Executive Summary
Backgrounder
Published by The Heritage Foundation

No. 1750
April 26, 2004

Fixing the New Medicare Law #1: An Agenda for Constructive Change

Robert E. Moffit, Ph.D.

When Congress takes up a drug benefit again, it should keep things simple and concentrate on the risk, approaching certainty, that it wishes to prevent: people going without drugs—or without food—because of the cost. That means concentrating on poor people.

—Michael Kinsley

Taxpayers are in big trouble. Although Medicare is facing exploding costs, Congress has just added an expensive universal drug entitlement to the program rather than simply targeting assistance to poor seniors who lack drug coverage. Some prominent Members of Congress want to expand the new program, making Medicare's financial situation even worse.

By enacting the Medicare Prescription Drug Improvement and Modernization Act of 2003, commonly called the Medicare Modernization Act of 2003, Congress and the Administration aggravate Medicare's worsening financial condition without introducing the level of real reform necessary to contain future costs. As the editors of *The Washington Post* recently noted, "Congress…by approving a drug benefit without deeper reforms, wasted a golden opportunity."

The 12 titles of the 681-page Medicare legislation, accompanied by a 402-page narrative report, constitute a mammoth set of program changes. The regulatory regime spawned by this massive legislation will likely dwarf all previous Medicare amendments. Together, these major changes in law and regulation will have an enormous impact on current and future Medicare patients and taxpayers, as well as hospitals, doctors, and other medical professionals, for many years to come.

Bad Drug Policy. There is simply no need for the federal government to displace existing drug coverage, pre-empt new private-sector options, or accelerate the loss of employer-based drug coverage. Government entitlement programs cannot control cost, except through budgeting mechanisms or price controls that reduce the supply of services. One can reasonably expect that, ultimately, the government drug program will do precisely that, either through tightened drug formularies and price controls on drugs or indirectly through government-monopsony purchasing of prescription drugs. Moreover, recent survey data yield no evidence that the senior population appreciates the congressional handiwork on the prescription drug issue.

How to Improve the New Medicare Law. There is still time to fashion a superior Medicare

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/bg1750.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, N.E.
Washington, DC 20002–4999
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policy. While the Medicare Modernization Act of 2003 creates a universal drug benefit, it does not take effect until 2006. Meanwhile, the new law creates a discount prescription drug card, effective this year, combined with comparative price information and a $600 subsidy for low-income seniors. The discount card is projected to secure savings for seniors of between 10 percent and 25 percent, and initial research indicates that these projections are valid. Regrettably, Congress made this attractive drug provision temporary and set to expire in 2006.

To address the real needs of the senior population, Congress should make the drug discount card permanent and increase the subsidies for the targeted Medicare population (i.e., low-income seniors without existing coverage). Making the discount card the foundation of a new and targeted market-based Medicare drug policy would slow the needless displacement of existing drug coverage and the otherwise inevitable price controls on pharmaceuticals.

Meanwhile, Congress should ensure that the new Medicare Advantage program is neither deliberately weakened by legislation designed to discourage the participation of health plans nor implemented in a way that discourages continued participation among health plans. Congress has no excuse to repeat the failed regulatory and payment policies that undermined Medicare+Choice.

Finally, Congress should speed up the competitive demonstration project, scheduled to begin in 2010, and see that it is implemented fairly and honestly. That project should not be sabotaged by congressional opponents of real consumer choice and free-market competition.

Congress has a chance to reverse its flawed Medicare drug policy well before it is implemented and spare both seniors and taxpayers needless pain and expense.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation. This is the first of a special series of Center for Health Policy Studies papers on the new Medicare law.

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Taxpayers are in big trouble. Although Medicare is facing exploding costs, Congress has just added an expensive universal drug entitlement to the program rather than simply targeting assistance to poor seniors who lack drug coverage. Some prominent Members of Congress want to expand the new program, making Medicare's financial situation even worse.

By enacting the Medicare Prescription Drug Improvement and Modernization Act of 2003,[2] commonly called the Medicare Modernization Act of 2003, Congress and the Administration aggravate Medicare's worsening financial condition without introducing the level of real reform necessary to contain future costs. As the editors of *The Washington Post* recently noted, "Congress…by approving a drug benefit without deeper reforms, wasted a golden opportunity."[3]

Talking Points

- Costs of the massive Medicare drug entitlement will explode, burdening current and future taxpayers. Congress should delay its implementation until Congress determines how to pay for it.
- The Medicare drug entitlement will accelerate the loss of existing drug coverage by progressively crowding out existing drug programs, including those that are popular with seniors. Congress should instead build on the discount prescription drug card and target financial assistance to seniors who lack drug coverage.
- At best, the tight time frame for implementing the drug entitlement in 2006 is a formidable challenge to central government planning. At worst, it will become an administrative nightmare, resulting in millions of complaints from confused, frustrated, and unhappy senior citizens.
- The new Medicare Advantage program holds promise of delivering high-quality health care for future retirees, but only if Congress is a reliable business partner with the health plans and refrains from micromanaging and undercutting them.

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1. Michael Kinsley, "A Tough Pill," *The Washington Post*, August 2, 2002.
2. Public Law 108–173.
3. Editorial, "Bankruptcy Countdown," *The Washington Post*, March 25, 2004, p. A22.

The 12 titles of the 681-page Medicare legislation, accompanied by a 402-page narrative report, constitute a mammoth set of program changes. The regulatory regime spawned by this massive legislation will likely dwarf all previous Medicare amendments. Together, these major changes in law and regulation will have an enormous impact on current and future Medicare patients and taxpayers, as well as hospitals, doctors, and other medical professionals, for many years to come.

Serious Problems

While the law's main provisions do not take effect until 2006, staggering problems are already surfacing, particularly with the new drug entitlement program under Title I.

Exploding Costs. If left unchecked, future costs of the universal prescription drug entitlement will explode. Even without the new drug entitlement, Medicare spending is projected to grow by 43 percent in real dollars by 2013.[4] The Medicare trustees now report that the drug entitlement alone will add a stunning $8.1 trillion to Medicare's unfunded liabilities over the next 75 years, sharply increasing the financial burden on current and future taxpayers.[5]

Moreover, projected costs of the new Medicare law apparently were significantly higher than the projections publicly available when Congress enacted these provisions last year. Richard S. Foster, chief actuary for the Medicare program, recently revealed that his estimates showed that the drug benefit would cost $500 billion to $600 billion over 10 years[6]—far in excess of the $400 billion budgeted in 2003 during debate on the Medicare Modernization Act.

