Executive Summary
Backgrounder
Published by The Heritage Foundation
No. 1860
June 14, 2005

High Anxiety: Implementing the Medicare Prescription Drug Program

Robert E. Moffit, Ph.D.

Members of Congress deserve an early warning: On January 1, 2006, the huge Medicare prescription drug entitlement goes into effect. At issue is whether or not the Medicare bureaucracy can administer the program without disrupting the lives of millions of senior citizens and within the rigid requirements and tight timetables established by Congress.

Over the next several months, the Medicare bureaucracy must accomplish an enormous number of difficult tasks that entail large risks to seniors if they are not done right. One thing is certain: If there are glitches in the Medicare drug implementation next year, Congress can expect angry calls and letters.

In January 2005, the Centers for Medicare and Medicaid Services (CMS) issued 1,162 pages of final regulations governing the administration of the Medicare prescription drug entitlement. This massive regulatory output is the culmination of months of preliminary work to implement Congress's latest, and perhaps most ambitious, experiment in government central planning. Congress authorized $1 billion to fund implementation of this program, including outreach and education of seniors.

Multiple Problems. Over the next few months, Members of Congress, seniors, and taxpayers will have an opportunity to see how well the federal government regulates the financing and delivery of prescription drugs. In a program of this size, one can expect a variety of administrative glitches. But the most serious problems, rooted in the Medicare law itself, are already surfacing:

- **Gaps in Drug Coverage.** Millions of seniors will fall into the congressionally designed "doughnut hole" next year and will be paying 100 percent of their drug costs until they spend a total of $3,600 and then qualify for catastrophic protection. Kaiser Family Foundation analysts estimate that roughly 6.9 million seniors will end up in the doughnut hole in 2006. A recent Heritage Foundation analysis using Congressional Budget Office (CBO) data shows that the number of Medicare beneficiaries entering the doughnut hole will increase steadily each month, peaking toward the end of the year. Meanwhile, plan contractors will have to track seniors' "true" out-of-pocket spending, under CMS supervision, and track it accurately. If they do not, Congress will surely hear from angry seniors.
- **Loss of Existing Private Coverage.** While the federal government will end up purchasing 60 percent of all drugs sold in America, millions of

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/bg1860.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
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seniors will lose their existing drug coverage or have it degraded. The CBO estimates that 2.7 million seniors will be moved out of their existing employer-based coverage into the new Medicare drug program in 2006. An estimate published by *The New York Times* puts the figure at 3.8 million. The actual number could be even higher.

- **Greater Cost Shifting to Seniors and Taxpayers.** Because of the way that Congress drafted the Medicare drug provisions, many large employers will be able to get approximately $71 billion worth of taxpayer subsidies for the costs of providing the drug coverage to retirees over the next 10 years, even if they shift more of the total cost onto retirees. As a result, many seniors will be paying more out of pocket for an inferior drug benefit while employers collect new taxpayer subsidies. This, too, will ensure that Congress receives angry calls and letters next year.
- **Disruption of Existing Drug Coverage for the Poor.** For 6.4 million seniors on Medicaid, their drug coverage ends on January 1, 2006. Preliminary research shows that these beneficiaries see no reason why they should be forced to change their existing drug coverage. Meanwhile, state Medicaid officials, by their own account, face serious practical difficulties in meeting the congressionally imposed deadlines for enrolling millions of these very poor seniors, including those in nursing homes, in Medicare within the statutory timetables.
- **More Bureaucracy and Red Tape.** Before enactment of the Medicare Modernization Act, total CMS staff numbered 4,500. However, the new law is increasing the size of the Medicare bureaucracy and broadening its regulatory reach. The CMS says it will need to add at least 500 new employees to administer the drug benefit.

A Better Policy. Short of outright repeal, Congress could at least delay the drug entitlement and avoid the massive cost and disruption guaranteed by its implementation. To this end, Representative Jeff Flake (R–AZ) has proposed the Prescription Drug COST (Control Overspending to Save Taxpayers) Containment Act of 2005 (H.R. 1382). The bill would delay the onset of the drug entitlement for one year, retain Medicaid drug coverage for the dual-eligible beneficiaries in 2006 under current terms and conditions, and continue to provide the Medicare drug discount card and subsidies to low-income persons for another year.

A delay of a year or longer would not only save tens of billions of dollars in the first year alone, but also enable Congress to take the time to fashion a rational and responsible drug benefit and to determine precisely how the taxpayers and seniors are going to finance it. Meanwhile, Congress can still target generous help to seniors who do not have drug coverage or who need direct help in purchasing drug coverage.

—Robert E. Moffit, Ph.D., is Director of the Center for Health Policy Studies at The Heritage Foundation.

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CMS recognizes the enormity of the transition from Medicaid drug coverage to Medicare and is working diligently to ensure the process for beneficiaries is as quick and efficient as possible.

—Mark McClellan, Director,
Centers for Medicare and Medicaid Services[1]

I don't know how Oregon will successfully do this within this timeframe.

—Tina Kitchin, Director,
Oregon Department of Human Services[2]

Members of Congress deserve an early warning: On January 1, 2006, the huge Medicare prescription drug entitlement goes into effect. Millions of senior citizens will see major changes in their drug coverage, regardless of their personal wishes in the matter. Moreover, recent survey data show that more seniors disapprove of the Medicare drug bill than approve of it. Recent survey data also show that most are unaware of how these changes will affect them.

The Managerial Challenge

Beneath the renewed debate on the increased spending in the Medicare drug bill[3] is another issue: the capacity of the Medicare bureaucracy to implement and manage the complex congressional drug program.[4] The issue is whether or not the Medicare bureaucracy can administer the program without disrupting the lives of millions of senior citizens and

Talking Points

- The new Medicare prescription drug benefit will be the largest entitlement expansion since the Great Society.
- Medicare officials face a number of formidable administrative tasks in implementing the new prescription drug benefit, ranging from putting in place new systems to pay providers and track beneficiary spending to coordinating the enrollment of millions of "dual-eligibles" with state officials.
- Timetables are tight, with little room for error. The Medicare drug program takes effect on January 1, 2006, but seniors will not receive enrollment information until October 15, 2005. Enrollment begins on November 15, 2005.
- Drug coverage for 6.4 million seniors on Medicaid will end on January 1, 2006. An estimated additional 2.7 million seniors will be moved out of their existing employment-based coverage into the new Medicare drug program in 2006.

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within the rigid requirements and tight timetables established by Congress.

Over the next several months, the bureaucracy must accomplish an enormous number of different and difficult tasks that entail large risks to seniors and the program itself if they are not done right. One thing is certain: If there are glitches in the program's implementation next year, Congress can expect angry calls and letters.

The root problem is not the leadership of the Centers for Medicare and Medicaid Services (CMS), the agency that runs the giant Medicare program, or the civil servants who staff the agency. The problem is Congress's insistence on central planning and detailed government regulation as the preferred method of delivering medical goods and services to senior citizens. Medicare administration is outdated. It remains a highly centralized decision-making process, burdened by a wide range of unwieldy tasks that Congress has imposed on agency personnel. In enforcing the many provisions of the Medicare Modernization Act of 2003 alone, the CMS has thus far taken 210 actions, including regulatory actions and notices.[5]

In implementing just the drug provisions under Title I of the Act, the CMS administrative tasks are formidable. They include putting in place systems to pay providers and to track beneficiary spending; enforcing rules and exercising oversight over drug formularies ("preferred drug lists" in health plans); determining employer eligibility for government drug subsidies in employer plans; working with the Social Security Administration (SSA) to target new drug subsidies to low-income beneficiaries; and enrolling beneficiaries who are eligible for both Medicare and Medicaid (dual-eligible beneficiaries or "dual-eligibles") in the new drug program in coordination with state officials.[6]

For the remainder of the year, the CMS must accept the Medicare Advantage plan bids for Part D benefit, continue mass mailings to millions of Medicare beneficiaries who are deemed eligible for federal drug subsidies, conduct a "drug claims training" program for Medicare providers, approve the private plans' drug benefit packages, hold forums and conferences on enrollment and payment, mail information to seniors on the 2006 Medicare costs and benefits, oversee the marketing of plans to seniors who will enroll in the Medicare drug program, and oversee "open enrollment" of millions of seniors in the program before the entitlement begins on January 1, 2006.

