The New Medicare Prescription-Drug Benefit — A Pure Power Play

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Every so often, U.S. presidents pursue goals that turn the political orthodoxy of the time on its head. Memorable modern examples include the historic move by Richard M. Nixon to normalize relations with Communist China, the controversial step by Bill Clinton to embrace welfare reform, and now, the decision by George W. Bush to sign legislation that will entitle the 41.7 million disabled and elderly beneficiaries of Medicare to new coverage of prescription drugs. Defying traditional Republican principles that favor fiscal restraint and retrenchment of the welfare state, but outflanking Democrats in the process, Bush achieved a major political goal that seemed to drive his interest in this issue throughout the past year. That goal was inoculating himself and his party against the inevitable Democratic charges in an election year that Republicans were the enemies of Medicare and thus would oppose enactment of an expensive new benefit for those covered by the program.

In this report, I discuss the political highlights of the legislation, the surprising conclusion of which came on December 8, when Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003. In a subsequent report, I will focus on the provisions of the 678-page bill that most directly affect the relationship of Medicare to the 600,000 physicians who provide medical care to its beneficiaries. Although Bush took the political prize, the new law favors key policy priorities of Democrats, including enactment of a guaranteed drug benefit that would apply to all Medicare beneficiaries, whether they remained in the program's traditional fee-for-service component or — as the administration strongly prefers — enrolled in a private health plan.

The drug benefit alone will cost an estimated $409.8 billion (the amount calculated by the Congressional Budget Office on which legislators based their policy decisions) over the period from 2004 through 2013 and represents the largest expansion of Medicare since its enactment in 1965. These resources will help beneficiaries reduce the overall costs of prescription drugs, which, for the entire U.S. population in 2002, increased at a rate of 15.3 percent and represented 10.5 percent of all personal health care expenditures that year.

Surrounded by his Republican allies and an invited throng of Medicare beneficiaries, Bush signed the measure in one of Washington's largest concert halls, which had been selected for the event. But only two Democratic legislators — those who had been allowed to participate in the closed-door negotiations during which the political compromises were struck — witnessed the event. At the ceremony, Bush said, "First and foremost, this new law will provide Medicare coverage for prescription drugs. Medicare was enacted to provide seniors with the latest in modern medicine. In 1965 it usually meant house calls, and, for operations, long hospital stays. Today, modern medicine includes outpatient care, disease screenings, and prescription drugs. Medicine has changed but Medicare has not. Until today."

On Capitol Hill, at about the same time, critics of the new law — Democratic legislators, leaders of organized labor, and some advocates for the elderly — gathered at a rally to assail the measure as a major Republican step toward privatizing the program. Never before had Congress enacted major Medicare legislation about which the divisions between the political parties run so deep. The most critical voice was that of Senator Edward M. Kennedy (D-Mass.), who in the closing weeks of the debate had reversed his position of support for an earlier version of the measure. At the rally, Kennedy asked, "Who do you trust? The HMO-coddling, drug-company-loving, Medicare-destroying, Social-Security-hating Bush administration? Or do you trust Democrats who created Medicare and will fight with you to defend it every day of every week of every year?" At a news conference on January 5, Kennedy said, "If Republicans think this fight is over, they are wrong," and he pledged that Democrats would raise their concerns about the law every day on the Senate floor.
The Democratic congressional leadership — Senate Majority Leader Tom Daschle of South Dakota, who was barred by Republicans from participating in the House-Senate conference committee where the final bill was fashioned, and House Minority Leader Nancy Pelosi of California — plus 80 of their party colleagues have already introduced legislation to repeal sections of the new law.