Displacement of Existing Prescription Drug Coverage. The increasingly unpopular Medicare prescription drug provisions will accelerate the displacement of existing drug coverage, including private, employer-sponsored prescription drug coverage. In recent years, many employers have been cutting back on retirees' health coverage, but the economic incentives created by Title I of the Medicare law, which provides for a universal drug entitlement, will surely accelerate the displacement of existing drug coverage, shifting billions of dollars of costs from private corporations directly onto taxpayers.

Moreover, months of polling from a variety of sources show that the complex drug entitlement is already proving unpopular with senior citizens who have read about it and understand it.[7] According to a *USA Today*/CNN/Gallup Poll released on March 30, 2004, only 36 percent of respondents aged 65 and older favor the new drug benefit, while 48 percent oppose it and 16 percent expressed no opinion.[8] Thus, bad drug policy is compounded by its growing unpopularity.

A Risky Experiment in Central Planning. With the universal drug entitlement going into effect on January 1, 2006, the Medicare bureaucracy will have limited time to prepare for the administration of the complex new government drug program. Of course, the Medicare bureaucracy has no experience in managing such a drug benefit.

However, to enforce the new Medicare law, Medicare officials must track the spending of each of the millions of Medicare beneficiaries who participate in the program, determining whether or not they meet their statutorily defined thresholds for deductibles and catastrophic coverage. This will require that the Centers for Medicare and Medicaid Services (CMS), which administers Medicare, update its voluminous computer files

4. David M. Walker, U.S. Comptroller General, "Health Care System Crisis: Growing Challenges Point to the Need for Fundamental Reform," PowerPoint presentation, January 13, 2004.
5. Centers for Medicare and Medicaid Services, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Insurance Trust Funds*, March 23, 2004, p. 109, at *www.cms.hhs.gov/publications/trusteesreport*. Hereafter cited as *Trustees' Report*.
6. Robert Pear, "Democrats Demand Inquiry into Charge by Medicare Officer," *The New York Times*, March 14, 2004.
7. Public opinion can change quickly, but the rapidly accumulating polling data reveal a high level of confusion about the Medicare law among seniors, as well as hostility or skepticism.
8. William M. Welch, "More Seniors Now Against Drug-Benefit Law, Poll Says," *USA Today*, March 30, 2004, at *www.usatoday.com/news/washington/2004-03-30-medicare-usat_x.htm*.

and make all of the necessary adjustments and modifications. As Nancy Anne DeParle, Medicare's administrator during the Clinton Administration, has recently observed, "It can be done, but it is not simple. And if it is not done perfectly, millions of beneficiaries and pharmacists will be calling CMS and Congress to complain."[9]

Sooner or later, Congress will have to address these growing problems, either in technical amendments or major legislation.

A Better Policy

The issue is increasingly not just whether to amend the Medicare law and bring its costs back under control. Congress must also take constructive steps that expand seniors' health care choices and improve the functioning of the new competitive system authorized in statute.

Specifically, Congress should:

- **Delay the costly drug provisions scheduled to go into effect in 2006.** Congress should delay these provisions until it establishes a serious mechanism to control costs, preferably through a financing system that is compatible with real reform of the Medicare program. The best mechanism to control costs over time is a "premium support" financing system, broadly similar to one used by the popular and successful Federal Employees Health Benefits Program (FEHBP). This option was recommended originally in 1999 by the majority of the National Bipartisan Commission on the Future of Medicare.

  Under an FEHBP-style formula, the government would make a payment to the health plan chosen by the enrollee. The payment would reflect the real costs of providing care, based on the weighted average premium of competing health plans, but the government contribution per enrollee would be capped at an annual amount. Such a system would provide for reliability and predictability in government health care payments and be far more humane than controlling costs through across-the-board cuts in Medicare spending or tighter price controls on Medicare services.

- **Make the new prescription drug discount card and the accompanying low-income subsidies a permanent feature of Medicare.** The new law provides for a Medicare prescription drug discount card, available this year, that will enable seniors to buy prescription drugs at a 10 percent to 25 percent discount off retail prices. Seniors could choose between at least two cards, sponsored by a variety of entities, including pharmacies, pharmacy benefit managers, and private insurers. Low-income seniors would also be eligible for a $600 subsidy on their cards without an asset test for eligibility.

  Even though the program has the potential to succeed, however, Congress has scheduled it to end in 2006. In other words, Congress would take the discount card program away from seniors, whether they want to keep it or not, thus depriving seniors of the choice of continued participation. Congress should quickly reverse this wrong-headed policy.

- **Restructure the Medicare drug benefit and transform it into a cost-effective catastrophic program.** Title I of the new law provides for a voluntary prescription drug benefit to be offered through private health plans and new "drug only" insurance plans, effective in 2006. More than three-fourths of senior citizens currently have some form of drug coverage, but the new government entitlement would displace, disrupt, or downsize this existing coverage.

  A far better option would be to combine a catastrophic coverage requirement with a national system of debit cards, with subsidies targeted to low-income seniors who currently lack drug coverage. The funds in the debit card accounts could then be rolled over from year to year, tax-free, just as funds are rolled over in the new Health Savings Account.

- **Be a reliable business partner with private health plans serving seniors.** The Medicare Modernization Act can enable private health

9. Nancy Ann De Parle, "Does CMS Have the Right Prescription? Implementing the Medicare Prescription Drug Program," statement before the Committee on Governmental Affairs, U.S. Senate, April 8, 2004, p. 6.

plans, now covering an estimated 4.7 million Medicare enrollees, to provide seniors with modern, high-quality, integrated health care coverage. Reversing the previous policy of capping plan payments at 2 percent annually, the new funding will enhance coverage for Medicare enrollees.

An estimated 95 percent of the initial 2004 Medicare funding for health plans will be used to expand access to doctors and other medical professionals, enriching benefits, and reducing premiums. The remaining 5 percent is earmarked for a new "stabilization fund," which will enable health plans to enhance benefits in the future.[10] To build on this initial success, Congress should remain a reliable business partner with private health plans and refrain from costly and inefficient micromanagement of the program.