Congress has provided CMS officials with $1 billion to implement the program.[7]

Tight Time Frame. In January 2005, the CMS issued 1,162 pages of final regulations governing

1. Mark McClellan, M.D., Ph.D., Director, Centers for Medicare and Medicaid Services, "The Transition of Full Benefit Dual Eligible Beneficiaries to the Medicare Prescription Drug Benefit," testimony before the Special Committee on Aging, U.S. Senate, March 3, 2005.
2. Tina Kitchin, Director, Oregon Department of Human Services, testimony before the Special Committee on Aging, U.S. Senate, March 3, 2005.
3. When the Bush Administration released its upwardly revised 10-year cost of the Medicare drug benefit—$724 billion for the period from 2006 to 2015—the revelation set off an angry response in Congress, including renewed calls for congressional investigations. Worsening the Medicare outlook is the growth in long-term estimates of the program's unfunded liabilities by $2 trillion in just one year. See Derek Hunter, "Medicare Drug Cost Estimates: What Congress Knows Now," Heritage Foundation *Backgrounder* No. 1849, April 28, 2005, at *www.heritage.org/Research/HealthCare/bg1849.cfm*.
4. This has been a recurrent issue in the Medicare drug debate. 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/bg1583es.cfm*.
5. See Centers for Medicare and Medicaid Services, "Medicare Modernization Update: Regulations and Notices," at *www.cms.hhs.gov/mmu/regulations*.
6. For a brief overview of these key regulatory tasks, see Robert E. Moffit, "Early Warning on Medicare Drug Implementation," Heritage Foundation *WebMemo* No. 631, January 4, 2005.
7. Ceci Connolly, "Millions to Be Automatically Enrolled in Medicare Drug Plan," *The Washington Post*, January 22, 2005, p. A4.

the administration of the Medicare drug entitlement.[8] This massive regulatory output is the culmination of months of preliminary work conducted throughout 2004 to implement Congress's latest, and perhaps most ambitious, experiment in government central planning.[9]

While the drug entitlement is to go into effect on January 1, 2006, seniors are scheduled to receive educational information from the CMS on October 15, 2005. Seniors can start to enroll in the new Medicare drug program on November 15, 2005. Seniors who have drug coverage through Medicaid must enroll by January 1, 2006. The enrollment period for all other seniors ends on May 15, 2006. Any senior who misses the May 15 deadline must pay a late enrollment penalty. Meanwhile, the amount of administrative and regulatory work yet to be completed is staggering.

Multiple Problems. Over the next few months, Members of Congress, seniors, and taxpayers will have an opportunity to see how well the federal government regulates the financing and delivery of prescription drugs. In a program of this size, one can expect a variety of administrative glitches, but the most serious problems, rooted in the Medicare law itself, are already surfacing:

- **Gaps in Drug Coverage.** Millions of seniors will end up in the congressionally designed "doughnut hole" next year and will be paying 100 percent of their drug costs until they spend a total of $3,600 and then qualify for catastrophic protection. The Kaiser Family Foundation estimates that roughly 6.9 million seniors will end up in the doughnut hole in 2006.[10] A recent Heritage Foundation analysis using Congressional Budget Office (CBO) data shows that the growth in the number of Medicare beneficiaries entering the doughnut hole will increase steadily each month, peaking toward the end of the year.[11] Recent research also shows that many of those who end up in the doughnut hole the longest will be among the sickest and most vulnerable seniors and that, without assistance, many will not take their medicines. Meanwhile, plan contractors will have to track seniors "true out-of-pocket spending," under CMS supervision, and track it accurately. If they do not, Congress will be sure to hear from angry seniors.
- **Loss of Existing Private Coverage.** While the federal government will end up purchasing 60 percent of all drugs sold in America, millions of seniors will see a loss or degradation of existing drug coverage. The CBO estimates that 2.7 million seniors will be moved out of their existing employer-based coverage into the new Medicare drug program in 2006. An estimate published by *The New York Times* puts that figure at 3.8 million. Because of litigation pursued by the American Association of Retired Persons (AARP), which claims to represent senior citizens, the actual number could be even higher. Regardless of first-year estimates, the new law

8. Centers for Medicare and Medicaid Services, "General Information: Prescription Drug Benefit/Medicare Advantage Programs," Web site, modified May 27, 2005, at *www.cms.hhs.gov/medicarereform/pdbma/general.asp* (June 1, 2005).
9. The CMS published the final rule governing the provisions of Title I of the Medicare Modernization Act of 2003 (Public Law 108–173) on January 28, 2005; see 70 *Federal Register* 4194. For an excellent summary of the Final Rule governing the Medicare drug entitlement, see Health Policy Alternatives, "Prescription Drug Coverage for Medicare Beneficiaries: Summary of the Final Rule to Implement the Medicare Prescription Drug Benefit," prepared for the Henry J. Kaiser Family Foundation, February 10, 2005, at *www.kff.org/medicare/upload/51141_1.pdf* (May 31, 2005).
10. Jim Mays, Monica Brenner, Tricia Neuman, Juliette Cubanski, and Gary Claxton, "Estimates of Medicare Beneficiaries' Out-of-Pocket Drug Spending in 2006: Modeling the Impact of the MMA," Henry J. Kaiser Family Foundation, November 2004, p. iv, at w*ww.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=48943* (May 31, 2005). The Kaiser analysts accept the Congressional Budget Office assumption that 29 million out of an estimated 42.6 million Medicare beneficiaries will be enrolled in the Medicare drug program in 2006.
11. Edmund F. Haislmaier, "Weird Science: Projecting the Effects of Medicare's Odd Benefit Design," Heritage Foundation *WebMemo* No. 674, March 3, 2005, at *www.heritage.org/Research/HealthCare/wm674.cfm*. See also Deroy Murdoch, "Lyposuction Needed," *National Review Online*, March 3, 2005.

contains powerful incentives to accelerate the movement of seniors out of existing private coverage into the taxpayer-subsidized prescription drug program.

- **Greater Cost Shifting to Seniors and Taxpayers.** Because of the way that Congress drafted the Medicare drug provisions, many large employers will be able to get approximately $71 billion worth of taxpayer subsidies for the costs of providing the drug coverage to retirees over the next 10 years, even if they shift more of the total cost onto retirees. As a result, many seniors will be paying more out of pocket for an inferior drug benefit while employers collect new taxpayer subsidies. This, too, will ensure that Congress gets angry calls and letters next year.
- **Disruption of Existing Drug Coverage for the Poor.** For 6.4 million seniors on Medicaid, their drug coverage ends on January 1, 2006. While Congress advertises the drug program as voluntary, these beneficiaries have no personal choice in the matter. Preliminary inquiries reveal that these beneficiaries see no reason why they should be forced to change their existing drug coverage even though they are "deemed eligible" for generous subsidies. At the same time, state Medicaid officials, by their own account, face serious practical difficulties in meeting the congressionally imposed deadlines for enrolling millions of these very poor seniors—including those in nursing homes—in the new Medicare drug program.
- **More Bureaucracy and Red Tape.** Before enactment of the Medicare Modernization Act, total CMS staff numbered 4,500.[12] However, the new law is increasing the size of the Medicare bureaucracy and broadening its regulatory reach. The CMS says it will need to add at least 500 new employees to administer the drug benefit,[13] and the regulatory output has been massive. The final drug regulations alone amount to more than 1,000 pages.

