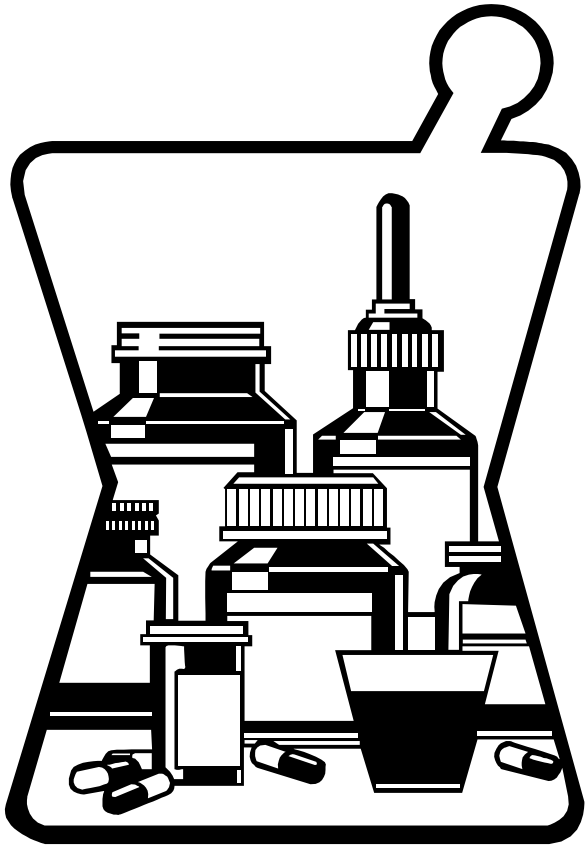
# Medicare Prescription Drugs: Conference Committee Agreement Asks Beneficiaries to Pay Too High a Price For Modest Benefit



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# Medicare Prescription Drugs: Conference Committee Agreement Asks Beneficiaries to Pay Too High a Price For Modest Benefit

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## Acknowledgments

Special thanks to Ven Neralla, legislative assistant to Congressman Peter DeFazio, for his technical assistance in developing the drug calculator that takes into account an individual's own assumptions about the annual rate of growth of drug spending and an individual's prescription drug expenditures. Thanks also to CU's Theresa Thomas for her expertise and assistance with the charts.

## EXECUTIVE SUMMARY

The proposed Medicare conference agreement is fundamentally flawed. That is because Congress made three crucial decisions that severely limited the ability of the Medicare prescription drug bill to meet the needs of consumers:

- Congress set aside money in the budget resolution that would cover just 22 percent of anticipated prescription drug expenditures.
- It created a structure that foreclosed (and even literally prohibits) negotiating deep prescription drug discounts on behalf of consumers, assuring that prescription drug costs will continue to spiral.
- Both the House and Senate decided to rely on private insurance companies and health plans, guaranteeing a perpetual flood of lobbyists requesting more money (or threatening to cut off benefits).

The **Overview** section identifies the best and the worst overall features of the reported conference committee agreement, pointing out that the elements on the "best list" come with caveats that mean that even the good things are not as good as they should be. It is nothing short of tragic that legislation that was meant to offer relief to Medicare beneficiaries comes laden with so many provisions that will harm Medicare beneficiaries and even threaten the program's long-term viability.

This report analyzes how consumers would fare under the conference agreement (based on the information currently available) on ten key elements, summarized below. A calculator, on page B-1, allows individuals to estimate their own out-of-pocket costs in 2007.

***Adequacy of benefit***: The new Medicare benefit will be considered at best modest (e.g., for those who now have drug coverage through medigap) and at worst skimpy (e.g., for those who lose more comprehensive employer coverage or have no coverage at all for drugs). The continued growth of prescription expenditures and the benefit design combine to mean that many beneficiaries will face higher out-of-pocket costs (when they *have* this new coverage) than they do today (when they do not have drug coverage), if prescription drug expenditures continue to grow at recent levels (17 percent per year). Coverage will vary from plan to plan, because private pharmaceutical benefit managers (PBM's) will be free to limit the drugs on their formulary (i.e., list of drugs that are covered), without basing decisions on science and without accountability to the public.

***Prescription Drug Cost Containment:*** The conference committee proposal is premised on a private marketplace model that precludes the benefit of deep discounts possible through the pooled purchasing power of the federal government. Growth of prescription drug expenditures is likely to continue at double-digit rates, with U.S. consumers

continuing to pay prices higher than those in Canada and Europe. The Secretary of Health and Human Services can block the reimportation of low-cost medicines from Canada.

***Universality of Medicare.*** The conference committee proposal rejected the most dangerous provisions that would have eroded the universal coverage of all individuals over 65 of the Medicare program (means-testing of benefits, coverage of dual eligibles through Medicaid), but has opened the door to reduced participation in Medicare of those with high incomes by relating Part B premiums to income, thereby reducing their Part B subsidy. The administrative complexity and potential for privacy incursion may be a high price to pay for very little additional revenue for the Medicare program which already has relatively progressive financing.[1]

***Role of the Private Marketplace.*** By calling for competition between private health plans and traditional fee-for-service Medicare in 2010 (or possibly earlier) in three to six metropolitan areas and perhaps one region, the Conference committee proposal takes a dangerous step toward privatization of Medicare, which could ultimately result in widely varying premiums across the country, financial pressure on beneficiaries to enroll in private plans that severely restrict choice of doctor, and burdensome premium increases for beneficiaries who value freedom of choice of doctor and wish to remain in traditional fee-for-service Medicare. Instead of requiring private plans to demonstrate cost savings that result from efficiency, the proposal provides additional subsidies to private plans and even allows them to benefit financially from cherry-picking the healthy, perpetuating the shameful history of overpayments that have existed for many years.