- **Guarantee a fair and honest demonstration of a real competitive system.** Title II provides for a limited FEHBP-style demonstration program, but in only six metropolitan areas beginning in 2010. Hostility to competition is nothing new. A limited demonstration project of this type is often a pretext for killing a proposal or designing it to fail. Already, Members of Congress have stated their intention to prevent the demonstration program from taking effect in their jurisdictions and other selected areas of the country. As Robert Reischauer, President of the Urban Institute and former Director of the Congressional Budget Office (CBO), recently remarked, "The notion that this thing will get off the ground is absolutely fanciful."[11]

  A fair and honest demonstration of a truly competitive system like the FEHBP is possible if Congress and the Administration have the political will to do it. One way would be to start the demo program in 2007, confine it to *new* retirees, and open it up to all existing health plans that meet federal or state standards, including federal and state government employees' plans. This could be done in the 12 largest U.S. metropolitan areas.

What the New Medicare Law Does

The Medicare Modernization Act is the largest entitlement expansion since the enactment of the Medicare program in 1965.

A Massive Statute. The scope of the new Medicare law is enormous. It provides for:

- **A universal drug entitlement and discount card program.** Title I creates a universal, although voluntary, prescription drug entitlement under a new Medicare Part D, effective in 2006. It also provides for a prescription drug discount card, available in 2004.
- **A new system of competing private health plans.** Title II amends Medicare Part C and replaces the existing Medicare+Choice program with Medicare Advantage, a new system of competitive, regionally based private health plans, particularly preferred provider organizations (PPOs) that are to be operational in 2006. It also creates an FEHBP-style competitive demonstration program confined to six metropolitan areas in 2010. The demonstration program was a substitute for the creation of a real competitive system based on the FEHBP.
- **Numerous changes in traditional Medicare.** Titles IV, V, VI, and VII make numerous changes in the traditional Medicare program, including Medicare Part A and Part B, particularly in reimbursements for hospitals, doctors, and other health care professionals. It provides for new benefits, including wellness and screening, and authorizes billions of dollars in additional Medicare reimbursements to hospitals, doctors, and other health care professionals in rural areas.
- **A congressional process to track future Medicare costs.** Title VIII establishes new "cost containment" procedures, outlining the specific steps that Congress must or should take to track and curtail the excessive growth

10. Karen Ignani, "The Medicare Endorsed Prescription Drug Discount Card Program," statement before the Special Committee on Aging, U.S. Senate, March 9, 2004, p. 3.
11. Julie Rovner and Emily Heil, "Dems Target Administration's Rising Cost of Drug Benefit," *Congress Daily*, February 3, 2004.

of Medicare spending.

- **A modicum of administrative and regulatory reform.** Title IX changes Medicare administration and institutes modest reforms of the regulatory regime that governs health care providers and Medicare contractors. It also provides for new measures to combat Medicare waste, fraud, and abuse. However, the law does not significantly change either the administrative pricing system or the central planning apparatus that governs the provision of medical services. Thus, the Medicare regulatory structure, a target of the original reform proposals, is left fundamentally unchanged.
- **Medicaid changes and drug importation.** Title X makes changes in the Medicaid program, allows Medicaid beneficiaries to take advantage of the new Medicare drug provisions, and sets conditions for importing prescription drugs.
- **Health savings accounts.** Title XII, in a provision separate and distinct from Medicare, creates new tax incentives for the creation of health savings accounts (HSAs) for the nonelderly population.

Continued Bureaucracy and Red Tape. The new Medicare law continues to expand the power of the Medicare bureaucracy. The new law is highly prescriptive and will prove to be a powerful engine of massive regulation. In its practical operations, this will undermine a key goal of Medicare reform, which was to transform and streamline Medicare governance.

The majority of the National Bipartisan Commission on the Future of Medicare, co-chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA), proposed a very different method of governance. It proposed to transform the program into a "premium support" system that much more closely resembled the popular and successful Federal Employees Health Benefits Program, the original and most prominent model for Medicare reform. In sharp contrast to the roughly 40 pages of statute that govern the FEHBP,[12] the new 681-page Medicare law largely amends existing Medicare statutes and adds even more layers of administrative complexity.[13]

Compared with the private sector, government health programs are often touted as relatively simple. Particularly in the case of the Centers for Medicare and Medicaid Services, the opposite is true. Medicare's regulatory complexity is likely to increase—notwithstanding enactment of the new law to "reform" the program—from setting and enforcing price controls on thousands of medical treatments and procedures performed by doctors and hospitals in traditional Medicare, to implementing the new Medicare Advantage program under Part C, to administering the new prescription drug entitlement under Part D.

Administering Drugs. An estimated 42 million beneficiaries will be eligible to enroll in the new drug program on November 1, 2005. To meet this deadline, the CMS must deal with a wide variety of daunting challenges.

According to Dr. Cynthia Tudor, Director of the CMS's Division of Program Analysis and Performance Measurement, there is hardly one sentence in the 10 major sets of provisions under Title I that is *not* subject to regulatory interpretation.[14] Enforcing these provisions will occupy the Secretary of HHS and CMS staff for the next several months. They must establish regions for the drug plans; set standards for the Medicare Advantage plans and the new prescription drug plans (PDPs) that provide drug-only coverage; determine Part D premiums for the drug coverage; provide employer subsidies to

12. U.S. Code, Title 5, Chapter 89.
13. On the comparative governance of the two programs, see Walton J. Francis, "Using the Federal Employees' Model: Nine Tests for Rational Medicare Reform," Heritage Foundation *Backgrounder* No. 1675, August 7, 2003, at *www.heritage.org/Research/HealthCare/bg1675.cfm*.
14. Cynthia Tudor, Ph.D., Director, Division of Program Analysis and Performance Measurement, Centers for Medicare and Medicaid Services, "The Medicare Prescription Drug Benefit," presentation at America's Health Insurance Plans conference on Medicare, Washington, D.C., March 11, 2004.

firms that retain drug coverage; provide federal subsidies for low-income beneficiaries; provide guidance to the states that will have primary responsibility for determining eligibility for low-income subsidies; establish rules to provide for at least two private health plans in every region of the country; and establish a fallback drug plan if two plans fail to materialize.[15]

It is worth noting that the drug-only PDPs are not some robust product of market reality, but largely a creation of congressional imagination. Some private-sector analysts question whether or not these types of plans will even materialize, much less in sufficient numbers.[16] Nonetheless, the Administration is expecting them to play a substantial role in delivering the new drug entitlement.