A Better Policy. The right focus of a Medicare drug program should be help for low-income seniors without drug coverage. While the new Medicare law achieves that laudable goal, it goes well beyond it. Three-quarters of seniors already have some form of drug coverage, so creating a universal entitlement is unnecessary. Short of outright repeal, Congress could at least delay the drug entitlement and avoid the massive cost and disruption guaranteed by its implementation. To this end, Representative Jeff Flake (R–AZ) has proposed the Prescription Drug COST (Control Overspending to Save Taxpayers) Containment Act of 2005 (H.R. 1382). The bill would delay the onset of the drug entitlement for one year, retain Medicaid drug coverage for the dual-eligible beneficiaries in 2006 under current terms and conditions, and continue to provide the Medicare drug discount card and subsidies for low-income persons for another year.

A delay of a year or longer would not only save tens of billions of dollars in the first year alone, but also enable Congress to take the time to fashion a rational and responsible drug benefit and determine precisely how the taxpayers and seniors will finance it. Meanwhile, Congress can still target generous help to seniors who do not have drug coverage or who need direct help in purchasing drug coverage.

The Expanded CMS Regulatory Role

The Centers for Medicare and Medicaid Services, the agency that has responsibility for the Medicare program, has the main responsibility for administering and managing the drug entitlement. A key byproduct of the Medicare Modernization Act of 2003 has been the quantum leap in the power of the Medicare bureaucracy.

For CMS officials, there is a complicating factor in managing the Medicare drug benefit. The new Medicare prescription drug benefit, created under

12. This includes central office and regional office staff. For an overview of CMS budget, operations, and staffing, see Centers for Medicare and Medicaid Services, "The CMS Chart Series," modified September 16, 2004, at *www.cms.hhs.gov/charts/series* (May 31, 2005).
13. Stephen Barr, "Hundreds Have Been Hired to Provide New Medicare Drug Benefit," *The Washington Post*, April 6, 2005, p. B2.

Medicare Part D, has no analogue in the private sector. In sharp contrast with practice in the private sector, where drug benefits are integrated into a single insurance package, the Medicare drug benefit is a separate benefit with separate premiums, deductibles, and coinsurance requirements. It is also an odd and complicated benefit, with congressionally prescribed gaps in coverage, even though it is to be delivered by heavily regulated private plans.

Table 1 B 1860

Coverage Design Provisions of Medicare Part D (in 2006)

Deductible	$250
Initial Cost Sharing	Beneficiary pays 25% of the next $2,000 of drug spending (including a maximum of $500 out-of-pocket spending) up to the initial coverage limit of $2,250 in total drug spending.
Coverage Gap	Beneficiary pays 100% of the next $2,850 in drug spending.
Limit on Out-of-Pocket Spending	Medicare reimburses at least 95% of all drug spending over $5,100. Up to this point, the beneficiary has paid a total of $3,600 in deductibles and co-pays.

Under Medicare's final rules, the drug benefit can be offered by the new Medicare Advantage plans (also scheduled to go into effect in January 2006), the new prescription drug plans (PDPs), or special government "fallback" plans if there is an insufficiency of Medicare Advantage or PDP plans in a given geographical region. The CMS has designated 34 regions for prescription drug plans.[14]

Odd Benefit Design. In creating the new Medicare Part D, Congress established a complex standardized benefit with deliberate gaps and an entitlement financing arrangement that broadly resembles the arrangement under the Medicare Part B benefit, which pays for physicians' services. Writing recently in *Health Affairs*, analysts noted that there are "no plans in the market today with similar benefit designs."[15]

Beginning in 2006, seniors will pay an estimated monthly premium of $37, a $250 deductible, and a coinsurance payment of 25 percent up to the first-year limit of $2,250. These amounts will be indexed to the annual estimated costs of the benefit.[16] This is why the projected annual cost of the drug entitlement is of such vital importance to seniors enrolled in the program. Meanwhile, the government will pay an estimated 75 percent of the cost of the benefit, drawn from general revenues, up to the annual dollar amount.

Above the annual amount ($2,250 in 2006), the senior will pay all annual out-of-pocket costs for drugs between $2,250 and $5,100. This is the notorious "doughnut hole," which an estimated 25 percent of participating seniors are expected to reach in 2006.[17] Catastrophic coverage for drug costs kicks in when the senior's total out-of-pocket costs reach $3,600 in 2006 dollars. Complicating

14. News release, "HHS Announces Regions to Administer New Medicare Prescription Drug Benefit and Medicare Advantage Program," Centers for Medicare and Medicaid Services, December 6, 2004, at *www.hhs.gov/news/press/2004pres/20041206.html* (June 1, 2005).
15. Bruce Stuart, Linda Simoni-Wastila, and Danielle Chauncey, "Assessing the Impact of Coverage Gaps in the Medicare Part D Drug Benefit," *Health Affairs* Web Exclusive, April 19, 2005, p. W5–167.
16. For example, the CBO estimates that by 2013, the Medicare beneficiary's annual drug deductible will reach $445 and the out-of-pocket threshold will be $6,400. See Jack Rodgers and John Stell, *The Medicare Prescription Drug Benefit: Potential Impact on Beneficiaries* (Washington, D.C.: AARP Public Policy Institute, November 2004), p. 5.
17. Mays *et al.*, "Estimates of Medicare Beneficiaries' Out-of-Pocket Drug Spending in 2006," p. iv.

cost calculation in the doughnut hole and the oversight of those costs is that some beneficiary payments, or payments on behalf of beneficiaries, will count as "true" out-of-pocket payments and others will not. (See Text Box.)

The doughnut hole will affect millions of seniors in 2006. According to a recent Heritage Foundation analysis based on CBO data, the number of seniors falling into the doughnut hole will grow progressively during the year and peak toward the end of the year, and the process will repeat itself the following year.[18] Recent research published in *Health Affairs* also indicates that seniors with chronic conditions will have a particularly difficult time when they fall into the doughnut hole:

> Based on our findings the standard Part D benefit structure will exact a disproportionate toll on people with diabetes, chronic lung problems and mental illness in the form of both higher out-of-pocket costs and reduced use of medications compared with beneficiaries with average drug spending.[19]

This appears to be one of the new Medicare law's unintended consequences.

Subsidies for Poor Seniors. The Medicare drug benefit also comes with a rich body of federal subsidies for low-income seniors. Persons with annual incomes below 135 percent of the official federal poverty line ($12,920 for an individual and $17,321 for a couple) will pay no premium and no deductible, and they will experience no gap in coverage. Such persons will be fully subsidized for catastrophic drug costs, and co-payments for drugs will be limited to $5 for brand names and $2 for generics.

Persons with incomes between 135 and 150 percent of the official poverty line ($14,355 for an individual and $19,245 for a couple) will pay only a $50 annual deductible and benefit from a sliding scale of premium subsidies up to an estimated $37 per month in 2006. Such persons will pay a coinsurance of 15 percent and also experience no gaps in coverage. Persons who are now dually eligible under Medicare and Medicaid will also receive federal subsidies for their drug coverage. Altogether, the CMS estimates that 14.4 million persons—roughly a third of the estimated Medicare population—will be able to secure these generous federal subsidies in 2006.[20]

An Administrative Challenge. Because the new drug entitlement is a complex, legislatively defined benefit, its efficient administration will present the CMS with major managerial challenges. Over the next few months, the CMS will have to make numerous decisions in enforcing the provisions and requirements of the Medicare drug entitlement while educating plans, providers, employers, state officials, and millions of Medicare beneficiaries on the components of the benefit, including their eligibility for additional federal subsidies.