***Impact on Retirees with Employer Coverage.*** The conference committee proposal could cause millions of Medicare beneficiaries to lose generous retiree sponsored prescription drug coverage and could result in some retirees having considerably less generous coverage than they currently have.

***Those eligible for Medicare and Medicaid.*** The conference committee proposal helps to preserve the universality of the Medicare program by covering dual eligibles in Medicare, not Medicaid. However, many Medicaid enrollees will find they have *less* coverage than they do now because the proposal prohibits states from providing "wrap around" coverage. ("Wrap around" coverage would fill in the gaps not covered by the Medicare benefit). The clawback provision (a provision that requires state governments to pay a substantial share of the dual eligible drug costs) limits the fiscal relief to states; with limited relief and additional administrative responsibilities, states may be forced to cut back health coverage for children and others under 65, under Medicaid and the state children's health program (SCHIP).

***People with Low-Income.*** While the conference committee proposal provides comprehensive subsidies to people with incomes below 150 percent of poverty, its failure to adopt the Senate bill's more generous eligibility limit of 160 percent, combined with

its strict asset test, will preclude several million low-income beneficiaries from getting the financial relief that they need. Individuals with incomes above about $13,000 and couples with incomes above about $16,300 (2002 figures) will be unlikely to afford the coverage and are ineligible for additional subsidies.

***Federal fallback.*** The conference committee proposal includes a fallback provision that is likely to leave many beneficiaries facing very limited competition and choices for their prescription drug coverage. People in rural areas, in particular, are likely to have a choice between *one* high-priced drug-only plan and one preferred provider organization which restricts choice of doctor and imposes high costs for out-of-network care.

***Cap on Use of General Revenues***. The conference committee proposal establishes an arbitrary ceiling on the percent of Medicare funding that should come from relatively progressive revenue sources and will create an artificial crisis when this trigger calling for Presidential and Congressional action is reached, probably in about 2010. It will probably lead to cutbacks in Medicare benefits (hospital care, doctor care, and prescription drug coverage), increased cost-sharing for Medicare beneficiaries, and a shift to less progressive sources of Medicare financing.

***Health Savings Accounts.*** The conference committee proposal will rename (and expand) medical savings accounts, calling them Health Savings Accounts. These tax-advantaged savings accounts are likely to erode comprehensive employer-based health insurance for people under 65, substantially increase premiums paid by those who want to buy comprehensive health insurance, shift out-of-pocket costs to the sick, and provide an inappropriate and expensive tax shelter for the wealthy.

**Conclusion.** Medicare beneficiaries have waited for a long-time for relief from the financial burden of high prescription drug costs, and are desperate for some relief. **When Congress set aside $400 billion (over ten years) to address the problem, we understood that whatever proposal emerged would be able to address only a fraction of the problem. Because the Conferees failed to adopt a plan that curbs prescription drug expenditures, and instead developed a model that relies on an insurance industry eager to see Medicare privatized while collecting more government subsidies, Consumers Union reluctantly concludes that, on balance, Medicare beneficiaries will be severely harmed by this proposal.** We urge consumers to request their Representatives and Senators go back to the drawing board to enact legislation that meets the needs of seniors and the disabled, not legislation that is shaped by special interests.

## OVERVIEW

After several years of failed attempts, Congress appears "ready" to get Medicare prescription drug legislation enacted this year. Indeed a reported "deal" has been announced by the conference committee and by Congressional Leaders. There are numerous controversial and complex issues in play, issues that impact Medicare beneficiaries' health and financial well-being profoundly, yet it is challenging for the average person, even individual Members of Congress, to understand the implications of the proposed "deal."

The goal of this report is to assess the effect of elements of the possible conference committee agreement – as we best understand them – on consumers. It is our understanding that the Leadership plans to rush this important legislation to the floor for votes in the House and the Senate very quickly. **We believe that it is vital for the American public – and individual Members of Congress – to understand the provisions of the bill before a vote is taken.** We can not be certain that this report reflects all permutations of the latest agreement, but we believe that it is important to provide the public with our analysis of the best information that we have.

When the history of this year's Medicare debate is written, several pivotal decisions that shaped the direction of the legislation must be noted:

- The Congressional Budget Resolution (H.Con.Res.95) reserved $400 billion for 2004-2013 for a Medicare prescription drug benefit. This represents 22 percent of the amount Medicare beneficiaries are expected to spend on prescription drugs during this time period, setting the stage for a modest benefit, at best.[2]
- Both the Senate and the House passed bills that rely on a private insurance and private health plan model that precludes, and the bill even literally prohibits, the federal government from using its purchasing power in the marketplace to negotiate deep discounts on behalf of Medicare beneficiaries; this means that prescription drug expenditures can be expected to continue to grow at double digit rates (and pharmaceutical company profits will soar).
- The bills in both the House and the Senate heavily subsidize private insurance companies and private health plans, and build in dependence on their participation. This structure guarantees that there will be a perpetual flood of special interest lobbyists, coupled with multi-million dollar advertising campaigns that tug at the heartstrings) coming to Congress year after year for more subsidies, threatening that seniors and the disabled will lose their drug coverage if Congress does not pay up.

As the public considers the merits of this legislation, and as Members consider how to vote, they must weigh the pro's and con's of the bill. Below are the best and worst features of the agreement, as we understand it.

**Best features of the agreement:**

- Provides meaningful prescription drug coverage for very low-income individuals with incomes below 150 percent of the federal poverty level, provided they can pass the bureaucratic hurdles and have very low assets.
- Provides prescription drug coverage through Medicare for those "dual eligibles" who are eligible for both Medicare and Medicaid (though many may face higher co-payments than they do now).
- Provides modest relief for the small percent of beneficiaries who have the highest (catastrophic) prescription drug needs (though they continue to face high out-of-pocket costs).
- Provides some relief for beneficiaries who now have no prescription drug coverage, or have high-priced medigap drug coverage, but relief will be modest and many will still face very high out-of-pocket costs.

