Gail R. Wilensky

Medicare bill sets precedent for future funding

Almost all seniors are better off under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, signed into law by President Bush on December 8, 2003.

***hfm* is pleased to welcome Gail R. Wilensky as a new Eye on Washington columnist. Dr. Wilensky will alternate with longtime columnist Jeanne Schulte Scott.**

Given the closeness of the vote—220 to 215 in the House of Representatives and 54 to 44 in the Senate—and the nearness to the next election, it is hardly surprising that many Democrats, and a few Republicans as well, have been increasing the volume and intensity of their criticism of the bill. As imperfect as the legislation is, I believe that Congress made the right decision in passing this legislation. There will be many opportunities for Congress to correct the legislation, reflecting both the known imperfections as well as the unintended consequences that are sure to present themselves.

Important Provisions

The legislation is very complex and involves much more than a prescription drug program for Medicare. Its most important provisions, however, concern the creation of a new voluntary prescription drug benefit under Part D of Medicare and the replacement of the existing Medicare+Choice program with a new program called Medicare Advantage. The prescription drug program begins in January 2006. Benefits will be provided either through private prescription drug plans or as part of a Medicare Advantage program. Beneficiaries will need to enroll and pay a monthly premium to receive benefits. Prior to 2006, beneficiaries will be able to purchase a drug discount card that can provide them with discounts on their drug purchases.

The benefit is also complex. In 2006, standard benefits include a $250 deductible, a 25 percent coinsurance for the first $2,250 of spending, no coverage for spending from $2,250 to $5,100, and catastrophic coverage thereafter. The latter is defined as a $2 generic copay, a $5 brand copay, or a 5 percent coinsurance payment. The dollar amounts in the bill are indexed to the percentage increase in spending on Medicare outpatient drugs.

Monthly premiums will start at $35 in 2006. Individuals with income less than 135 percent of the poverty line and with minimal assets will pay no premiums or deductibles, but they will pay a small copayment on each prescription. The subsidies will decline on a sliding scale between 135 percent and 150 percent of the poverty line.

Many politicians and policy analysts have already expressed a variety of concerns about the legislation just passed. I have at least four concerns of my own.

First, rather than having traditional Medicare compete directly with private plans in areas that have robust private-sector participation, direct competition will be limited to a demonstration program held in a few geographic areas and renewable only once. The political obstacles facing this demonstration are already formidable, and even successful demonstrations rarely make it into legislation. Second, removing the requirement that Congress act if spending on Medicare from general revenue exceeds 45 percent substantially lessens the pressure to act if spending exceeds estimates. Third, the amount of the subsidies paid to employers who continue providing retiree prescription drug benefits is excessive. Fourth, the lack of focus of drug benefits on beneficiaries with either low incomes or high expenditures increases the amount of drug spending

where there is no coverage—the so-called "doughnut hole."

Despite these concerns, the legislation contains many important benefits. The most obvious is that seniors and other beneficiaries with low incomes or with very high expenditures are much better off than they were before the legislation was passed. Although most seniors had some prescription drug coverage before the legislation, those with low incomes—but too much income to qualify for Medicaid—were the least likely group to have outpatient drug coverage.

In addition, many seniors who had drug coverage had only limited coverage. While the configuration of the benefit has been criticized, almost all seniors are clearly better off. One of the groups at risk for being made worse off includes the relatively small numbers who had good retiree coverage. Although it will be difficult to attribute drops in coverage specifically to the legislation, since employers already were eliminating or reducing coverage prior to the legislation, the large subsidies to employers providing coverage may help some retirees retain their employer coverage.

Another group that could be made slightly worse off is seniors who have been on Medicaid. Bringing the poorest seniors into a single program for the purposes of drug coverage makes the most policy sense and was advocated by many of the more liberal groups before the legislation was passed. The concern is that Medicaid may have offered some of these individuals better coverage with fewer restrictions due to formularies. Whether that is the case will depend on the beneficiary's state of residence and the quality of drug coverage that had been provided in the state under Medicaid. However, because states cannot wrap additional benefits around Medicare, it is at least possible that some of these individuals could be worse off.

But the new legislation has many appeals, and consumer protection provisions are more likely to occur through the implementing regulations. The likelihood that significant reductions in benefits for the lowest-income beneficiaries will persist in the future seems to me very small.

Setting a Precedent

Perhaps the most important but frequently overlooked benefit of the new legislation is the introduction of an income-relating component to the Part B premium as of 2007. Individuals with incomes exceeding $80,000 or couples with incomes exceeding $160,000 will be subject to higher Part B premiums. The increase will be calculated on a sliding scale and will be phased in over five years.

Individuals with incomes greater than $200,000 or couples with incomes greater than $400,000 ultimately will pay 80 percent of the Part B premium instead of the current 25 percent. Clearly, the levels of income at which individuals or couples will pay the maximum share of the premium are so high that only small numbers of seniors will be affected by such an increase, but the principle and precedent being set are very important, not so much for the current generation of seniors as for the babyboomers. The notion of limiting the general revenue subsidy for seniors with high incomes could be an important precedent influencing future strategies to help fund Medicare benefits for babyboomers. For me, this is the real "sleeper" provision of the legislation.

Rather than bemoan the imperfections of newly passed legislation, the country needs to recognize that adopting legislation that addresses legitimate social problems, such as this legislation, is better than indefinitely delaying legislation and hoping for better legislation at a later date. As imperfect as this bill is, I believe it is as good as this Congress could pass. Finally, at least as many technical fixes or pieces of "clean-up" legislation are likely to be passed following this legislation as occurred following the Balanced Budget Act. ●

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