Unlike participation in the Medicare drug discount card, set to expire on January 1, 2006, eligibility for drug subsidies under the entitlement includes an asset test as well as an income determination. While the dual-eligible beneficiaries are "deemed eligible" for generous subsidies, the other designated classes of low-income seniors must apply for them. They can apply either through the Social Security Administration or through a state's Medicaid office. As noted, seniors will qualify for drug subsidies by having an annual income that is below $14,355 for a single person ($19,245 for a couple). In determining a senior's income, Social Security officials will count the income of the senior or the senior's spouse, but not the income of other family members or persons living in the household, or welfare payments such as food stamps, home energy assistance, or housing assistance.[21]

Social Security officials must also determine the assets of individuals to qualify them for the new

18. Haislmaier, "Weird Science," pp. 2–4.

19. Stuart *et al.*, "Assessing the Impact of Coverage Gaps in the Medicare Part D Drug Benefit," p. W5–175.

20. McClellan, "The Transition of Full Benefit Dual Eligible Beneficiaries to the Medicare Prescription Drug Benefit," p. 4.

21. Social Security Administration, "Getting Help with Medicare Prescription Drug Plan Costs: Income and Resource Limits," SSA Publication No. 05–10115, May, 2005.

federal subsidies. Under the asset test, a senior must have assets that are valued below $10,000 ($20,000 for a couple). Under the new Medicare law, assets do not include a senior's house, car, furniture, or rental property that a senior would rely upon for financial support. They do, however, include such items as bank accounts, stocks, bonds, mutual funds, individual retirement accounts, real estate that is not a primary residence, or any cash at home or deposited elsewhere.[22] According to recent research sponsored by the Kaiser Family Foundation, the law's asset test will still disqualify almost 2.4 million low-income seniors—disproportionately widows—from receiving drug subsidies.[23] This appears to be yet another unintended consequence of the new Medicare law.

In concert with the asset test, federal officials will also have to coordinate provision of the drug subsidies for low-income programs with welfare assistance from federal programs. As noted, welfare assistance will not be included in the income test for drug subsidies. Nonetheless, provision of the new drug subsidies will require a reduction of a Medicare beneficiary's housing and food stamp assistance, although CMS officials are quick to point out that the value of the drug subsidies will offset the reduction in these other welfare benefits.[24] In any case, this process will entail a high degree of interagency cooperation.

Working with the Social Security Administration, CMS has already begun mailing the expected 20 million application forms to low-income seniors who might qualify for the different levels of federal subsidies. However, seniors will have to respond to inquiries about the value of their life insurance and monetary support received from friends and relatives to help pay for food, shelter, and utilities and to affirm the truthfulness of their responses under penalty of perjury.[25] This could be another formidable challenge. Historically, the response rate to official mailings to low-income seniors has been low. With respect to those eligible for special assistance programs in Medicare alone, 13 percent have enrolled in the Specified Low Income Medicare Beneficiary Program (SLMB); 25 percent have taken advantage of the subsidies in the Medicare drug discount card program; and 33 percent have availed themselves of the Qualified Medicare Beneficiary (QMB) program.[26]

If implemented, the drug provisions' impact on seniors will be mixed. Seniors who do not have drug coverage today will benefit greatly from major reductions in their out-of-pocket spending. While most seniors will see a reduction in out-of-pocket expenses and the drug bills of poor seniors will be heavily subsidized, seniors with more generous employment-based coverage will generally be worse off, and seniors with Medicaid drug coverage, regardless of their personal preferences, will lose that coverage.

Private plans will enroll and deliver the drug benefit. However, to enforce the provisions of the new law, the CMS must oversee the calculation of Medicare beneficiaries' true out-of-pocket drug spending. Under the new Medicare law, each Medicare beneficiary's out-of-pocket payment is capped at $3,600 per year, at which point the catastrophic coverage threshold is met.

The Medicare drug plans, under CMS supervision, must keep track of the true out-of-pocket

22. *Ibid.* Social Security officials say that asset values can be slightly higher (an additional $1,500 per person), and a senior would still meet the asset test for the drug subsidies, if those resources were used for burial expenses.

23. Thomas Rice and Katherine Desmond, "Low Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test," Henry J. Kaiser Family Foundation, April 2005, executive summary, p. 2.

24. Centers for Medicare and Medicaid Services, "Medicare Prescription Drug Coverage and Other Federal Means-Tested Programs," *Tip Sheet*, May 25, 2005.

25. Robert Pear, "Medicare Applications Sent to Low-Income Americans," *The New York Times*, March 29, 2005, p. A13.

26. Data presented by James Firman, Chairman of the Access to Benefits Coalition and President of the National Council on the Aging, at a "Policy Workshop on Low Income Subsidies and the Medicare Drug Benefit," sponsored by the Henry J. Kaiser Family Foundation, Washington , D.C., June 8, 2005. According to his data, seniors' take-up rates have been higher for the Supplemental Security Income program (53 percent); Medicaid (60 percent); and the earned income tax credit (68 percent).

Tracking True Out-of-Pocket Costs Toward Catastrophic Coverage

What Counts:

- Beneficiary payment of the deductible
- Beneficiary payment of coinsurance
- Beneficiary payment for any drug on a plan formulary
- State payments under state assistance programs
- Federal subsidies that reduce the cost-sharing requirement of low-income seniors
- Payments on behalf of a beneficiary by relatives
- Beneficiary payment for non-formulary drugs approved through the Medicare appeals process

What Does Not Count:

- Beneficiary payment of drug plan premiums,
- Beneficiary payment for drugs not on the plan formulary
- Medigap or other private insurance reimbursement of beneficiary cost sharing
- Employer payments to cover beneficiary costs in the doughnut hole with an employer's wraparound plan

spending. This spending includes spending on the deductible, cost of the coinsurance, spending in the doughnut hole, and any amounts paid in cost-sharing subsidies on behalf of low-income seniors who benefit from state-based wraparound programs or federal subsidies. The qualified spending does not include any spending by any senior for any drug that is not included in a drug plan's formulary.[27] Complicating this process for seniors is that, under the new Medicare law, drug plans can change the drugs that are on their formularies, or preferred drug lists, with 30 days' notice.[28]

Seniors' Skepticism. Further complicating the CMS's managerial task is that many seniors themselves are confused, skeptical, or hostile to the upcoming congressional drug program. According to the April 2005 Kaiser Health Poll Report, only 21 percent of seniors have a favorable impression of the Medicare prescription drug benefit, 34 percent have an unfavorable impression, and 45 percent are either neutral or do not know.[29]

According to an earlier Kaiser Family Foundation survey, 55 percent of Americans age 65 and older said that they understood the Medicare law "not too well" or "not well at all," and 59 percent said that they did not have enough information about the Medicare law to understand how it will affect them personally. Only 25 percent favored the Medicare law, 42 percent opposed it, and 33 percent declared that they were neutral or did not know what to think about it.[30] Seniors' skepticism about the Medicare drug entitlement, as expressed in various surveys, has been a routine feature of the continuing debate on the Medicare law since 2003.

27. Patricia McTaggart, "State Implications of the Medicare Modernization Act: Part D Pharmacy," presentation at the Women in Government Conference, Tucson, Arizona, December 2004.
28. *Ibid.*
29. Henry J. Kaiser Family Foundation, "Current Views of Medicare Prescription Drug Law," *Kaiser Health Poll Report*, March/April 2005, at *www.kff.org/healthpollreport/apr_2005/3.cfm* (June 1, 2005).
30. Henry J. Kaiser Family Foundation, "Selected Findings on the Medicare Drug Law," *Health Poll Report Survey*, January 2005, at *www.kff.org/kaiserpolls/upload/50510_1.pdf* (June 1, 2005). The poll was conducted by Princeton Survey Research Associates International between December 2 and December 4, 2004, among a nationally representative sample of 1,203 Americans ages 18 and older, including 237 adults age 65 and older.

Building on Medicare's Troubled Managerial Legacy

Historically, the Medicare bureaucracy has been plagued by serious problems of management and governance.[31] Congress has not only ignored these problems,[32] but also has aggravated them by expanding the agency's already formidable regulatory reach. Furthermore, this regulatory expansion has been accompanied by even more intense congressional micromanagement of the agency's operations.