**Worst features of the agreement:**

- Uses a model (and even explicit language) that precludes deep discounts for beneficiaries and assures that prescription drug expenditures will continue to spiral.
- The inadequate funding, failure to contain costs, and benefit design combine to mean that the benefit will be modest for most and skimpy for many; the benefit will not meet the public's expectations for comprehensive coverage that is similar to what Members of Congress enjoy. Millions will face large out-of-pocket costs because of the large gap in coverage (the doughnut).
- Subjects about one quarter of Medicare beneficiaries in 2010 (possibly earlier) to pressure to leave traditional fee-for-service Medicare, where they have freedom to choose their own doctor, by forcing traditional Medicare to compete with private health plans that limit choice of doctor and can offer lower premiums because they cherry-pick the healthy. (Private health plans' reimbursement levels do not adequately reflect the better-than-average health status of their enrollees, boosting HMO profits.)
- Will create a crisis atmosphere in about 2010 when projections show that funding from general revenues will exceed (at a future date) 45 percent of Medicare spending: likely to lead to cutbacks in Medicare benefits, increased cost-sharing, and increased reliance on relatively regressive financing sources.
- Creates a new tax shelter that will benefit the wealthy, to create health savings accounts; unprecedented tax policy that will undermine the provision of comprehensive policies by employers, drive up premiums for those who want comprehensive coverage, and shift costs to people under 65 who have existing health conditions.

- The model is premised on reliance on private insurance plans and private health plans to provide coverage, continuing the practice of over-paying private companies (by failing to take into account the lower costs of their enrollees), guaranteeing that special interests will come to Congress to lobby for more money (and threatening to cut back coverage otherwise).
- State governments will not be able to attain the prescription drug discounts achieved under Medicaid, since dual eligibles will be in Medicare.
- Millions of dual eligibles (including nursing home residents) will face higher co-payments than they pay today, and these co-payments will increase over time.
- Variation of actual "benefits" because of secret and private formularies used by the pharmaceutical benefit managers (PBM's). Lists of covered drugs will vary from plan to plan and from region to region. Selection of drugs for the formularies need not be based on scientific evidence, but can be based on secret deals that are hidden from the public and regulators. PBM's will have no accountability to the public or government and their business dealings will lack transparency. Conflicts-of-interests will cost taxpayers billions of dollars.
- Weak "federal fallback" provision means that beneficiaries in an area that lacks true private competition of drug-only plans (i.e., with just one drug-only plan and one "integrated plan") will not be eligible for Medicare fallback coverage. No assurance that the premium for the drug-only plan will be anywhere near the $35/month estimate. In other words, if a region has one drug-only plan, charging $70 a month, and one preferred provider plan (PPO) that severely restricts one's choice of doctor, there would be no federal fallback plan.
- The cutoff in eligibility for low-income subsidies is very low: an individual with income above $13,000 and a couple with income above $16,300 will be ineligible for the low-income subsidy (2002 federal poverty levels).
- Millions of people with comprehensive retiree drug coverage will lose this coverage, and will end up with a Medicare policy that is much less comprehensive. (Retiree coverage is typically comprehensive, without a "doughnut" in coverage; the proposed benefit structure, which does not count retiree plan payments toward the catastrophic level, is likely to lead many employers to drop their retiree coverage. The conference agreement's additional subsidies for employers is unlikely to eliminate this problem.)
- May weaken the existing quality reporting standards for private health plans, hindering consumers' ability to make informed decisions about private health plans and undermining the premise that choice of health plan is good for consumers.
- Results in continued profitability for the pharmaceutical industry (guaranteeing larger markets without governmental pressure to restrain prices) while asking nothing for the public good in return.

**It is troubling indeed that the elements on the "best list" come with caveats that mean that the good things are not as good as they should be. It is nothing short of tragic that legislation that was meant to offer relief to Medicare beneficiaries comes laden down with so many provisions that will harm Medicare beneficiaries and even threaten Medicare's long-term viability**. The next section considers the impact of the conference agreement on ten critical issues for consumers.

## HOW DOES THE MEDICARE PRESCRIPTION DRUG BILL AGREED TO BY CONFERENCE COMMITTEE MEASURE UP FOR CONSUMERS?

This section analyzes how the conference committee agreement affects ten key consumer issues, ranging from the adequacy of the benefit to the impact of provisions to privatize Medicare.

### 1. Adequacy of Benefit

As discussed below, Medicare beneficiaries with very low income (individuals with income below $13,000 and couples with income below $16,300) will be eligible for substantial subsidies for their prescription drugs. All Medicare beneficiaries with income above this level – which includes many millions of seniors and disabled who would be considered to have a fairly modest income and standard of living – would be eligible for policies with the following parameters:

- $275 deductible
- $35/month premium (estimated, not guaranteed)
- 75 percent benefit/25 percent cost-sharing on expenditures above deductible up to $2,200
- Gap in coverage (doughnut) for expenditures between $2,200 and $5,000
- 95 percent coverage/5 percent cost-sharing for expenditures after $5,000, when out-of-pocket costs total about $3,600.

A person's perception of the adequacy of this benefit will depend in part on what kind of coverage they may be eligible for when this is implemented in 2006. Those currently covered by retiree plans will not benefit from this plan. Employer-based coverage typically provides modest co-payments with coverage often around 75 percent of costs, often with no deductible, and without any doughnut. Often, employer plans have a cap on total out-of-pocket costs, including prescription drugs along with other types of health spending. Those who currently have employer-based coverage will be disappointed with this benefit, especially if their employer drops their coverage (which they feel they have earned) and leaves them with less drug coverage than they now have.