The drug benefit, the centerpiece of the law, takes effect in January 2006, but the measure also directs the Department of Health and Human Services to establish a temporary drug-discount program quickly as a stopgap measure. In addition, the law repeals a scheduled decrease of 4.5 percent in Medicare payments to physicians in 2004 and 2005 and authorizes a modest increase of 1.5 percent in each year. Underscoring the influence of two senators representing rural states who participated in the conference (Republican Charles Grassley of Iowa and Democrat Max Baucus of Montana), the law includes about $20 billion in additional payments to rural providers who care for elderly patients and believe they have been shortchanged by Medicare’s rates. But the law reduces Medicare payments to physicians and others for outpatient drugs (mostly chemotherapy) that it already covers and that are generally administered under the supervision of oncologists in their offices.4

The law also creates new “health savings accounts,” insurance products that feature high deductibles combined with tax-free savings that can be withdrawn to pay for medical care; enacts regulatory reforms intended to reduce the burden of Medicare paperwork on providers; freezes payments for durable medical equipment; establishes higher Medicare premiums for elderly beneficiaries with high income; and transfers to Medicare more of the cost of providing drug coverage for some 7 million elderly and younger persons with disabilities. These beneficiaries, who live on modest incomes, are currently eligible for both Medicare and Medicaid coverage. Shifting this entire expense ($16 billion in 20025) to the federal government was a top priority of the National Governors Association, but, as written, the law still requires states to pay for a substantial portion of this coverage.

THE EVOLUTION OF THE LAW

Last year began badly for the administration and its vision of how to encourage Medicare beneficiaries to enroll in private health plans that contract with the program. As outlined in documents that were leaked to journalists, the administration proposed that Medicare offer drug coverage to persons who enrolled in private plans but provide no prescription-drug coverage in the standard benefit package of the program’s traditional fee-for-service component.6 The administration soon abandoned the idea of different drug benefits for managed-care and fee-for-service enrollees when it came under sharp criticism from both Democratic and Republican members of Congress.7 The most lasting influence of this early controversy was an insistence by legislators in both parties that a new drug benefit should be no less generous for beneficiaries who remain in the traditional program (currently about 88 percent of all beneficiaries) than for those who enroll in a private plan.

After this setback, the administration decided not to introduce a formal legislative proposal, settling instead a “Framework to Modernize and Improve Medicare.”8 The initial versions of the Medicare legislation took shape in the first half of 2003 in committees with jurisdiction over the program. The partisan dialogue that dominated these discussions spilled over into the ensuing floor action in June, particularly in the House. Working with a thin majority (229 Republicans to 205 Democrats and 1 Independent), the Republicans eked out a 1-vote victory (216 to 215) on June 27 after a day of arm-twisting by House Speaker Dennis Hastert (R-Ill.), Vice President Dick Cheney, Health and Human Services Secretary Tommy Thompson, and others. The decisive vote was cast by Representative Jo Ann Emerson (R-Mo.), who reversed an earlier no vote after receiving a pledge from the Republican leadership that it would allow the House to consider, at a later time, another bill related to the importation of prescription drugs.

Fulfilling its pledge a month later to allow such a vote, the House, by a margin of 243 to 186, passed a bill that would have allowed individual patients, pharmacists, and drug wholesalers to import less expensive drugs from Canada and Europe that had been approved for use in this country by the Food and Drug Administration. However, before enactment of the final bill, conference leaders rejected this approach and instead reaffirmed current federal policy, which allows the “reimportation” of drugs from Canada only if the Department of Health and Human Services certifies that they are safe. Neither in the Clinton nor the Bush administration has the department been willing to grant such certification.
The Senate, after several preliminary votes that removed obstacles to moving the measure forward, approved its version of the Medicare bill by a vote of 76 to 21 on June 27. Ironically, Kennedy, who later became the most forceful opponent of the final bill, urged his Democratic colleagues to support this measure, ending any chance that they could kill it as they had on two earlier occasions in previous sessions of Congress.

A DIVIDED CONFERENCE COMMITTEE

The Medicare legislation emerged in its final form in November from a House-Senate conference committee that was appointed to reconcile the two versions of the legislation. Its proceedings, which were tightly controlled by the conference chairman, Representative Thomas (R-Calif.), went on for four months behind closed doors. One headline described it thus: "Hey, They're Taking Slash-and-Burn to Extremes!" Only 2 Democrats among the 7 who had been appointed to the 17-member committee were actually allowed to participate in the most sensitive deliberations. Thomas barred three House Democrats from participating in virtually all of the meetings. Two senators, Baucus and John Breaux of Louisiana, were granted entry because Thomas viewed them as part of "a coalition of the willing." Even with Republicans controlling the panel, reaching compromise proved elusive because of the widely different views held by its members.