While establishing standards for the drug plans and the provision of drug benefits under the new Part D, the CMS must also ensure that its rules are compatible with the new Medicare Advantage plans under the revised and updated Part C. The Medicare Advantage plans will, of course, also offer the new drug entitlement.

Beyond making rules for the Medicare Advantage plans, the CMS must also set standards for employer-based health plans to get the new tax-free government subsidies. Under the new law, the former employer is eligible for a 28 percent subsidy for qualified retiree drug benefits of between $250 and $5,000 annually. Thus, the CMS must determine whether the employer-sponsored plans are actuarially equivalent to the government prescription drug benefit. This will entail new government data requirements for employer-based health plans and government audits of the employer-based plans.

In the meantime, the CMS must develop rules to protect Medicare beneficiaries, including standards for drug price disclosure and a process for beneficiary grievances and appeals. The CMS must also deal with a variety of issues related to establishing the new drug benefit, including rules for enrollment and election periods, provision of information on premiums, cost sharing and coverage, the definition of "creditable" coverage under Part D, and drug formulary[17] standards.[18]

The development and implementation of drug formulary standards will be a crucial and potentially troublesome issue. As Anthony A. Barrueta, senior government relations counsel for the Kaiser Foundation Health Plan, has argued, the CMS will have to address the classes and categories of various drugs, as well as the rules governing brand names and generics. As Barrueta notes, the more drugs that are on health plans' formularies, the less health plans will be able to control drug costs.[19] Conversely, it can be expected that adoption of tighter drug formularies—or a rule that would allow or encourage the adoption of such formularies—will be politically unpopular.

Under the congressionally fixed time lines for administration of the drug benefit, this entire process will prove to be a formidable challenge. For example, in dramatic contrast to the wide variety of drug coverage available to federal workers and retirees, the congressional prescription of government supervision and control over the financing and delivery of the Medicare drug benefit is precise and detailed. Under the terms of the new Medicare law, "education" for the estimated 42 million eligible Medicare beneficiaries must begin by October 1, 2005. The initial enrollment in the government drug program begins one month later on November 1, 2005.

Former Medicare Administrator Nancy Ann De Parle has already given Members of Congress some

15. *Ibid.*

16. A central concern is the vulnerability of such plans to adverse selection, or the congregation of high risks in the plans. On this point, see Robert Laszewski, "Will the Conferees' Medicare Insurance Provisions Really Work?" Heritage Foundation *Lecture* No. 801, October 15, 2003, at *www.heritage.org/Research/HealthCare/HL801.cfm*.

17. Drug formularies are health plans' lists of "preferred drugs."

18. Tudor, "The Medicare Prescription Drug Benefit."

19. Anthony A. Barrueta, Senior Counsel, Government Relations, Kaiser Foundation Health Plan, "The Medicare Prescription Drug Benefit," presentation at America's Health Insurance Plans conference on Medicare, Washington, D.C., March 11, 2004.

flavor of what they can expect:

> For example, in order to make sure that the drug benefit's deductibles, cost-sharing and catastrophic limits work as stipulated in the law, CMS will have to develop a way to keep track of what *each Medicare beneficiary spends on drugs*.[20]

As DeParle further notes, CMS officials must adhere closely to the rules about spending on drugs, what is or is not a permissible cost, what drugs are and are not covered for purposes of reimbursement, and whether and when a Medicare beneficiary reaches the appropriate thresholds for deductibles and catastrophic coverage.[21] To reduce confusion and complaints among millions of Medicare patients, the government's computer files and programs must be updated and in excellent working order for this huge enterprise to be executed with efficiency and fairness.

Administering the Medicare Advantage Program. Beyond developing the new prescription drug program, HHS and CMS must also replace the flawed Medicare+Choice program with the new Medicare Advantage program, effective in 2006. This task includes conducting the health plan bidding and implementing the new payment system for health plans, defining regions and service for service areas, and setting benefit requirements, including the requirements for the new drug benefit under Part D.

The CMS will also need to develop guidance and rules for premium setting and allowable cost sharing, and conduct training programs for representatives of the health plans that enter the new system.

Administering Traditional Medicare. While implementing all the new programs, HHS and CMS will also be making numerous changes in the traditional Medicare program, including complex reimbursement changes for hospitals, doctors, and other medical professionals. Indeed, five of the 12 titles of the new law mostly focus on programmatic and reimbursement changes within the existing Medicare system.

In addition to administering traditional Medicare and its new programs, CMS officials must cope with the huge and growing Medicaid program, administer the State Children's Health Insurance Program (SCHIP), and enforce provisions of the Health Insurance Portability and Accountability Act of 1996. The enormity of these tasks will consume a great deal of time, energy, and effort from a career staff that is already overburdened.

Surveying the CMS's mounting administrative problems, Thomas H. Stanton, senior fellow at the Center for the Study of American Government at Johns Hopkins University, concludes: "In summary, an evaluation of the capacity, flexibility, accountability and life cycle of CMS reveals an agency that is losing its ability to administer the Medicare program."[22] Among federal agencies, the CMS already stands out as being among the most managerially challenged.[23]

In summary, the new Medicare law prescribes numerous mandates, standards, and regulatory requirements that must be met by health plans, hospitals, clinics, doctors, and other medical professionals. While Title IX provides some modest regulatory reform that will benefit physicians, the overall impact of the new law is to expand Medicare's regulatory regime. It will certainly invite even more congressional micromanagement, further undermining Medicare's effectiveness and efficiency.

Far Short of Reform. Despite its enormous complexity, size, and scope, the new Medicare law is largely an amendment to the existing Medicare statute, coupled with a prescription drug entitlement. In this respect, it is a major retreat from Medicare reform.

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20. De Parle, "Does CMS Have the Right Prescription?" (emphasis added).