A few million Medicare beneficiaries have medigap coverage that includes a limited first-dollar prescription drug benefit. Medigap coverage pays first dollar coverage, paying 50 percent of the cost, up to a maximum payment of $1,250 or $3,000, and extra premiums for this coverage often exceed the maximum benefit.[3] These beneficiaries will face a new $275 deductible, and then will face the same coinsurance amount that they currently have. The catastrophic coverage (which affects a small portion of beneficiaries) will be an improvement. In light of the deep subsidies and this catastrophic coverage, the new Medicare drug benefit will be an improvement to those with Medigap drug coverage in a standard plan, assuming they are able to qualify for a medigap policy (without drug coverage) at a substantially lower premium. Whether they will in fact save substantial money on their medigap premiums depends on the details of the legislation and the marketplace responses by medigap insurers.

The analysis in this section focuses on an important subset of Medicare beneficiaries: those who have *no* other prescription drug coverage (roughly 12 million people), and are not eligible for low-income subsidies. From a consumer point of view, perhaps the most important measure of effectiveness of a Medicare prescription drug bill is its impact on out-of-pocket costs. We assumed that prescription drug expenditures would continue to grow at the historical rate of increase, the same rate at which they have grown between 1997 and 2002.[4]

The proposal's modest benefits coupled with an expected high growth of prescription drug prices could result in major disappointment for many of these Medicare beneficiaries. Medicare beneficiaries in most prescription drug expenditure levels will actually face higher out-of-pocket costs when they have coverage in 2007 (one year after the bill is implemented) than they do in 2003 (when they do not have coverage). All estimates of out-of-pocket costs in 2007 are adjusted for inflation and are expressed in real 2003 dollars.

Chart 1 shows how out-of-pocket drug expenditures compare over time (2003 vs. 2007) for a person who lacks prescription drug coverage in 2003, but has the new Medicare prescription drug coverage in 2007. We assume that prescription drug expenditures grow at historic rates (17 percent). 2007 costs are adjusted for overall inflation and are expressed in 2003 dollars. The scatter diagram shows 2007 out-of-pocket expenditures as a percent of 2003 expenditures. Points above the 100 percent line are for expenditure levels for which 2007 out-of-pocket costs are *higher* than they are in 2003, despite the new benefit. Points below the 100 percent line (for the most part at drug expenditure levels in 2003 of $4,000 and more) represent those whose out-of-pocket burden is lower in 2007 than in 2003. The prevalence of points "above the line" for spending in the range of $1,500 to $4,000 reflect the absence of benefits over the doughnut range.

The benefit design, and the assumption of continued growth in expenditures combine so that people at most expenditure levels actually face out-of-pocket expenditures in 2007 (when they would have coverage) *greater* than their out-of-pocket expenditures in 2003 (when they have no drug coverage). Those with expenditures at the catastrophic level get measurable relief: at total drug spending of between $5,000 and $10,000, 2007 out-of-pocket costs are 46 to 83 percent of 2003 expenditures.

**For Many Consumers, Conference Committee Prescription Drug Proposal Does Not Lower Out-of-Pocket Costs**

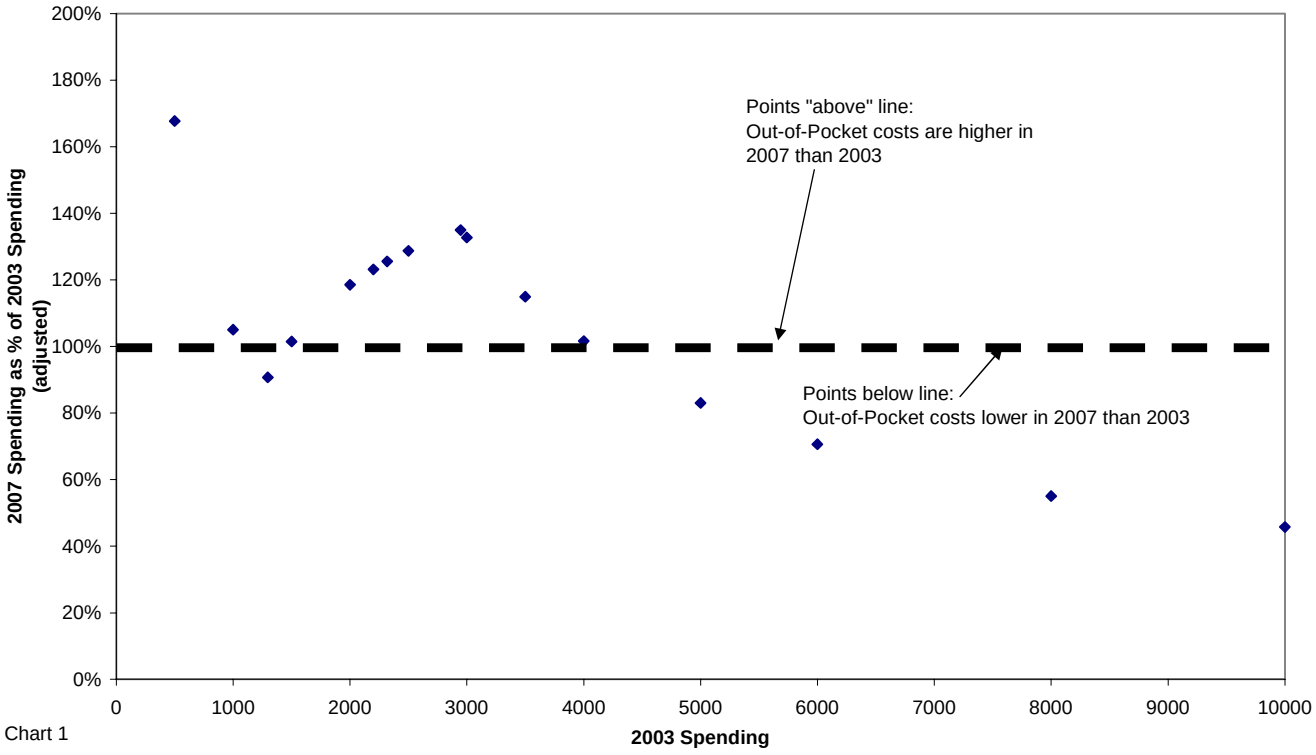


Chart 1

The remaining charts in this section contrast 2003 prescription drug spending (for a beneficiary with no drug coverage) and 2007 out-of-pocket drug spending, adjusted to 2003 dollars. Most beneficiaries will face higher out-of-pocket costs for prescription drugs after full implementation, despite the benefit. Those with catastrophic expenditures will experience some modest relief. These charts are for beneficiaries not eligible for additional low-income subsidies. Specifically, we found:

- The average Medicare beneficiary (without prescription drug coverage) spending $2,318 in 2003 would find that his or her out-of-pocket costs for prescription drugs (including: premium, deductible, co-payments, and "doughnut") are higher in 2007, despite the new prescription drug benefit, and would total $2,911 in 2007 (real 2003 dollars).
- A Medicare beneficiary with relatively low expenditures in 2003 of $500 (i.e., bottom third of spending) would find that his or her out-of-pocket payments for prescription drugs are $838 in 2007 (real 2003 dollars).
- The beneficiary in the middle third of spending has prescription costs of about $1,500 in 2003, and this person would find that his or her out-of-pocket spending for prescription drugs is $1,522 in 2007 (real 2003 dollars).
- A person in the top third of prescription drug spending, with costs of $3,000 in 2003, would find his or her out-of-pocket costs reach $3,981 in 2007 (real 2003 dollars).
- A person with prescription drug expenditures in the catastrophic range, $6,000 in 2003, would face *reduced* out-of-pocket spending of $4,235 in 2007 (real 2003 dollars).
- If prescription drug expenditure growth moderates from historical levels to 12 percent per year, then the average Medicare beneficiary will face out-of-pocket costs in 2007 of approximately the same level as those of 2003, even after enactment of a Medicare prescription drug benefit ($2,318 in 2003; $2,281 in 2007).

Charts 2 through 6 show how 2007 out-of-pocket costs (including deductible, premium, coinsurance, and doughnut) compare with 2003 out-of-pocket costs, for a person without drug coverage in 2003, based on the conference committee proposal. Drug expenditures are assumed to continue to increase at recent rates of 17 percent per year.

**Conference Committee Proposal:**
**Average-Spending Beneficiary (without prescription drug coverage)**
**Faces Increased Out-of-Pocket Costs**