In the end, only the intervention of House Speaker Hastert and Senate Majority Leader Bill Frist (R-Tenn.) produced a compromise that was acceptable to most of the conference. Fearing that time was running out, the two cobbled together an agreement designed to settle the issues that remained in dispute. Their intervention incensed Thomas, who abruptly canceled further negotiations and stormed out of the Capitol on the afternoon of November 12, announcing that he was flying home to California. But by that evening, with his well-known temper cooled, Thomas had returned to the negotiating table to continue bargaining into the night.

The key feature of the compromise offered by Hastert and Frist was the rewriting of the provision establishing a permanent national system of direct competition between private plans and traditional Medicare that many Republicans strongly favored but Democrats detested. Offered in its place were pilot projects in six metropolitan areas (to be named later), beginning in 2010, to test the concept. Now analysis are expressing doubt that even these limited experiments will ever take place. Previous efforts by the Centers for Medicare and Medicaid Services to mount a more limited demonstration in which health plans would bid competitively for the business of elderly patients but traditional Medicare coverage would not be involved were thwarted, either because health plans and interested parties resisted them or because Congress intervened to stop them.

A HISTORIC STRUGGLE ON THE HOUSE FLOOR

Although this brokered compromise moved the measure forward, President Bush, Secretary Thompson, and the House Republican leadership had to resort to some extraordinary last-minute tactics to persuade some of the party's more conservative members to vote for it. At 3 a.m. on November 22, Representative Richard "Doc" Hastings (R-Wash.), who was presiding over the House, announced that time for debate on the Medicare legislation had expired, stating, "Members will have 15 minutes to record their votes." But it was nearly 6 a.m. (2 hours and 51 minutes later) when the longest roll call in House history (more than double the previous record) ended, with Republicans cheering enactment of the bill by a vote of 220 (204 Republicans and 16 Democrats) to 215 (189 Democrats, 25 Republicans, and 1 Independent) and embittered Democrats denouncing it as a travesty.

For more than an hour, the vote had stood at 218 against and 216 for passage—an apparent victory for Democrats and conservative Republicans, the latter having objected to the cost of the measure and its lack of reform. But in the final hour, as reported by David Broder in the Washington Post, Bush, "jet-lagged from his flight home from Britain, phoned recalcitrant Republicans from the White House, and his secretary of health and human services, defying custom, jawboned members on the floor." During the long night, Hastert told Broder, "A lot of our folks, the hard-right guys, are not for Medicare. It's an entitlement they don't want to add on to. I had to convince them we had a chance really to reform Medicare and bend those cost curves so my kids don't end up paying 30 percent of their salaries for it."
ocrats, defeated an effort led by Kennedy to mount a filibuster against the Medicare legislation. The vote was 70 to 29. Next, Republicans eked out a one-vote victory over another last-ditch effort to scuttle the bill. Democrats objected to the bill on the grounds that its cost exceeded constraints imposed by the 2004 budget resolution, to which Congress had agreed earlier in the year. Frist moved to waive this budget strictures, an action that required 60 votes. For a time, the tally was frozen at 58 to 39, 2 votes short. Then, two Republicans who had withheld their votes — Senators Lindsey Graham of South Carolina and Trent Lott of Mississippi — cast them for the motion, as did Democrat Ron Wyden of Oregon, for a final tally of 61 to 39. By voting as he did, Lott came to the rescue of Frist, even though he opposed the bill and voted against it at the time of its final passage. At the beginning of 2003, Frist had replaced Lott as Senate majority leader after Lott was forced to resign over comments that colleagues considered racially insensitive. One Senate aide said, "At his core, Lott is a loyal Republican and that came out." After these two votes, on November 25, the Senate approved the Medicare bill 54 to 44 and sent it off to the White House.