21. *Ibid.*

22. Thomas H. Stanton, "The Administration of Medicare: A Neglected Issue," *Washington and Lee Law Review*, Vol. 60, No. 4 (Fall 2003), pp. 1373–1416.

23. On this point, see Robert E. Moffit, "Congress Should Think Twice About Allowing the Medicare Bureaucracy to Manage a Drug Benefit," Heritage Foundation *Backgrounder* No. 1583, September 9, 2002, at *www.heritage.org/Research/HealthCare/bg1583.cfm*. For a broader discussion of the serious governance problems in Medicare, see Kathleen M. King, Sheila Burke, and Elizabeth Docteur, eds., *Final Report of the Study Panel on Medicare's Governance and Management: Matching Problems with Solutions* (Washington, D.C.: National Academy of Social Insurance, July 2002).

The original proposals for Medicare reform, which were greatly influenced by the National Bipartisan Commission on the Future of Medicare, were based on the principle that Medicare enrollees should receive a generous, but fixed, government contribution toward a health plan of their choice. Such plans would contain a core benefits package and be approved by Medicare,[24] and these health plans would compete directly with each other for market share, just as health plans do today in the Federal Employees Health Benefits Program.

The House version of the Medicare bill contained this "premium support" approach,[25] although it would not have become effective until 2010. However, the House–Senate conference dropped it in favor of a weak and limited demonstration program.

If Medicare reform is understood as the creation of a new competitive system, broadly based on "premium support" with full and direct health plan competition, including competition with traditional Medicare, then the new Medicare law falls far short of reform. It is not the promised transformation of Medicare into a new competitive program similar to the FEHBP, notwithstanding the rhetoric of some of its proponents in and out of Congress.

Why Key Provisions Should Be Changed

Title I, which outlines the drug entitlement that is to become effective in 2006, is at the heart of the major problems with the Medicare Modernization Act. There is time—but not much—to address these problems. Congress can ignore them only at great cost to both seniors and current and future taxpayers.

Exploding Costs of the Prescription Drug Entitlement. A major objective of Medicare reform—now lost—was to absorb the coming demographic shock of the baby-boom generation in a cost-effective fashion. Instead, the new drug entitlement will guarantee even heavier unfunded obligations on current and future taxpayers and make Medicare's overall financial challenge even more demanding.[26] As noted, the Medicare trustees recently confirmed these misgivings and announced that the drug program's unfunded liabilities would cost at least $8.1 trillion over the next 75 years.

When the Medicare law was enacted last year, the CBO estimated—as it has recently reaffirmed—that the total 10-year cost of the law would be $395 billion. The Administration estimated its 10-year cost at $534 billion, based on different assumptions.[27] Joseph Antos, senior health policy analyst at the American Enterprise Institute and a former Assistant Director of the CBO, observed:

> The actual cost of MMA [the Medicare Modernization Act] will be much higher

24. For a discussion of this general approach to Medicare reform, see Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is the Next Step," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 8–30; Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47–61; and Walton J. Francis, "The FEHBP as a Model for Reform," in Robert B. Helms, ed., *Medicare in the Twenty-First Century: Seeking Fair and Efficient Reform* (Washington, D.C.: American Enterprise Institute Press, 1999), pp. 147–168.
25. The term "premium support," later adopted in 1999 by the majority of the National Bipartisan Commission on the Future of Medicare, was used by Henry J. Aaron of the Brookings Institution and Robert D. Reischauer, now president of the Urban Institute, to describe their program for Medicare reform: "We propose converting Medicare from a 'service reimbursement' system to a 'premium support' system. These changes would resemble many that are now reshaping private employer-based insurance. Our reform would encompass not just the public Medicare program but also the 'real' Medicare, which includes the supplemental plans to which most Medicare beneficiaries have access." See Aaron and Reischauer, "The Medicare Reform Debate."
26. See Stuart M. Butler and Robert E. Moffit, "Time to Rethink the Disastrous Medicare Legislation," Heritage Foundation *WebMemo* No. 370, November 17, 2003, at *www.heritage.org/Research/HealthCare/wm370.cfm*.
27. For a discussion of the different assumptions underlying the CBO–Office of Management and Budget estimates, see Congressional Budget Office, "Comparison of CBO and Administration Estimates of the Effect of HR 1 on Direct Spending," a CBO memo accompanying the February 2, 2004, letter from Douglas Holtz-Eakin to Representative Jim Nussle concerning the differing cost estimates. See also Derek Hunter, "How the Drug Entitlement Drives Different Medicare Cost Estimates," Heritage Foundation *WebMemo* No. 464, April 1, 2004, at *www.heritage.org/Research/HealthCare/wm464.cfm*.

> than either estimate reveals because the drug benefit represents a permanent commitment of resources to seniors rather than a benefit that will expire in a decade. It is likely that even the ten year cost will be much higher than today's estimates indicate. Those facts were widely known from the beginning of the debate but little acknowledged by the administration or congress.[28]

Recent revelations in the press have confirmed this assessment.[29]

Actuarial assumptions often differ, and 10-year estimates are only the tip of the proverbial iceberg. On December 8, 2003, the very day that President George W. Bush signed the Medicare Modernization Act into law, CBO Director Douglas Holtz-Eakin estimated that the legislation's second-decade costs could range between $1 trillion and $2 trillion, depending on the assumptions.[30]

Sharply Increasing Tax Burden. The coming explosion in Medicare drug spending will increase unfunded liabilities and impose huge burdens on taxpayers, as well as threaten the Bush tax cuts and undermine longer-term tax reform. As noted, the expansionary dynamics of a universal drug entitlement will generate huge unfunded liabilities in an already overburdened Medicare program.

This will have enormously unfavorable tax consequences. Medicare Trustee Thomas R. Saving has observed that, based on current assumptions, the "shortfalls" in the Medicare program would consume 24 percent of all federal income tax revenue in 2019, the year that the hospitalization trust fund is projected to be exhausted, and 51 percent of all federal income tax revenue in 2042.[31]

During the debate on the new Medicare law, Heritage Foundation analysts predicted that these rapidly rising costs and future liabilities would impose huge burdens on working families and threaten current and future tax reforms.[32] More recently, the Bush tax cuts are already in jeopardy as some congressional Republicans are beginning to rethink the future of the tax cuts that they have enacted.[33]

As Heritage Foundation analyst Daniel J. Mitchell notes, "Regardless of what happens to the 2001 and 2003 tax cuts, the prescription drug entitlement will likely be the death knell of further tax relief and fundamental tax reform."[34] While reopening the Medicare drug debate is a painful political prescription, leaving it in place guarantees sharply higher taxes.