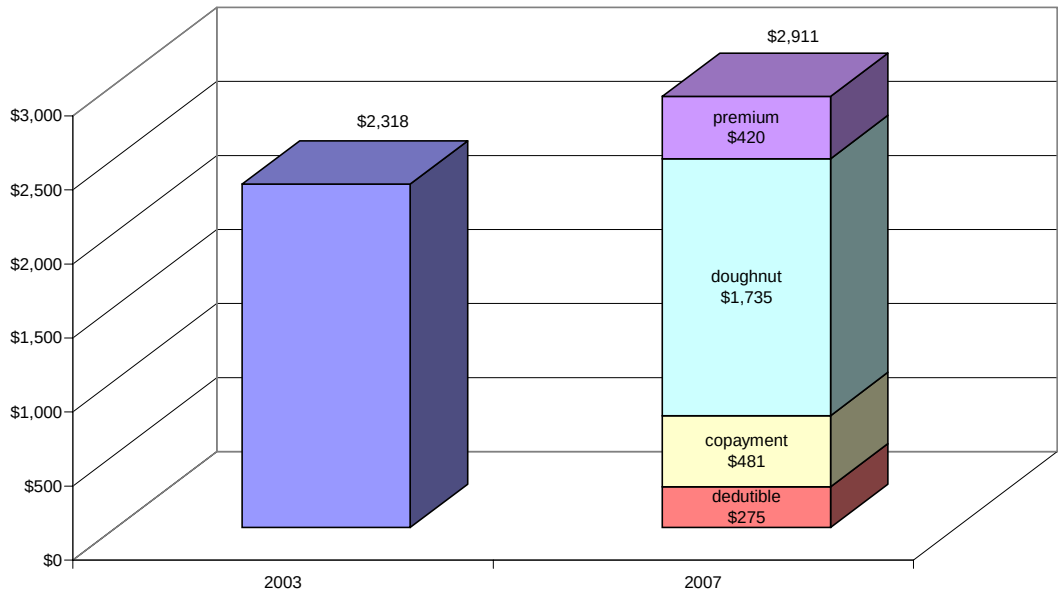


Chart 2

**Conference Committee Proposal:**
**Beneficiaries with Low Expenditures Face Increased**
**Out-of-Pocket Cost in 2007**

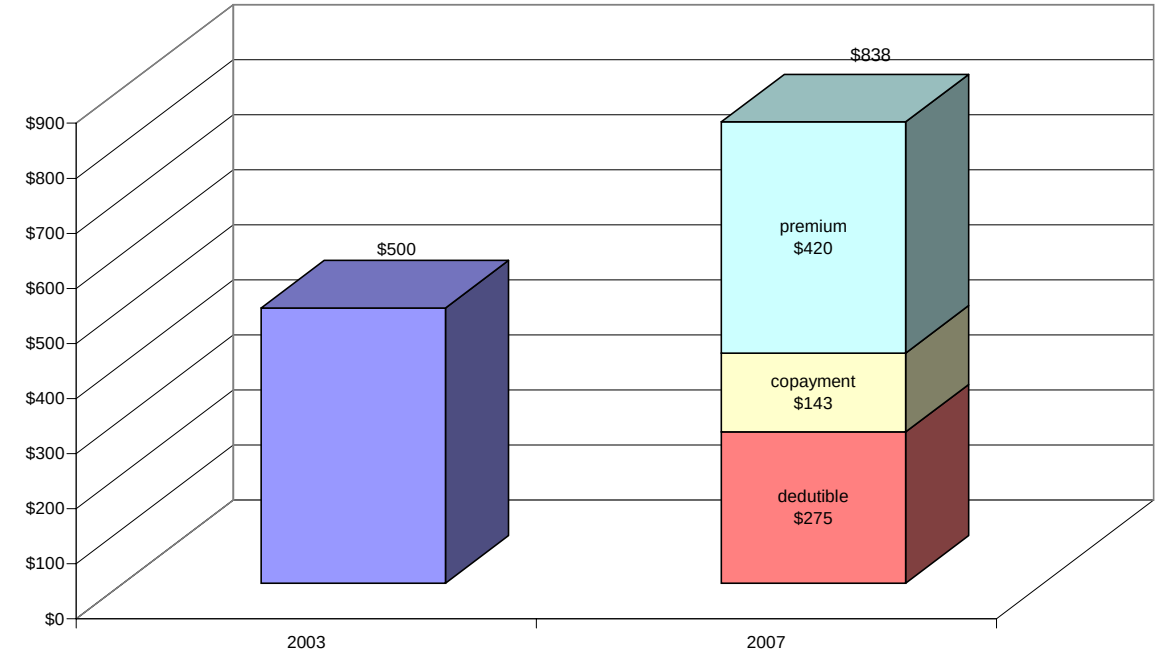


Chart 3

**Conference Committee Proposal:**
**Spender in Middle Third Pays More in 2007**

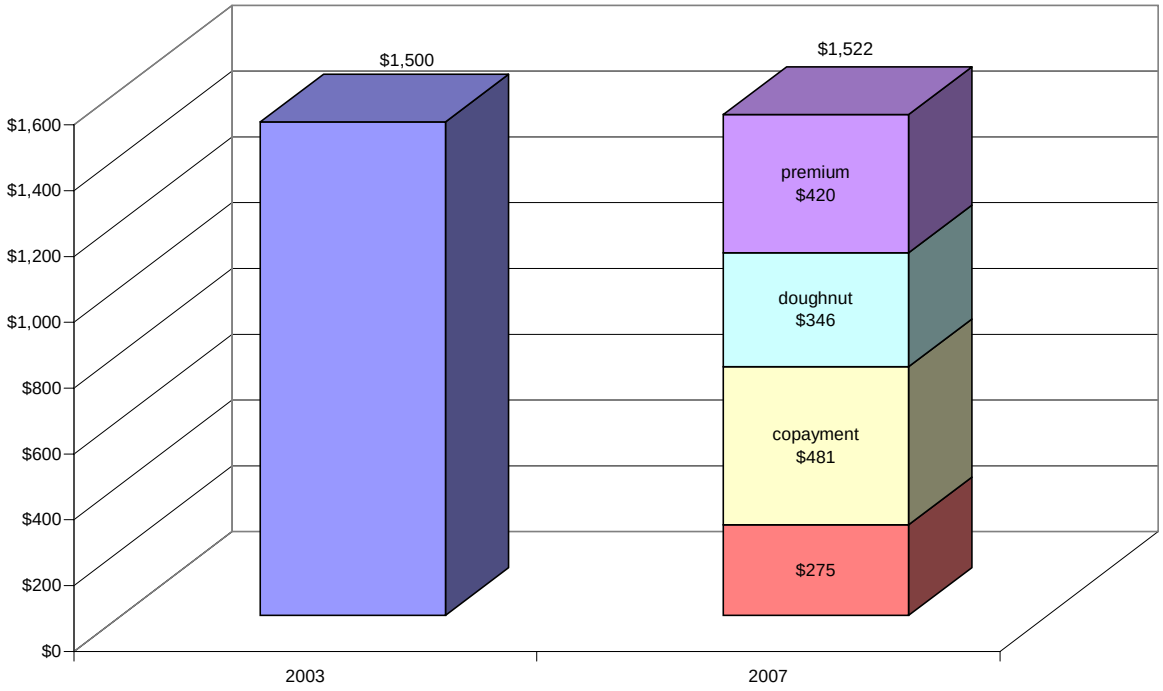


Chart 4

**Conference Committee Proposal:**
**Beneficiary (without prescription coverage in 2003) with High Spending**
**Faces Increased Out-of-Pocket Costs**