THE SCOPE OF THE DRUG BENEFIT

In designing a drug benefit, policymakers addressed four fundamental issues: how comprehensive to make it; how much of its cost should be borne by government, and how much by those who benefit directly; who should be eligible; and how the benefit should be managed and delivered. The scope of the benefit was defined by a general agreement that its total cost should not exceed $400 billion over the period from 2004 through 2013. Because of savings that were extracted from other Medicare-financed activities in this vast bill, the Congressional Budget Office (CBO) estimated its total cost at $395 billion. Without these savings, the drug benefit alone will cost an estimated $409.8 billion during the first decade. These monies will be drawn from general tax revenues and, as such, will be borne by society at large. Over these 10 years, beneficiaries will pay monthly premiums totaling an additional $130 billion, or approximately 25 percent of the total benefit.

In keeping with the political imperative that all beneficiaries, regardless of income or clinical need, should be eligible to receive some of the benefits of the new law, the coverage is universally available both to beneficiaries who receive care through health plans and to those in the traditional fee-for-service indemnity system. But there will be gaps in that coverage, as Figure 1 shows. Acceptance of drug coverage, like that of Medicare Part B, is voluntary, but if beneficiaries initially decline and then change their minds, they will have to pay a late enrollment fee that could quickly add up to real money. The penalty is a 1 percent increase in the premium for every month of delay. Beneficiaries can obtain coverage in one of three ways: by purchasing stand-alone drug insurance if they remain in the traditional Medicare fee-for-service program, by enrolling in a managed-care plan, or by participating in a plan for retirees offered by a former employer.

Currently, private insurers do not offer stand-alone drug insurance, principally because these products would be prohibitively expensive for the people whom they would primarily attract — patients with chronic illnesses who rely heavily on prescription drugs. Should such insurance be developed, actuaries estimate that beneficiaries would pay monthly premiums of about $35, or $420 a year. In addition, beneficiaries would pay a monthly premium of $66.60 in 2004 for Part B services obtained through traditional fee-for-service Medicare. Beneficiaries who enrolled in a health-maintenance organization or a preferred-provider organization under "Medicare Advantage" (the renamed Medicare + Choice managed-care program) would receive all of their covered services through these plans and would pay only on an overall monthly premium. All beneficiaries would be guaranteed at least two qualifying choices, including a stand-alone plan, in their area of residence. If two plans did not exist, the government would be required to provide coverage directly. Recipients with health benefits sponsored by a former employer could obtain drug benefits through either the traditional Medicare program or a health plan.

In order to gain a financial benefit that exceeds out-of-pocket expenditures, a beneficiary will have to incur annual drug expenses of at least $810, on average. The CBO estimates that the average beneficiary will use drugs that cost an estimated $3,155 in 2006. The coverage, of course, also provides beneficiaries with the peace of mind of knowing that they have drug insurance that is guaranteed, but this feature is difficult to quantify. Low-income beneficiaries with few assets (the CBO estimates that 14 million people, or about 33 percent of eligible elderly persons, fall into this category) will qualify for
much more generous coverage, including elimination of the gap in coverage (between $2,250 and $5,100) for higher-income beneficiaries and very low cost-sharing requirements.

Most of the legislative proposals that were introduced provided a role for private insurers, but Democrats generally cast them as fiscal intermediaries (as is the case now for Parts A and B of Medicare) and added the task of negotiating prices but not bearing risk. Republicans favored granting private insurers a larger role, including risk bearing, similar to their role in the Medicare+Choice component through which the program currently contracts with health plans. The compromise that passed Congress left health plans with this broadened role, but government is required to intervene if two choices are not available to beneficiaries in a given geographic area.

**DRUG-DISCOUNT CARDS**

The first tangible national sign of the new law will come when beneficiaries, more than one third of whom currently have no coverage, are able to enroll in a temporary Medicare-approved prescription-drug-discount program that is scheduled to begin this spring. Two days after Bush signed the measure into law, the Department of Health and Human Services issued interim final regulations under which the drug-discount program will operate. The key difference between currently available cards and the new ones that will be issued is that the issuer of the card, by meeting certain standards, will carry the endorsement of Medicare. The department estimates that Medicare beneficiaries will be able to obtain savings of 10 percent to 15 percent on their total drug costs. The actual savings will depend on how successful the issuers of drug-discount cards—pharmacy-benefit managers, health insurers, chain drug stores, and others—are in negotiating discounts with drug manufacturers and what proportion of the discounts they pass along to beneficiaries. The drug-discount program will end when the Medicare drug benefit takes effect in January 2006.