The management of the complex drug entitlement is consuming an enormous amount of CMS officials' time and energy. The agency staff is also tasked with administering the new Medicare Advantage system, the system of private health plans that must also be up and running by January 1, 2006. These new administrative responsibilities are in addition to the already existing and updated CMS responsibilities for managing the traditional Medicare program: Medicare Part A, which pays hospitals, and Medicare Part B, which reimburses doctors for the services to senior and disabled citizens. Indeed, most of the complex provisions of the Medicare Modernization Act focus on legislative adjustments and modifications to the traditional Medicare program. However, under the Medicare Modernization Act, most doctors and hospital officials will see little change in how they do business with Medicare on a day-to-day basis.[33]

Beyond Medicare, CMS officials are also responsible for overseeing Medicaid, the joint federal-state health program for the poor and the indigent, and the State Children's Health Insurance Program and for enforcing certain provisions of the Health Insurance Portability and Accountability Act.

Reversing Reform. During the late 1990s, a chief goal of Medicare reformers was a major transformation in Medicare's governance and a substantial reduction of bureaucracy and red tape in the program.[34] The most prominent model of reform was the indisputably superior Federal Employees Health Benefits Program (FEHBP), which has long been characterized by light, and targeted regulation, administrative efficiency, and minimal bureaucracy.[35]

By enacting the Medicare Modernization Act of 2003, Congress repudiated this key goal. In effect, Congress authorized a dramatic increase in the

31. On this point, see Michael E. Gluck and Richard Sorian, *Administrative Challenges in Managing the Medicare Program* (Washington, D.C.: AARP Public Policy Institute, 2004). See also U.S. General Accounting Office (since renamed Government Accountability Office), *Medicare Management: CMS Faces Challenges to Sustain Progress and Address Weaknesses*, GAO–01–817, July 2001, at *www.gao.gov/new.items/d01817.pdf* (May 31, 2005); Kathleen M. King, Sheila Burke, and Elizabeth Docteur, eds, *Matching Problems with Solutions: Improving Medicare's Governance and Management* (Washington, D.C.: National Academy of Social Insurance, 2002); and Robert E. Moffit, "Transcending Medicare's Regulatory Regime," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 15, 2001, at *www.heritage.org/Research/HealthCare/Test031501.cfm*.

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

33. The most complete Medicare reform proposal, outlined by the majority of the National Bipartisan Commission on the Future of Medicare in 1999, included an ambitious prescription for transforming the governance and financing of Medicare. The majority proposed creating a "premium support" system governed by an independent board. The board, independent of the civil service, would operate in a fashion similar to the administrative team at the U.S. Office of Personnel Management (OPM), the agency that governs the Federal Employees Health Benefits Program (FEHBP). The federal employees' program covers more than 8 million persons, including retirees, with a minimum of bureaucracy and regulation. In the FEHBP, OPM's limited number of regulations focus largely on enforcing basic benefit requirements, consumer protection, and health plan solvency; for example, no rigid benefit standardization, price controls, or agency rules govern private plans' drug formularies. Approximately 160 employees administer the entire program.

34. On this point, see Stuart M. Butler, "Restructuring Medicare for the Next Century," testimony before the Committee on Finance, U.S. Senate, June 16, 1999, at *www.heritage.org/Research/HealthCare/Test052799.cfm*.

35. See Walton Francis, "The FEHBP as a Model for Medicare Reform: Separating Fact from Fiction," Heritage Foundation *Backgrounder* No. 1674, August 7, 2003, at *www.heritage.org/Research/HealthCare/bg1674.cfm*.

level of Medicare regulation, particularly by expanding the Medicare bureaucracy's power over financing the delivery of prescription drugs.

As a result of the entitlement expansion, the federal government will purchase roughly 60 percent of all drugs bought within the United States, and a growing body of federal rules will govern the delivery of an ever-larger proportion of prescription drugs.[36] This, in turn, will guarantee even greater congressional micromanagement of the provision of prescription drugs[37] while intensifying the growing pressure in Congress to impose some form of price control regime on pharmaceuticals.

The Role of Employers Under Medicare

Beginning on January 1, 2006, the Medicare prescription drug entitlement will crowd out millions of seniors' existing drug coverage, including employer-based coverage. According to original CBO projections in 2003, only $70 billion of the estimated $407 billion in 10-year drug spending in the new Medicare law will be new spending that would not have occurred without enactment of the Medicare Modernization Act of 2003. In other words, the bulk of the first decade of spending ($337 billion) will simply be a massive replacement of existing drug spending by new federal spending.[38]

An estimated $71 billion in tax-free federal subsidies over 10 years will be available to employers if they offer drug coverage that is at least as generous as the Medicare drug benefit. This special federal subsidy is to cover 28 percent of the cost of the drug coverage between $250 and $5,000 per worker. In 2006, the maximum subsidy will be $1,330 per retiree, and the CMS estimates that the average subsidy payment per retiree will be $668.[39] Under the final rule, employer group health plans will qualify, including "account-based plans" that come under ERISA jurisdiction, such as health savings account and health reimbursement account plans.[40]

Spring Preparations. To participate and secure the subsidy, employers must meet the regulatory criteria recently spelled out in the final Medicare rules. Under Section 423.884 of the final rule, employers must attest that their plans are actuarially equivalent, notify their retirees that they have creditable coverage, maintain employer records for government auditing purposes, and submit an application for the subsidy as prescribed by the CMS with the relevant retiree information no later than September 30, 2005. Furthermore, the retiree health plan contracted by the employer must disclose retiree information to the CMS.[41]

The policy issue for employers will often be based on their calculation as to whether they want to continue to provide retiree drug coverage and secure the additional subsidy for continuing the coverage, scale back the coverage to the level prescribed by Medicare's rules, or drop coverage altogether.

The CMS has already issued guidance on actuarial equivalence methodology and actuarial methods so that firms can determine whether or not they can maintain or craft drug benefits that qualify

36. John Vernon, Rexford Santerre, and Carmelo Giacotto, "Are Drug Price Controls Good for Your Health," Manhattan Institute, Center for Medical Progress, *Medical Progress Report* No. 1, December 2004, at *www.manhattan-institute.org/pdf/mpr_01.pdf* (May 31, 2005).

37. The recent congressional flare-up over Medicare's coverage of Viagra, a drug to treat impotence, is a harbinger of future controversies. The congressional effort to ban Viagra is only the first instance of Members of Congress intervening to reverse Medicare's administrative decisions or to prescribe what drugs will or will not be available to seniors under the universal drug entitlement. This kind of controversy is simply unavoidable under a defined-benefit entitlement. Seniors and taxpayers have gotten their first glimpse into the political micromanagement that will characterize the administration of the Medicare drug entitlement.

38. Rodgers and Stell, *The Medicare Prescription Drug Benefit: Potential Impact on Beneficiaries*, p. ES2.

39. Robert Pear, "Employers Can Get Medicare Subsidies for Lower Benefits," *The New York Times*, January 31, 2005, p. A1.

40. Health Policy Alternatives, "Prescription Drug Coverage for Medicare Beneficiaries," p. 91 (Section 423.882).

41. *Ibid.*, pp. 92–93.

for the federal government's tax-free subsidies.[42] This spring, the CMS issued further guidance and instructions on how participating employers can attest to the actuarial standards spelled out by the government and how to submit data and payments.[43] Medicare officials acknowledge that making these calculations could be "enormously complicated."[44]

Wrinkle in the Rules. There is, however, a wrinkle in the final Medicare rules. The calculation of the new taxpayer subsidy to a company is to be based on the total expenditures for drugs by both employers and retirees. In short, this means that employers could conceivably shift more and more of the benefit cost onto the retiree in the form of increased out-of-pocket payment requirements and that the employer could still get the 28 percent taxpayer subsidy. Whether or not this is an unintended consequence of the law is unclear.