Accelerated Loss of Private Drug Coverage. According to a recent ruling by the Equal Employment Opportunity Commission (EEOC), a federal civil rights panel, employers can reduce or eliminate health benefits for retirees who are eligible for Medicare without violating current federal law against age discrimination.[35] The Medicare pre-

28. Joseph Antos, "Don't Ask, Don't Tell," American Enterprise Institute *Health Policy Outlook*, March–April 2004, p. 2.
29. During consideration of S. 1, the Senate version of the Medicare bill, CMS actuaries estimated on June 11, 2003, that the 10-year cost would be $551 billion. Recent press accounts indicate that there have been numerous CMS estimates of the costs of the Medicare legislation. See Pear, "Democrats Demand Inquiry into Charge by Medicare Office."
30. Douglas Holtz-Eakin and Jeff Lemieux, "The Cost of Medicare: What the Future Holds," Heritage Foundation *Lecture* No. 815, December 15, 2003.
31. Thomas R. Saving, "Examining the 2004 Social Security and Medicare Trustees Reports," congressional briefing on behalf of the National Center for Policy Analysis, Washington, D.C., March 23, 2004.
32. On this point, see Brian M. Riedl and William W. Beach, "New Medicare Drug Entitlement's Huge New Tax on Working Families," Heritage Foundation *Backgrounder* No. 1673, July 30, 2003. The tax calculations in the Riedl–Beach analysis were made on the basis of the earlier, agreed upon $400 billion price tag for the drug benefit.
33. "Confronted with ever widening deficit forecasts, some key congressional Republicans worried about the long-term budgetary effects of President Bush's tax cuts are preparing legislation to scale back the cuts by the end of the decade." Jonathan Weisman, "Some GOP Lawmakers Aim to Scale Back Bush Tax Cuts," *The Washington Post*, March 2, 2004, p. A4.
34. Daniel J. Mitchell, "Medicare: A Ticking Time Bomb for Tax Increases," Heritage Foundation *WebMemo* No. 462, March 31, 2004, p. 1, at *www.heritage.org/Research/HealthCare/wm462.cfm*.

scription drug benefit can be expected to accelerate the loss of private employer-based drug coverage among seniors while producing windfalls for large corporations. Prominent independent analysts, as well as the CBO, predicted that enactment of the drug entitlement would encourage large corporations to scale back or even drop their existing retiree coverage to the level prescribed by the new law.[36] By providing the government-prescribed level of drug coverage, they can receive billions of dollars in new taxpayer subsidies.

Less than two years before the drug entitlement goes into effect, that process is already underway. According to *The Wall Street Journal*, 18 large companies have estimated that the new Medicare law will reduce their drug benefit costs by a total of $11.8 billion, while employers who retain drug coverage at government-prescribed levels will be eligible for tax-free government subsidies.[37] For example, Lucent Corporation will receive a projected $500 million in taxpayer subsidies under the new Medicare law.[38]

How Congress Should Improve the New Medicare Law

Over the next several months, Members of Congress need to debate major changes in the new Medicare law.

However, seniors and taxpayers should realize that Congress is quite capable of making the current problems even worse by enacting changes that would dramatically increase the current taxpayers' cost of the drug entitlement, thus worsening Medicare's overall financial condition and imposing enormous unfunded liabilities on future taxpayers.

Responsible Members of Congress can target the new law's problems while improving on provisions that could expand patient choice and enhance competition among health plans. By so doing, they can secure high-quality care for current and future generations of Medicare patients without imposing enormous burdens on current and future generations of taxpayers.

Specifically, Congress should:

Step #1: Delay Introduction of the 2006 Provision Until Meaningful Controls on Future Entitlement Spending Are in Place.

The drug benefit will be financed directly out of general revenues, with beneficiary premiums paying for about one-sixth of the estimated prescription drug benefit costs between 2006 and 2014.[39] This will certainly change. To many seniors, the drug benefit, with its gaps in coverage, is unattractive and far inferior to their current coverage. Given the gaps in coverage, particularly the infamous "doughnut hole"[40] and projected future premium increases, pressure is already building in Congress to eliminate these gaps, thus making the drug benefit far more expensive than originally projected.

35. Laurie McGinley and Sara Schaefer Munoz, "EEOC Votes to Let Employers Cut Retirees' Health Benefits," *The Wall Street Journal,* April 23, 2004, p. A6.

36. See Derek Hunter, "Recent Research Confirms That Seniors Will Lose Coverage Under New Medicare Legislation," Heritage Foundation *WebMemo* No. 345, October 7, 2003, at *www.heritage.org/Research/HealthCare/wm345.cfm*. See also Edmund F. Haislmaier, "How Congress's Medicare Drug Provisions Would Reduce Seniors' Existing Private Coverage," Heritage Foundation *Backgrounder* No. 1668, July 17, 2003, at *www.heritage.org/Research/HealthCare/bg1668.cfm*.

37. Lingling Wei, "Expected Cost Savings from Medicare Act May Top $11.8 Billion," *The Wall Street Journal*, March 22, 2004, at *online.wsj.com/article-email/_,,SB107999160997362073-IjjgYNglaJ3o2pZoCIcae*.

38. Ellen E. Schultz and Theo Francis, "How Lucent's Retiree Programs Cost It Zero, Even Yielded Profit," *The Wall Street Journal*, March 29, 2004, p. A1.

39. See "The Spending Outlook," Chapter 3 in Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2005 to 2014*, January 2004, at *www.cbo.gov/showdoc.cfm?index=4985&sequnce=4*.

40. Beneficiaries would have 75 percent of their drug spending covered by Part D for the first $2,250 after satisfying a $250 deductible. Those spending more than $2,250 would receive no additional reimbursement until they have spent $3,600 out of pocket. The gap in coverage is called the "doughnut hole."