**THE EXERCISE OF POWER**

The final Medicare measure was an odd mixture of provisions that are part of the give-and-take of a political process, but its enactment demonstrated the enormous power of the presidency, once a chief executive takes up an issue. Bush paid little mind to Democrats who sought to thwart achievement of his goals. But he also ignored the protests of conservative-leaning think tanks, editorial-page writers, columnists, and Republican legislators who argued persistently that the Medicare legislation failed to modernize the program adequately and would pass...
on an enormous financial burden to the next generation. Part of that financial burden not only greased the legislative skids on behalf of a drug benefit but also provided additional support to a broad coalition of other interest groups that lobbied aggressively for the measure.

Judith Feder, a senior health official in the Clinton administration and a critic of the legislation, told a reporter: "There's a tremendous amount of money floating in this bill. While we think it's about prescription drugs, the promoters of this bill put money into every interest group — physicians, hospitals, rural providers, cancer doctors, [and] on the drug side, the pharmaceutical and insurance industries, and it's tough to fight all those bucks." David Brooks, a conservative columnist, attributed the actions of Republicans to their blossoming as a majority party and wrote: "The Republicans used the powers of government to entrench their own dominance. They used their control of the federal budget to create a new entitlement, to woo new allies and service a key constituency, the elderly. . . . The Democrats don't even know the state of play." The decision of the American Association of Retired Persons (AARP) to support the legislation was the single most important stroke that enabled the administration to achieve its enactment. William D. Novelli, chief executive officer of the AARP, announced the association's support only days before the House and Senate voted on the measure, and the group's endorsement made national news. The decision came as a surprise to many Democrats, because the AARP had long favored the more expansive social-welfare policies of the Democratic Party as best serving the interests of its 41 million members. The AARP's policy director, John Rother, said in an interview that the decision was the logical outcome of working more closely than ever before with Republicans to modify certain provisions of the bill that were troublesome to the association. Rother said, "We pressed Republicans successfully to build in larger incentives designed to deter employers from dropping drug coverage for their retirees and to increase assistance for beneficiaries with modest incomes. Senator Baucus was also an important participant in this process. We also were successful in helping to convince Republicans that the direct competition they favored between traditional Medicare and private health plans should be an experimental project, not a permanent feature." But the decision also recognized that, given the growing federal deficit, it was unlikely that $400 billion would be made available again any time soon to pay for a drug benefit.

THE PRICE OF SUPPORT

The American Association of Health Plans and the Health Insurance Association of America, which recently merged, lobbied successfully to increase Medicare payments to managed-care plans that enroll its beneficiaries. Between 1999 and 2003, 2.4 million of about 6.8 million beneficiaries who had enrolled in these plans were forced to return to traditional Medicare coverage because many companies pulled out of the program, citing inadequate payments. The case made by health plans was reinforced by Republicans who believed strongly that these companies could save money for Medicare over the long run. This belief is based on what is known as the "premium support" model, an idea introduced by Henry Aaron and Robert Reischauer in 1995, but renamed the "comparative cost adjustment" model in the new law. It is this concept that will be tested as an experiment in six cities. Under this model, Medicare, rather than offering a defined package of benefits, would provide a fixed premium subsidy to beneficiaries. If beneficiaries selected a plan that cost more than the premium subsidy, they would be responsible for the full price difference. If they selected a plan that cost the same as or less than the amount of the subsidy, they would pay nothing extra or have their premiums reduced. This approach would allow the government to predict and control its expenses, but critics worry that under this system the traditional fee-for-service Medicare system could require additional payments from beneficiaries and be prohibitively expensive for some elderly persons, who would then be forced into health plans.