According to a report in *The Wall Street Journal*, Mark Hamelburg, director for the CMS "employer policy and operations group," conceded that the Medicare final rules allowed for this cost shifting onto retirees as a way to secure the employer subsidy:

> But the agency had no choice, he said, because the way of calculating subsidies was specified in the law passed by Congress. The agency rejected proposals by retiree advocates to calculate the subsidy on employers' actual expenditures alone.[45]

Dumping Coverage. According to the U.S. Government Accountability Office, the percent of employers offering retiree coverage has declined steadily since the early 1990s. This trend leveled off in 2001 and remained stable through 2004.[46] Implementation of the Medicare drug benefit, with powerful new incentives to shift costs to taxpayers, will introduce a new dynamic into calculations by the nation's employers.

Today, an estimated 11.8 million retirees have employer-based drug coverage.[47] However, independent analysts, including Heritage Foundation analysts and others, predict that many employers will either scale back coverage or drop it altogether—some immediately, the rest over the next several years—because of the new Medicare drug benefit.[48] For 2006, the CBO has estimated that approximately 2.7 million retirees will be moved out of their private employer-based coverage into the government drug program.[49] Another estimate for 2006, based on government documents, indicates that as many as 3.8 million seniors could find their drug benefits reduced or eliminated altogether.[50]

For many retirees, this process is already underway. For example, on August 3, 2004, ArvinMeritor, a firm based in Troy, Michigan, notified its retirees that effective January 1, 2006, in response to the new Medicare law, the health care coverage provided by the company to supplement Medicare benefits would be dropped, including the prescription drug benefits.[51] Likewise, the Delphi Corpora-

42. Centers for Medicare and Medicaid Services, "Employer Policy and Operations Group: Timeline for Future Guidance Regarding Employer and Union Sponsored Plans," January 2005.

43. *Ibid.*

44. Pear, "Employers Can Get Medicare Subsidies for Lower Benefits."

45. Theo Francis and Ellen E. Schultz, "Rules Let Firms Get Subsidy for Retirees' Drug Costs," *The Wall Street Journal*, January 28, 2005, p. A4.

46. U.S. Government Accountability Office, *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits Under the Medicare Modernization Act*, GAO–05–205, February 2005, p. 4, at *www.gao.gov/new.items/d05205.pdf* (May 31, 2005).

47. Rodgers and Stell, *The Medicare Prescription Drug Benefit*, p. 20.

48. For example, see 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*.

49. Rodgers and Stell, *The Medicare Prescription Drug Benefit*, p. 23.

50. Robert Pear, "Medicare Law Is Seen Leading to Cuts in Drug Benefits for Retirees," *The New York Times*, July 14, 2004, p. A1.

tion, the world's largest supplier of auto parts, recently announced that it will drop health benefits for 4,000 current retirees and all future retirees once retirees are eligible for Medicare benefits, including prescription drugs. The Delphi cutback will save the company an estimated $500 million, but retirees will end up paying more for medical services.[52]

A Legal Glitch. Further complicating the future of retirees' employment-based drug coverage is recent litigation pursued by the AARP. The AARP recently won a federal district court case (*AARP et al. v. Equal Employment Opportunity Commission*) in which the court ruled that the EEOC may not exempt employers from the Age Discrimination in Employment Act when they cut back on health insurance benefits for retirees as they become eligible for Medicare.[53] Because they cannot make a legal distinction between retirees in health care coverage, employers will likely—as the federal court frankly acknowledged—reduce or eliminate health benefits for all company retirees, regardless of age.[54] "As a result of this ruling," Ed Lorenzen, a senior analyst with Centrist.Org, a politically "moderate" think tank, has emphasized, "employers will be faced with an all or nothing decision: assume the potential cost of providing health benefits to all retirees, whether Medicare eligible or not; or don't provide coverage to any early retirees."[55] The EEOC announced that it would appeal the decision.

In any case, regardless of this or any other litigation, or even the January 1, 2006, changes, the displacement of employment-based drug coverage by the government drug program will increase with the passage of time. According to a PricewaterhouseCoopers study conducted for the AARP, "The retirement of the baby boom generation will put significant stress on retiree health plans, which will cause general coverage to drop over the long-term."[56]

Congressional Requirements on the States

Today, state officials are responsible for administering the bulk of the Medicaid program, the nation's largest health insurance program, which covers approximately 46 million poor and indigent citizens. Under the Medicare Modernization Act of 2003, state officials, working with the CMS and SSA, are to help enroll the 6.4 million Medicaid dual-eligible beneficiaries in the new drug program.

Under Section 423.904 of the final rule, state officials are to determine eligibility of these beneficiaries for the purpose of securing federal subsidies for them; to screen individuals who apply for the Part D subsidies; to provide them with information, assistance, and application forms for low-income subsidies; to require them or their representatives to complete the appropriate forms; and to provide the CMS with any other relevant information that the CMS may require to implement the Part D benefit.[57]

For their part, CMS officials are working overtime with state officials and other public and private agencies to ensure that plan drug formularies are appropriate and that there are no gaps in drug coverage for this population. They are working with state officials to secure data on these beneficiaries, to prepare outreach efforts for them, to educate them on their options under the new Medicare drug program, and to provide them with forms, detailed information, and points of contact.

To smooth the transition, in the fall of 2005, the CMS ruled that members of this senior population will automatically be enrolled in randomly selected

51. Letter to ArvinMeitor retirees from Richard D. Greb, Senior Director of Benefits, ArvinMeitor, August 3, 2004.
52. Brett Clanton, "Delphi to Cut Retiree Benefits," *The Detroit News*, March 8, 2004.
53. Albert B. Crenshaw, "Retiree Benefits Can't Be Cut at 65, Judge Says," *The Washington Post*, March 31, 2005, p. E6.
54. *Ibid.*
55. Ed Lorenzen, "AARP 'Victory' in Court Would Reduce Retiree Health Benefits," *Centrists.Org*, March 31, 2005, at *www.centrists.org/pages/2005/03/29_lorenzen_health.html* (May 31, 2005).
56. Rodgers and Stell, *The Medicare Prescription Drug Benefit*, p. 23.
57. Health Policy Alternatives, "Prescription Drug Coverage for Medicare Beneficiaries," p. 99.

Medicare drug plans but will have an opportunity to choose another plan during 2006.[58] Moreover, the CMS has pledged to ensure that these beneficiaries will get access to all "medically necessary" treatments based on "best practices" in providing drug benefits for seniors and people with disabilities, to establish a coverage and appeals process for beneficiaries, and to appoint a Medicare beneficiary ombudsman to secure the right of seniors to their drug benefits.[59]

The difficulties confronting CMS and state officials are compounded by the special characteristics and health status of this population. The dual-eligibles are among the oldest and sickest of the Medicaid population. Not only are many of them mentally and physically handicapped, but almost 25 percent are also in nursing homes.[60] Among the Medicaid population, these beneficiaries have the highest reliance on prescription drugs, accounting for 52 percent of total drug expenditures.[61]

Medicaid officials, interviewed by analysts for the Kaiser Family Foundation, also found that the characteristics of the population will complicate their tasks:

> While any transition can prove difficult, the Medicaid officials noted [that] the movement of dual eligibles to Medicare is likely to be particularly hard given their low income, cognitive limitations, and other health issues that characterize the dual-eligible population.[62]

No Choice. While the congressional authors of the drug entitlement routinely describe it as a "voluntary" benefit, that description is inaccurate. Third-party payment systems often frustrate personal choice, and that is certainly the case for the Medicaid dual-eligibles. These are also the only seniors who cannot under any circumstances keep their existing drug coverage under the Medicaid program, regardless of their personal wishes in the matter. A recent, though limited, Kaiser Family Foundation analysis found strong opposition among these beneficiaries to any change at all:

> Since they are very satisfied with their current drug coverage under Medicaid, their initial reactions are negative. They want to know who wants them to change and why. Many simply deny that changes will occur or hope that they will be unaffected by Medicare changes because they have Medicaid.[63]

Unquestionably, federal subsidies for this population are generous. Beginning in 2006, federal subsidies for this population under the Medicare drug program will be equally generous. Dual-eligibles with incomes under 100 percent of the federal poverty level ($9,570 for an individual and $12,830 for a couple) pay no premium, and their co-payments for drugs are limited to $1 for a generic drug and $3 for a brand-name drug. Those over 100 percent of the federal poverty level will still pay no premium and no more than $2 for a generic drug and $5 for a brand-name drug.[64] A recent PricewaterhouseCoopers analysis indicates that out-of-pocket spending on drugs by this pop-

58. McClellan, "The Transition of Full Benefit Dual Eligible Beneficiaries to the Medicare Prescription Drug Benefit," p. 7.