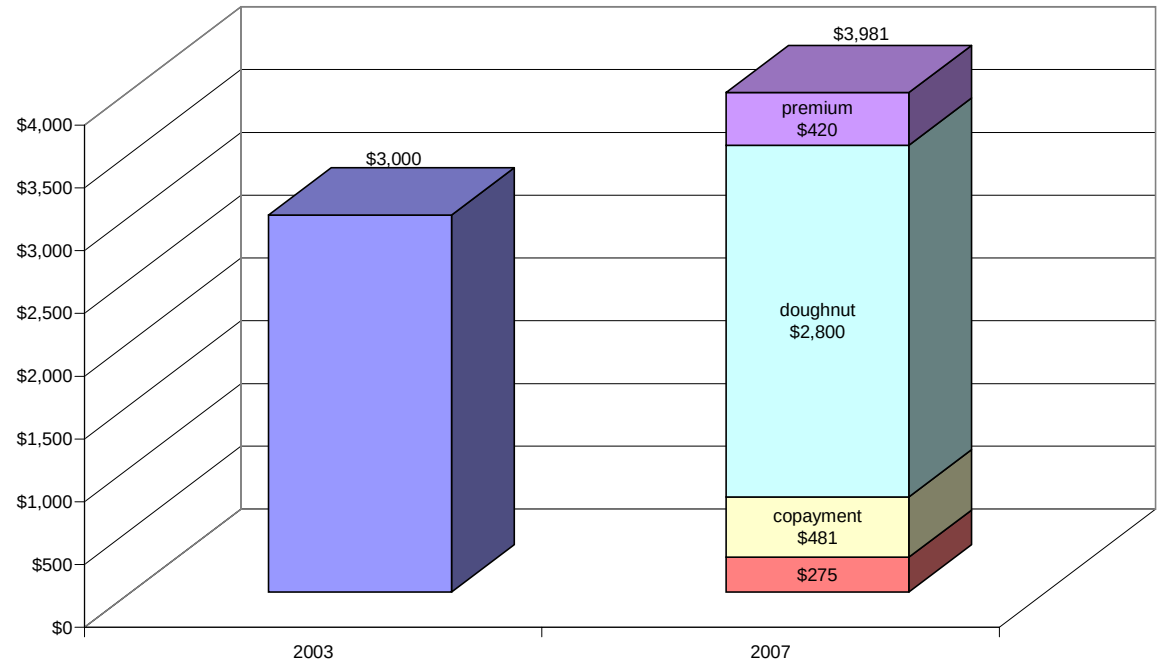


Chart 5

**Conference Committee Proposal:**
**Person with Catastropic Needs Gets Modest Relief**

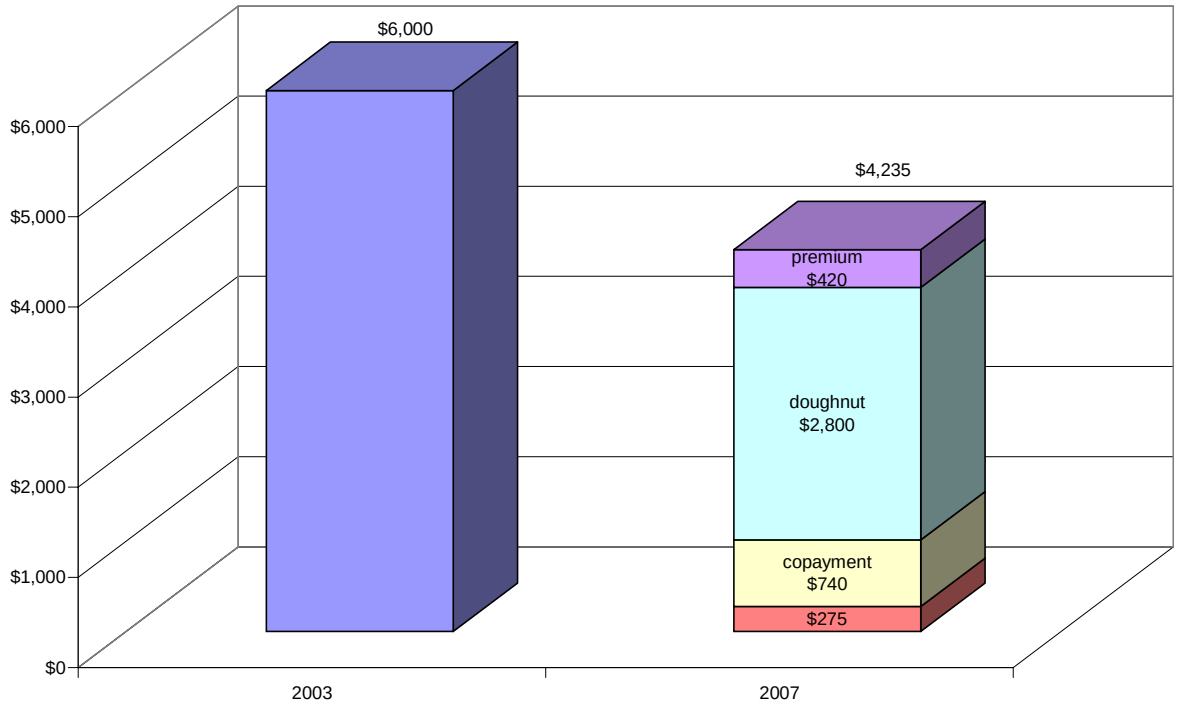


Chart 6

What if prescription drug expenditures grow at rates lower than the historical rate of growth of 17 percent? Table 1 below compares out-of-pocket costs in 2007, at varying prescription drug expenditures, assuming that expenditures grow at 17 percent and at 12 percent, much lower than historical rates.

Table 1
Out-of-Pocket Costs and Benefits:
Conference Committee's Benefit Structure
At Various Drug Expenditure Levels
(Historical growth of prescription drug expenditures)

| 2003 Expenditures (no prescription drug coverage) | Total out-of-pocket costs in 2007, 17 percent annual growth (including premium) | Total out-of-pocket costs, 2007, 12 percent annual growth (including premium) |
|---|---|---|
| 0 | 420 | 420 |
| 500 | 838 | 804 |
| 1500 | 1522 | 1161 |
| 2318 | 2911 | 2281 |
| 3000 | 3981 | 3253 |
| 6000 | 4235 | 4154 |

Lower growth in prescription drug expenditures results in more Medicare beneficiaries experiencing some relief as measured by real (2003 dollars) out-of-pocket prescription drug costs. Someone with average spending in 2003 would have approximately the same level of out-of-pocket costs in 2007 and 2003, despite the new benefit, with 12 percent growth. Individuals with spending of around $1,500 would experience modest relief; individuals spending $3,000 in 2003 would face somewhat higher out-of-pocket costs in 2007.

Appendix A includes a table that shows both the out-of-pocket cost breakdown, and the benefit breakdown, of this proposal at various levels of prescription drug expenditure and at rates of prescription drug expenditure growth of 17 percent and 12 percent per year.

