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THE HOUSE MEDICARE DRUG PLAN: A MODEST STEP TOWARD REFORM

JAMES FROGUE

The Medicare Rx 2000 Act (H.R. 4680)—the Ways and Means Committee Medicare prescription drug bill sponsored by Health Subcommittee Chairman William Thomas (R–CA)—would provide a voluntary prescription drug benefit to Medicare patients. Its bipartisan sponsors include Representatives Richard Burr (R–NC), Collin Peterson (D–MN), and Ralph Hall (D–TX), and the chairman of the House Commerce Committee, Representative Thomas Bliley (R–VA).

America's seniors would be served best by an overhauled Medicare system adapted to the needs of the 21st century and modeled on the Federal Employees Health Benefits Program (FEHBP), which serves Members of Congress and other federal workers and retirees. This was the solution endorsed last year by a bipartisan majority of members of the National Bipartisan Commission on the Future of Medicare. Such an overhaul would give Medicare beneficiaries access to competing private health insurance plans. Such competition would ensure that a drug benefit would be integrated into those plans—as it has been in the FEHBP—removing the need for seniors to have to purchase additional insurance to bridge gaps in Medicare coverage. The Thomas bill falls short of the broad reform needed, but it is intended as a step in that direction.

What H.R. 4680 Would Do. Instead of offering comprehensive reform of Medicare, H.R. 4680 would provide beneficiaries with a stand-alone prescription drug benefit. To be sure, there are dangers in an incremental approach. For instance, this kind of stand-alone benefit is vulnerable to the problem of adverse selection, where only heavy users of prescription drugs opt for coverage.

Nevertheless, H.R. 4680 contains a number of positive aspects that make it far superior to the prescription drug proposals offered by President Bill Clinton and Senate Democrats. A good feature of H.R. 4680 is that the new drug benefit would not be managed by the Health Care Financing Administration (HCFA), which has a long history as an over-regulating, micromanaging agency that is an unreliable partner for private plans. Recognition that HCFA's role in benefit management of this kind should be limited is long overdue.

H.R. 4680 would change the management of Medicare by creating a new Medicare Benefits Administrator (MBA) within the Department of Health and Human Services to oversee the drug benefit. The legislation specifically prohibits the MBA from using price controls and establishes an advisory board of private-sector representatives to

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ensure that the MBA would not become another type of HCFA. The long-term benefit of this approach is that this new overseer could serve as a platform for future comprehensive Medicare reform. By contrast, the Clinton plan puts HCFA squarely in charge of running the drug benefit.

Significantly, the new MBA also would gain oversight of all Medicare+Choice plans, removing that authority from HCFA. This would give Medicare managed care plans the opportunity to operate with less bureaucracy while allowing HCFA to concentrate on running the fee-for-service program.

H.R. 4680 also guarantees Medicare beneficiaries in every region of the country that they would have access to at least two competing prescription drug plans. This provision would ensure that seniors in rural areas are not underserved. As a condition of participation in a region, the plans must offer local pharmacy access, ensuring that drugs would be available for seniors in rural locations and not just obtainable by mail order. In the unlikely event that two private plans do not establish operations within a particular area, the bill gives the MBA tools to entice plans to set up operations. The Clinton proposal, by contrast, offers only one plan per region, which would deny seniors the benefits of choice and the inherent advantages of competition.

Catastrophic insurance protection for drug costs is also included in H.R. 4680, unlike the Clinton plan. Under the Thomas bill, seniors would no longer be liable for drug costs once their out-of-pocket expenditures reached $6,000. Beyond that amount, the plan would pick up 100 percent of costs. In other words, H.R. 4680 is true "insurance," compared with the Clinton plan's partial subsidy for lower-end drug costs. Neither the Clinton plan nor the Senate Democratic plan (S. 2541) specifically mentions a stop-loss limit. The President's plan depends on a future President and Congress to establish a stop-loss subsidy in 2006, while S. 2541 depends on the Secretary of Health and Human Services to draw up a plan for catastrophic protection in 2002 if Congress fails to design one by 2001.

H.R. 4680 targets its subsides to the lowest-income Americans. Every eligible person up to 135 percent of the poverty level would receive a subsidy for the full cost of the premium for a plan with standard coverage. That subsidy would phase out to zero at 150 percent of poverty. In this respect, the Clinton plan and S. 2541 are similar to H.R. 4680.

H.R. 4680 also relies on private, state-regulated entities to run the drug benefit and to assume some of the risk associated with high-cost enrollees. This would make it less objectionable than the Clinton or Senate Democratic plans in which the taxpayers assume all of the risk.

Conclusion. Newer and more effective pharmaceuticals for America's seniors are constantly being developed. In many cases, these prescription drugs make expensive and riskier surgical procedures unnecessary. Seniors should have access to these drugs with solid prescription drug coverage. Yet even as the benefits of drugs are clear, their cost continues to climb. To address this matter appropriately, Congress should build on the work done by Senator John Breaux (D–LA) and Representative Bill Thomas and the National Bipartisan Commission on the Future of Medicare. Short of that, provisions like those in H.R. 4680 to provide prescription drug coverage to Medicare beneficiaries would take a modest step toward implementing needed structural reforms in Medicare.

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