph.D., "Restructuring Medicare for the Next Century," testimony before the Senate Finance Committee, 106th Cong., 1st Sess., May 27, 1999, available online at *http://www.heritage.org/library/testimony/test052799.html.*

26. See *http://hiicap.state.ny.us/mgap/mgap03.htm*.

CONCLUSION

Members of Congress should proceed with caution in considering the legislative proposals to add a prescription drug benefit to the troubled Medicare program. Some of the approaches not only would be enormously expensive, but they also could entangle the prescription drug benefit in a bureaucratic web. Congress must remember the hard Medicare lessons of its past attempts and take a page from the successful Federal Employees Health Benefits Program, which provides Members of Congress and other federal employees and retirees with coverage for prescription drugs.

But Congress should recognize that the majority of seniors do not experience significant problems in obtaining their medications. Moreover, many of the proposals to include a prescription drug benefit in Medicare include price controls, a policy that would stymie the very innovations Americans have come to expect from the pharmaceutical industry. The best way to change the heavily bureaucratic Medicare system to allow a prescription drug benefit for those seniors who truly need it would be to provide an open and competitive health care market. Congress also should establish a voucher system to assist poor seniors with buying needed drugs; it should allow consumers and seniors organizations to bargain directly for prescription drugs at reasonable prices; and it should make long overdue changes in the rules governing Medigap coverage for drugs.

In rushing to provide a prescription drug benefit, Congress should not promise seniors a low-cost prescription drug benefit it could not deliver or that would further erode the already weak financial foundations of the Medicare program. Fortunately, there is no need for Members of Congress to repeat the mistakes they made in 1988 and 1989 in passing and then repealing the Medicare Catastrophic Coverage Act. By building on the majority proposals of the National Bipartisan Commission on the Future of Medicare, they could modernize the outdated Medicare benefits package, improve Medicare's organization, and ensure that all seniors have cost-effective prescription drug coverage.

—James Frogue is Health Care Policy Analyst at The Heritage Foundation.