59. *Ibid.*, pp. 10–15. There are five levels of appeals in the new Medicare coverage and appeals process.

60. Richard Jensen, "The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans," Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, January 2005, p. 1.

61. McTaggart, "State Implications of the Medicare Modernization Act."

62. Vernon Smith, Kathleen Gifford, and Sandy Kramer, "Implications of the Medicare Modernization Act for States: Observations from a Focus Group Discussion with Medicaid Directors," Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, January 2005, p. 2, at *www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50422* (June 1, 2005).

63. Michael Perry, Michelle Kitchman, and Jocelyn Guyer, "Medicare's New Prescription Drug Benefit: The Voice of People Dually Covered by Medicare and Medicaid," Henry J. Kaiser Family Foundation, January 2005, p. 9. The Kaiser survey of these beneficiaries was based on five focus groups in November and December 2004.

64. McTaggart, "State Implications of the Medicare Modernization Act." The poverty level referenced here is in 2005 dollars.

Medicare Drug Timetable for the States: 2005

February. The CMS begins an "Awareness Campaign" in February. States should be "ready to answer questions from the public."

March. The states submit test enrollment files to the Social Security Administration, and the SSA conducts a "test run" mailing to the Medicaid dual-eligible population.

April. The CMS sends the "production file" of "deemed beneficiaries" to the SSA.

May. The SSA identifies the deemed beneficiaries and starts mailing information to these low-income seniors who are eligible for federal subsidies for drug coverage.

June. The states begin submitting enrollment files to the federal officials on a monthly basis.

July. The states begin accepting applications from seniors eligible for the low-income drug subsidies.

October. The states start receiving the new drug cost information from the CMS. The CMS launches its Medicare beneficiary enrollment campaign and publishes the 2006 per capita drug costs to the states.

November. On November 15, enrollment in the new prescription drug program begins.

December. On December 1, the SSA begins withholding the Medicare drug premiums from the Medicare beneficiaries' Social Security checks. On December 31, 2005, Medicaid coverage ends for the 6.4 million dual-eligible beneficiaries.[1]

1. Information taken from Centers for Medicare and Medicaid Services, "Key Projected Dates in the Implementation of Title I and Title II," revised June 2, 2005, at *www.cms.hhs.gov/medicarereform/mma-t1t2-calendar.pdf* (June 6, 2005).

ulation will remain constant. Today, Medicaid insurance pays 95 percent of their drug costs, and their payments under the Medicare Modernization Act will remain roughly the same.[65]

Like CMS staff, state officials are under enormous pressure. They must carry out a variety of difficult tasks in order to transfer this population from Medicaid to Medicare. They must not only learn the provisions of the new Medicare law, but also correctly identify the dual-eligible population and confirm their eligibility for subsidies or extra assistance, update their information technology systems, revise state rules and regulations governing care for this population, revamp anti-fraud efforts to cope with the new program, work with providers and health care institutions, and help to enroll the dual-eligibles in the new Medicare drug program.

Racing the Clock. While all other seniors have until May 15, 2006, to enroll in the Medicare prescription drug program, the dual-eligibles must enroll in the new program by January 1, 2006, because Medicaid funding for their drug coverage ends that day. Since enrollment in the drug plan does not begin until November 15, 2005, this imposes a very tight time frame on millions of senior and disabled citizens. As remarked by Richard Jensen, an independent health policy consultant, "To avoid gaps in coverage, this means that over six million dual-eligibles must be enrolled in the new Medicare drug plans and begin using them for coverage just six weeks after they become available."[66]

State Medicaid officials, interviewed by Kaiser Family Foundation analysts, expressed nearly unanimous disapproval of the tight time frames within which they must operate. According to analysts with

65. Rodgers and Stell, *The Medicare Prescription Drug Benefit*, p. 24.

66. Jensen, "The New Medicare Prescription Drug Law," p. 2.

the California Health Care Foundation, the Medicare drug program's impact will be felt "throughout the California health care system," but state lawmakers and officials will nonetheless be forced to make important decisions "in the absence of perfect information."[67] Likewise, in their survey of state officials, the Kaiser Family Foundation analysts report:

> Some used the term "disaster" to describe the ambitious time table and the likely outcome of its implementation. They noted that detailed information on the private plans is scheduled to become available in the fall of 2005, leaving as little as a month or two to enroll dual eligibles before their Medicaid drug coverage ends on January 1, 2006.[68]

These analysts also see the timetable problem both as universal for officials in all the states and as a bipartisan concern.[69]

Danger of Disruption. Under the new Medicare law, state officials must help dual-eligibles make the transition to the new Medicare program and help them to pick a drug plan by January 1, 2006. If these beneficiaries do not or cannot pick a drug plan, they can be randomly assigned to a drug plan in their region.[70]

Random assignment and automatic enrollment are designed to smooth dual-eligibles' transition into the Medicare drug program, but as Jensen notes, even automatic enrollment will not avoid dangerous disruptions:

> Gaps in data and information, or inaccurate data, could mean that some dual-eligibles will not be picked up by the automatic enrollment process, at least initially. The high volume of assignments made in a short period of time provides little room for error, and could exacerbate potential problems with the data and systems used.[71]

Tina Kitchin, director of the Oregon Department of Human Services, told the Senate Special Committee on Aging that random assignment by itself will not guarantee a smooth transition, because "it will maximize the chances that a beneficiary is enrolled in a plan that does not meet their needs."[72]

Potential Gaps in Coverage. In the transition from Medicaid to Medicare, a major concern is that beneficiaries may choose or be randomly assigned to drug plans that do not include the precise drugs that they need.[73] CMS officials are keenly aware of the problem, and Medicare drug plans must offer these beneficiaries formularies that are "equivalent" to Medicaid formularies.[74] Moreover, CMS Administrator Mark McClellan has indicated that his agency will allow doctors to write 90-day prescriptions for this population in December, when their Medicaid coverage ends, helping to ease their transition into the Medicare program during the first three months of 2006.[75]

Other problems are more difficult. In some cases, for example, the Medicare law specifically disallows certain classes of drugs, such as benzodiazepines, which are used for the treatment of anxiety disorders.[76] If Medicare drug plans do not include the drugs that the dual-eligibles have been using under the Medicaid program, then dual-eligible beneficiaries must resort to the

67. Chiquita White, Jonathan Blum, and Ryan Padrez, "The Medicare Drug Benefit: Implications for California," California Health Care Foundation *Issue Brief*, April 2005, p. 11.

68. Smith *et al.* "Implications of the Medicare Modernization Act for States," pp. 2–3.

69. *Ibid.*, p. 8.

70. McTaggart, "State Implications of the Medicare Modernization Act."

71. Jensen, "The New Medicare Prescription Drug Law," p. 2.

72. Julie Rovner, "Senate Panel Told of Dual Eligible Drug Transition Worries," *Congress Daily*, March 4, 2005, p. 11.

73. Jensen, "The New Medicare Prescription Drug Law," p. 3.

74. Charles J. Milligan, Jr., "Impact of the Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs," Commonwealth Fund *Issue Brief*, April 2005, p. 4.