The Department of Health and Human Services has announced that as of March 1, 2004, according to the provisions of the new law, health plans that contract with Medicare will begin receiving payment increases averaging 10.6 percent, which, the CBO estimates, will total an estimated $800 million this year. The law requires plans to use the additional funds on behalf of their elderly enrollees — for example, by closing gaps in coverage, reducing premiums, or expanding their provider networks. The new law also creates a "stabilization" fund, which the CBO estimates will cost Medicare $12.5 billion over a decade. The fund has been placed at the dist
posals of the Department of Health and Human Services for the purposes of attracting new plans to Medicare and deterring other plans from dropping out.

The contributions of pharmaceutical manufacturers that provide financial assistance to candidates through their political action committees, soft-money contributions that support advertising designed to influence policy, and other efforts add up to one of Washington's most elaborate advocacy strategies. These efforts reinforced the natural instinct of most Republicans (and more than a few Democrats) to accommodate the interests of private enterprise when making policy, if at all possible. These interlocking interests helped pharmaceutical companies persuade Congress to maintain, in effect, the ban on the reimportation of drugs and to prohibit Medicare from directly negotiating drug prices with manufacturers. Direct negotiations were actually never contemplated, even in most of the Medicare bills introduced by Democrats or in the bill passed by the Senate, but in the latter stages of the debate, some Democrats called for such negotiations to score political points. Prices will be negotiated with health plans and companies that manage pharmacy benefits, as is now the case with employer-sponsored coverage. The CBO has estimated that these efforts and other cost-control measures could ultimately reduce overall drug expenditures by about 25 percent for elderly patients who now pay full retail prices.

Large employers that are among the declining number of companies that still offer retiree health benefits (the proportion is down from 66 percent in 1988 to 38 percent in 2003) were also among the winners in the Medicare legislation. About one third of retirees with drug coverage obtain it through their former employers. A number of Fortune 500 corporations formed the Employers' Coalition on Medicare to emphasize that the best way to prevent a further drop in retiree health insurance coverage would be for the government to pay part of the costs. The new law provides direct public subsidies to employers, amounting to an estimated $89 billion over the period from 2004 through 2013, that are designed to discourage companies from dropping the drug coverage they currently offer to retirees. The subsidies will cover up to 28 percent of what an employer currently pays for drug coverage for retired workers. The subsidies are not taxed; thus, the federal treasury will forgo $17 billion, which is a part of the total amount ($89 billion).

On January 8, 2004, the Wall Street Journal reported, "Some companies with many retired workers are expected to post big earnings gains for 2003 and 2004, thanks to accounting guidelines for subsidies under the federal prescription-drug program."

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**THE PARTISAN WARS CONTINUE**

No expression of the displeasure of many Democrats with the Medicare drug benefit has been louder than the voices of the party's contenders for its presidential nomination. All have criticized the drug benefit on the grounds that it either is too meager or will endanger traditional Medicare. One of the Democratic Party's battle themes was articulated on January 10 by Governor Jim Doyle of Wisconsin in the party's weekly radio address: "Instead of using Medicare's enormous bargaining power to get the best discounts for our seniors, American taxpayers and seniors will be forced to foot the bill for greater drug company profits." Health and Human Services Secretary Thompson wasted little time in striking back, telling reporters at a briefing on January 12, "There's a lot of misinformation out there. Just about every one of the Democratic candidates running for president has been criticizing the Medicare law. As a consequence, Thompson said, Republicans "must be much more aggressive in telling our story."

The story is that the Medicare law will certainly help many beneficiaries pay for their prescription drugs, but the process of assuring that coverage, gaps and all, will pose new challenges for the elderly. And there will be other effects as well. The measure will add to a federal deficit that is already soaring. The administration has estimated in its new 2005 budget that the cost of the drug-benefit program will be $530 billion over a 10-year period—about one third more than the CBO estimated about two months ago. CBO director Douglas Holtz-Eakin has testified that its "cost would exceed $1 trillion and could approach $2 trillion during the following decade." Nevertheless, Republicans determined to break the long hold that Democrats have maintained on Medicare as a political asset seem to have achieved that goal by winning enactment of a drug benefit. Democrats who have pledged to expose the law's shortcomings will have a difficult time of it in this election year, since the drug benefit does not take effect until 2006 and federal budget deficits have had little resonance in the minds of voters.
HEALTH POLICY REPORT


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