With drug costs certain to rise over the next several years, it is likely that many Members of Congress will try to hold beneficiaries' premium increases at artificially low levels and shift the rising costs to the taxpayers. Even before 2011, when the first wave of baby boomers retires, the pressure to keep premiums artificially low will intensify.

This powerful combination of economic, demographic, and political pressures inevitably will accelerate the movement—already well underway—toward some form of government pricing or price controls on prescription drugs.[41] In another variant of the same "cost containment" strategy, the Medicare cost explosion could encourage Members of Congress to impose expenditure caps on drugs or even Medicare itself, reducing the supply of drugs or medical services to the senior population.

Process Is Not Enough. The new law does provide for a special congressional process to control Medicare costs. Under Title VIII, when the Medicare trustees determine that general revenues constitute 45 percent of Medicare spending in two consecutive annual reports, the President is required to submit legislation to Congress, and Congress is urged to act.[42] According to the most recent trustees report, Medicare spending will reach this general revenue threshold in 2012.[43]

A far more humane and efficient alternative to axing Medicare budgeting, imposing tough price controls on drugs, or mandating tighter payment rules for other medical services is to establish a single-payment formula for Medicare, broadly similar to the one used in the Federal Employees Health Benefits Program. Under such a formula, the federal government calculates a contribution to an enrollee's health plan based on the weighted average of competing plans, coupled with a cap on the annual amount of the government's contribution. If enrollees wish, they can buy a more expensive plan, above the level of the government's contribution, by paying the difference.

A central weakness of the existing FEHBP formula is that it does not adjust for either risk or income. That can and should be altered for a reformed Medicare program. If Congress wanted to assure protection to low-income retirees or retirees with higher health care costs, it could means test or otherwise adjust the annual government contribution.

Such an arrangement would be far superior to today's open-ended Medicare entitlement. Regrettably, many in Congress seem to assume that taxpayers' generosity is unlimited.[44]

Step #2: Make the New Prescription Drug Card Permanent.

Medicare beneficiaries should be permitted, if they wish, to continue using the drug discount card beyond 2006. It should not be taken away from them in 2006, as required under current law.[45]

The drug card program holds promise. Initial independent research indicates that seniors without drug coverage would secure average savings of 17.4 percent over current retail prices.[46] Of the 7.3 million expected to sign up for the discount cards, an estimated 4.7 million persons will qualify for the $600 low-income subsidy.[47] Under the card program, the companies offering them must

41. For example, see Section 302 of the Defense of Medicare and Real Medicare Prescription Drug Benefit Act (S. 1992), sponsored by Senator Edward M. Kennedy (D–MA). Under Section 302, the Secretary of Health and Human Services would have the authority to purchase prescription drugs in bulk and negotiate contracts with drug manufacturers for drugs covered under Medicare Part D.

42. Title VIII provides for discharge provisions to bring corrective legislation directly to the floor of the House of Representatives.

43. This date is based on the Trustees' "intermediate" assumptions. Thus, the actual date could be earlier. *Trustees' Report*, p. 29.

44. A program for Medicare cost containment is addressed in Joseph R. Antos, "Fixing the New Medicare Law #2: How to Promote Real Medicare Cost Containment," Heritage Foundation *Backgrounder* No. 1751, April 26, 2004.

45. A superior drug discount policy is outlined in Grace-Marie Turner and Joseph R. Antos, "Fixing the New Medicare Law #3: How to Build on the Drug Discount Card," Heritage Foundation *Backgrounder* No. 1752, April 26, 2004.

46. Juliette Cubanski, Richard G. Frank, and Arnold Epstein, "Savings from Drug Discount Cards: Relief for Medicare Beneficiaries?" *Health Affairs* Web Exclusive, April 14, 2004, at *content.healthaffairs.org/cgi/reprint/hlthaff.w4.198v1.pdf*.

provide three drugs in each of 209 therapeutic classes of drugs and agree to protect the privacy of the cardholders.[48]

Subsidies for low-income seniors should be retained and perhaps increased, while the drug subsidy program itself could be transformed into a means-tested program for a broader cross section of the Medicare population. Moreover, any unspent funds for those who are subsidized through the discount card could be rolled over tax-free from year to year, much as funds are rolled over in a health savings account.

Step #3: Transform the Drug Entitlement Into a Catastrophic Coverage Requirement Combined with Income-based Subsidies for Drug Coverage.

Under Title I of the new Medicare law, Congress has created a new and complex drug benefit. It mirrors nothing that currently exists in the private health care markets. Under the terms of the law, participating seniors would pay a $35 monthly premium, a $250 deductible, and a 25 percent co-insurance toward the benefit. The government would pay 75 percent of the prescription drug costs, up to $2,250 annually. Beyond that amount, seniors would pay 100 percent of drug costs up to $3,600, above which catastrophic coverage would pay 95 percent and seniors would pay 5 percent of the catastrophic costs. The new entitlement is expected to displace much of existing drug coverage and accelerate the decline of employer-based retiree drug coverage.

There is a much better way to guarantee prescription drug access to seniors who lack coverage. Instead of displacing existing drug coverage with a universal entitlement, Congress could target federal subsidies to low-income seniors or those without drug coverage. Subsidies could be delivered through debit cards, and the subsidized debit cards could be marketed by health plans on the condition that they cover catastrophic drug costs.

Congress could build such a new system on the newly created Medicare drug discount program. This year, 106 organizations have applied to become card sponsors,[49] and a variety of companies already have been selected.[50] This is a strong indication of genuine enthusiasm for the new program among private-sector sponsors.

Step #4: Ensure that the New Medicare Advantage System Works.

By 2006, the Medicare Advantage program will fully replace the Medicare+Choice program. While the Medicare Advantage system is far less robust than the FEHBP, it is nonetheless an improvement over Medicare+Choice, and the revitalization of private plan competition in Medicare already shows promise. As noted, the initial changes in Medicare payments to private plans appear promising, with more than nine out of 10 plans enhancing benefits and reducing seniors' cost sharing or premiums.