75. Julie Rovner, "Dually Concerned," *Congress Daily*, April 7, 2005, p. 5.

Medicare appeals process.[77] For beneficiaries taking these and other prescription drugs as maintenance therapies, this could be both time-consuming and frustrating. It could also adversely affect their care.

Several state Medicaid officials have expressed deep concern over potential gaps in drug coverage and formulary restrictions. According to Kaiser Family Foundation analysts, "Prescription drug coverage is so important for this group that Medicaid officials were concerned that any slip up, however small, could be a major issue."[78] Because this population and its subgroups are so heavily dependent on prescription medications, gaps in coverage or the inability to secure the same drugs in Medicare that they depended on in Medicaid could jeopardize their health and, depending on their condition, even their lives.[79]

Moreover, if the dual-eligibles are assigned to low-cost plans, they are more likely to be enrolled in plans with greater formulary restrictions. Dr. Carl Clark, chief executive officer of the Mental Health Center of Denver, Colorado, observes that the problems of coverage gaps could be particularly serious for those who are mentally disabled and who are randomly assigned to health plans without the appropriate drug coverage, noting that the instruction for them to re-enroll in a plan that includes their specific medication regimens will be difficult to follow in practice.[80] Dr. Clark adds:

> CMS has stated that dual eligibles with severe mental illnesses who are randomly assigned to plans that don't reflect their current medication regimens can re-enroll into PDPs that do. Based upon my years of clinical experience with this population, I have very serious doubts about this approach.[81]

Many states also have pharmacy assistance programs to help needy seniors with drug coverage and to help pay for drugs. Under the Medicare drug bill, the states could use these existing programs to "wrap around" the standard Medicare Part D coverage for low-income seniors who may need the extra assistance to secure a richer drug benefits package. In principle, plans participating in the Medicare drug program could offer a richer benefit package than the legislatively required standard drug benefit. However, under the tight congressional time frames for the transition, state officials are concerned that they would not know exactly how to supplement the Medicare drug coverage for these beneficiaries:

> As one Medicaid Director put it: "How are we going to deal with the issues to wrap around benefits, when nobody will know what Medicare will cover until October 15th of next year—two and one half months before we implement?"[82]

Congress obviously did not anticipate problems with this process.

What Congress Can Still Do

Members of Congress will soon be getting a continuing education in detailed central planning. As in all cases of central planning, there will be major and minor miscalculations. The planners either will make miscalculations themselves or will dutifully carry out the miscalculations that Congress

76. Approximately 1.7 million dual eligibles are currently taking benzodiazepines, including 12 percent of nursing home residents. See Wendy Gerlach, "The Long Term Care Pharmacy Alliance," testimony before the Special Committee on Aging, U.S. Senate, March 3, 2005, p. 4.

77. Smith *et al.*, "Implications of the Medicare Modernization Act for the States," p. 10.

78. *Ibid.*, p. 7.

79. *Ibid.*, p. 8. See also Milligan, "Impact of the Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs."

80. Rovner, "Senate Panel Told of Dual Eligible Transition Worries," p. 11.

81. Carl Clark, M.D., Chief Executive Officer, Mental Health Center of Denver, testimony before the Special Committee on Aging, U.S. Senate, March 3, 2005, p. 3.

82. Smith *et al.*, "Implications of the Medicare Modernization Act for the States," p. 12.

itself enacted into law. Regrettably, the consequences—intended or not—will directly affect millions of seniors and taxpayers.

Since roughly three-quarters of seniors already have drug coverage, the displacement of existing private and public spending is unnecessary, as is the attempt to compensate for this displacement through an administratively complex government program. A rational and responsible policy would simply target assistance to seniors without drug coverage, particularly low-income seniors who do not qualify for Medicaid.

Short of repeal, Congress can at least delay the onset of the universal entitlement and give itself a chance to craft a sensible, simpler, and targeted drug benefit, guaranteeing drug coverage to low-income seniors or seniors without coverage. Beyond that, Congress can take the time to conclude the unfinished debate over the future financing of Medicare, including ways to control the growing unfunded liabilities that will burden current and future taxpayers. A judicious delay would also give a welcome reprieve to state Medicaid officials, millions of dual-eligible beneficiaries, and seniors in existing private plans.

In any case, however, seniors on Medicaid should be free to choose to enroll in the Medicare program for their drug coverage. Congress should not coerce them.

To effect a delay, Representative Flake has introduced the Prescription Drug COST Containment Act of 2005. The bill would delay the Medicare drug entitlement for one year and would continue the Medicare drug discount card program, its "transitional assistance" or subsidies to low-income seniors, and Medicaid coverage of prescription drugs for those now covered under the Medicaid program.

Beyond fixing the drug benefit, Congress can restart work on the unfinished task of reforming the entire Medicare program. It can build on the best features of the Medicare Advantage program and the Medicare drug discount card program and create a new system for the next generation of retirees.

A new Medicare system should be the product of a comprehensive structural reform, changing the financing of the program from a complex defined benefit to a more simplified defined contribution, establishing means testing for government contributions to seniors' health care, and replacing its outdated system of bureaucracy and red tape with a new regulatory regime that closely resembles the superior system that governs the FEHBP, the health care program for current and retired federal employees and their families.[83]

In a new Medicare system, drug coverage would be fully integrated into the benefits packages of health insurance plans, and beneficiaries would be allowed to pay one premium for one plan with one set of co-payments and deductibles. Personal choice—for all classes of Medicare beneficiaries—would characterize the new system.

Conclusion

Congress has launched the largest entitlement expansion since the Great Society, accompanied by an equally massive new experiment in central planning. This will have enormous consequences, not only for taxpayers who must finance a large and growing Medicare debt, but also for millions of seniors, as the Medicare bureaucracy tries to administer a complex drug benefit through increasingly detailed rules, regulations, and guidelines. This will be a vast regulatory enterprise.

The Medicare bureaucracy will struggle to manage this program within the tight time frame established under the new law. Next year, millions of seniors currently without drug coverage will be provided with coverage—especially low-income seniors, who will be heavily subsidized. However, millions of other seniors will lose their existing drug coverage, have their existing coverage

83. For a detailed description of how this approach would work, 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*, and Robert E. Moffit, "A Road Map to Medicare Reform: Building on the Experience of the FEHBP," testimony before the Special Committee on Aging, U.S. Senate, May 6, 2003, at *www.heritage.org/Research/HealthCare/test050603.cfm*.

degraded, or find themselves struggling with congressionally engineered gaps in drug coverage. Many who find themselves in these gaps will be among the sickest and most vulnerable members of the Medicare population.

The new Medicare law will also displace existing private and public spending on drugs. For seniors with coverage through Medicaid, enrollment in the new Medicare program is not a matter of choice, and state Medicaid officials have no option but to manage a very difficult task the best they can within a limited amount of time. Meanwhile, taxpayers will be spending billions of dollars more to encourage employers to retain drug coverage for retirees, even as the law allows those employers to lower the level of drug coverage for their retirees while still receiving taxpayer subsidies. Given its powerful incentives, regardless of the outcome of court litigation on the subject, the new Medicare law will accelerate the loss of private employment-based retiree drug coverage.

The complex Medicare drug benefit, with its strange gaps in coverage, is a creation of the congressional imagination. It is not a free-market model. It does not reflect current market reality; it displaces it. By enacting it, Congress has repudiated one of the key goals of Medicare reform: reducing bureaucracy and red tape. Instead, Congress has dramatically expanded the power of the Medicare bureaucracy and massively increased red tape, inviting ever more counterproductive and costly congressional micromanagement of the program.

Unless Congress reverses course and repeals or at least delays it, the Medicare drug entitlement will go into effect on January 1, 2006, and another major portion of the health care sector of the American economy will come under direct government control.

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