Medicare Advantage's future success, however, will depend upon Congress's not only maintaining a reliable and predictable payment to private health plans, but also resisting the temptation to micromanage the new competitive process. Moreover, the character and quality of the Administration's regulatory regime will also determine Medicare Advantage's success. Over-regulation could discourage plan participation and undermine the program's capacity to function efficiently. In a recent speech to the American Enterprise Institute, Leonard Schaeffer, Chairman of Wellpoint (the nation's second largest publicly traded health insurer), said that Wellpoint's participation would depend upon the character and quality of CMS regulations: "We have to see the regulations."[51]

47. Marc Kaufmann, "HHS Picks Companies to Offer Senior Discount Cards," *The Washington Post*, March 26, 2004, p. A21.

48. *Ibid.*

49. Remarks by Daniel C. Lyons, M.D., Senior Vice President, Government Programs, Independence Blue Cross, on "The Medicare Endorsed Discount Drug Card," presented at a conference sponsored by America's Health Insurance Plans, Washington, D.C., March 11, 2004.

50. Kaufmann, "HHS Picks Companies to Offer Senior Discount Cards," p. A21.

51. Julie Rovner, "Second Largest Insurer Debating Participation in Medicare Program," *Congress Daily*, April 7, 2004.

There is a crucial lesson here: Beyond stubborn congressional insistence on artificially capped plan payments that did not reflect changing market conditions, over-regulation proved to be particularly damaging to the older Medicare+Choice program, undermining the enthusiastic participation of health plans.[52]

Congress can make other improvements. For example, Congress should allow the Medicare Advantage health plans to integrate the newly created drug discount card and low-income assistance subsidies into their annual health plan offerings.

Step #5: Design the Competitive Demonstration Project to Work, Not Fail.

Rather than a transition to a new system of health plan competition based on the FEHBP model, the House–Senate conference committee produced a limited demonstration program in six metropolitan areas. Based on previous experience, this demonstration program is not likely to get underway, much less succeed, because of a strong historic congressional aversion to Medicare competitive pricing programs.[53] When economic efficiencies are thwarted and savings are lost, seniors and taxpayers both lose.

Seniors and taxpayers can expect a repeat performance. In a revealing November 24, 2003, speech on the Medicare legislation, Senator Max Baucus (D–MT), ranking member of the Senate Finance Committee and a strong supporter of the new Medicare law, reminded his skeptical colleagues:

> What has happened in the past when we have had these demos? They have been repealed. They have not been extended. In 1997, Congress set up premium support demonstration projects. Congress then rushed in to repeal them as quickly as they could. They were gone. The same will happen here. Do my colleagues know why? Because the dollars provided to private plans in the premium support demonstration areas will be much less than in other parts of the country. The private plans will not be able to survive.[54]

If Congress and the Administration are serious about "premium support" competition among plans, including Medicare itself, they can make a fair test a reality by speeding up and expanding the proposed competitive demonstration program. This could be done by establishing the demo program in the 12 *largest* U.S. metropolitan areas as early as 2007 and by allowing any *new* retirees to carry their private health plans into retirement with them as their primary coverage. For demonstration purposes, the competition could be open to all private health plans, including employer-based health plans, that meet current federal or state regulatory requirements, as well as all state and local government employee health plans. Many state employee health plans are private health plans that provide solid coverage, including prescription drug coverage.

Of course, the numerous health plans already offering coverage in the Federal Employees Health Benefits Program, available in every locality and every state of the union, should be automatically qualified to participate, and federal retirees, just like any other retirees, should get a contribution from Medicare to offset the cost of the health plan as their primary coverage if they wish to do so. As federal employees and retirees know, all of the health plans in the FEHBP, although they differ, are solid plans with good benefits.

Conclusion

Medicare is facing serious challenges. Whatever merits one may ascribe to the recently enacted

52. For an excellent account of the regulatory excesses in the older Medicare+Choice program, see Bruce Merlin Fried and Janice Ziegler, *The Medicare+Choice Program: Is It Code Blue?* (Washington, D.C.: ShawPittman, 2000).

53. For an account of the flaws and failures of previous Medicare competitive pricing demonstration programs, see Robert E. Moffit, "A Demonstration Project Equals No Medicare Reform," Heritage Foundation *Backgrounder* No. 1708, November 19, 2003, at *www.heritage.org/healtcare/bg1708.cfm*.

54. Senator Max Baucus, "Remarks on the Medicare Prescription Drug, Improvement and Modernization Act of 2003," *Congressional Record*, November 24, 2003, p. S15677.

Medicare law, it has aggravated, not controlled, rapidly rising Medicare costs. Its major feature is a massive entitlement expansion.

The new law also embodies some bad health care policy. There is simply no need for the federal government to displace existing drug coverage, pre-empt new private-sector options, or accelerate the loss of employer-based drug coverage.

Government entitlement programs cannot control cost, except through budgeting mechanisms or price controls that reduce the supply of services. One can reasonably expect that, ultimately, the government drug program will do precisely that, either directly through tightened drug formularies and price controls on drugs or indirectly through government-monopsony purchasing of prescription drugs. Moreover, recent survey data yield no evidence that the senior population appreciates Congress's handiwork on the prescription drug issue.

There is still time to fashion a superior Medicare policy. While the Medicare Modernization Act of 2003 creates a universal drug benefit, it does not take effect until 2006. Meanwhile, the new law creates a discount prescription drug card, effective this year, combined with a $600 subsidy for low-income seniors. The discount card is projected to secure savings of between 10 percent and 25 percent. Regrettably, Congress made this attractive drug provision temporary, and it is set to expire in 2006.

To address the real needs of the senior population, Congress should make the drug discount card permanent and increase the subsidies for the targeted Medicare population (i.e., low-income seniors who are without existing coverage). Making the discount card the foundation of a new market-based Medicare drug policy would avoid the needless displacement of drug coverage and the otherwise inevitable access or price controls on pharmaceuticals.

Meanwhile, Congress should ensure that the new Medicare Advantage program is neither deliberately weakened by legislation designed to discourage the participation of health plans nor implemented in a way that discourages continued participation among health plans. Congress has no excuse to repeat the failed regulatory and payment policies that undermined Medicare+Choice.

Finally, Congress should speed up the competitive demonstration project, scheduled to begin in 2010, and see that it is implemented fairly and honestly. It should not be sabotaged by congressional opponents of real consumer choice and free-market competition.

Congress has a chance to reverse its flawed Medicare drug policy well before it is implemented and spare both seniors and taxpayers needless pain and expense.

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