**Calculate *your* out-of-pocket costs, with *your* own projection of growth in prescription drug expenditures**

Whether an individual will experience true relief from the burden of prescription drug costs depends on two key factors: the assumed average rate of growth of prescription drug expenditures, and the individual's anticipated prescription drug expenditures. By

going to the following website, you can enter your own assumption about the rate of growth of expenditures, and your anticipated prescription drug expenditures, in order to calculate what your out-of-pocket costs are likely to be in 2007 when this bill is implemented. Note that this calculator adds all out-of-pocket costs: premium, deductibles, and doughnut.

**Calculator:**

To calculate what *you* will pay
Out-of-pocket for drugs in 2007, go to:

http://defazio.house.gov/medicarerxcalc.html

**Pharmacy Benefits Managers (PBM's).** While hospital and doctor coverage through Medicare tends to be equivalent regardless of where you live (other than variations through Medicare+Choice), the proposed prescription drug program would result in widely varying coverage because of the role for private PBM's, which would select drugs for the plans' formulary. Formularies will be free to select drugs (with perhaps only one drug available for a therapeutic category) on any basis that they like, with no transparency of methodology, and no accountability to the public. Patients with, for example, mental illness, who are sensitive to the choice of drug, will be out-of-luck if their needed drug is not on the formulary. Drug coverage will vary within a region (in different plans) and between different parts of the country. The whole notion of a standard Medicare benefit will be undermined. Researchers at the Loyola University Chicago Law School estimate that the cost to taxpayers of the conflict of interest (when PBMs both administer the benefit and sell drugs to the health plan) range from $14.5 billion to $29 billion over 10 years.[5]

**In sum: The new Medicare benefit will be considered at best modest (e.g., for those who now have drug coverage through medigap) and at worst skimpy (e.g., for those who lose more comprehensive employer coverage or have no coverage at all for drugs). The continued growth of prescription expenditures and the benefit design combine to mean that many beneficiaries will face higher out-of-pocket costs (when they *have* this new coverage) than they do today (when they have not drug coverage), if prescription drug expenditures continue to grow at recent levels (17 percent per year). Coverage will vary from plan to plan, because private pharmacy benefit managers are free to limit the drugs on their formulary (i.e., list of drugs that are covered), without basing decisions on science and without accountability to the public.**

## 2. Prescription Drug Cost Containment

2001 marked the seventh consecutive year of double-digit expenditure growth for prescription drugs.[6] The conference committee proposal, like the underlying House and Senate bills, uses a private marketplace model that precludes putting the extensive purchasing power of the federal government to work to negotiate low prices for the benefit of consumers and taxpayers (e.g., models used by the Veterans Administration and Medicaid.) It relies on voluntary participation of health insurers in the private marketplace, an approach that is unlikely to yield deep discounts and is fraught with questions about transparency and accountability to the public interest.

In addition, the conference committee proposal, like the underlying House and Senate bills, explicitly *prohibits* the federal government from negotiating low prices on behalf of beneficiaries.[7] This provision will prevent the type of negotiating that enabled Department of Health and Human Services Secretary Thompson to secure a discount of 80 to 84 percent from the average wholesale price of Cipro during the anthrax crisis of 2001. This reduction in price came at a time of national emergency. Undoubtedly, Bayer was concerned that it not appear to be profiteering at the time of crisis. Nevertheless, it provides a benchmark for potential discounts that can be achieved if the federal government puts its negotiating and purchasing power to work on behalf of the public.

Developments in the states illustrate the potential savings that can result from the pooling of purchasing power. Vermont, Michigan, and South Carolina joined forces to get favorable prices for their combined pool of 1.5 Medicaid beneficiaries. A Vermont state staffer reported that by joining together, the three states managed to save 25 to 50 percent more than they had saved previously, when they implemented preferred drug lists separately.[8] State Medicaid directors are concerned that under the proposed legislation, they will be unable to use cost containment measures that have helped contain their Medicaid prescription drug costs, since the program for dual eligibles will be administered through Medicare.[9]

Covering "dual eligibles" under Medicare, not Medicaid, as provided in the conference committee proposal is beneficial in that it preserves the universality of Medicare and avoids treating those with low-incomes as second-class citizens. However, one possible drawback is that the program may end up paying higher prices for drugs than have been achieved by many state Medicaid programs.

**Generics.** Both the House and the Senate bills had an important provision that would close some of the loopholes that delay the introduction of generic drugs. The Congressional Budget Office has scored the savings of both the House and Senate provisions (beyond the effect of the FDA rule of 2003) to be $7 billion from 2004 to 2013. [10] This provision is important and benefits not only Medicare beneficiaries but all

consumers. At times, it appeared that the conference committee was poised to exclude this important provision, costing both Medicare beneficiaries, taxpayers, and those under 65 billions of dollars. The November 14, 2003 Wall Street Journal headline correctly depicts the influence of the pharmaceutical industry: "Big Drug Firms Gain in Medicare Talks."[11] Later that day, pharmaceutical company stocks increased dramatically.[12] As of November 17, 2003, there are indications that the language to close the loopholes may be included in the agreement, but the fine print will be important to determining the strength of the provision.

**Reimportation.** U.S. consumer anger and frustration about paying the highest prescription drug prices in the world has lead many to resort to the illegal purchase of their medicines from Canada. For many, this "illegal" activity is viewed as preferable to going without their medicine because of its unaffordable price. Reimportation of drugs from other countries is at best a short-term solution because over time, more drug companies will cut their sales to Canada, and prices in Canada are likely to increase if sales to the U.S. become a large share of the market. There are indications that the Canadian government may step in to end this practice, to protect the interest of the Canadian public who may face supply restrictions when pharmaceutical companies cut shipments to Canada. It is essential that policymakers in the U.S. stay focused on steps that can be taken to improve the value that U.S. consumers and taxpayers get for their prescription drug dollars. The CBO has projected sizable savings *for all payers of prescription drugs* totaling $40 billion over 10 years from H.R. 2427, the bill that would allow for expanded reimportation of prescription drugs, without requiring the Food and Drug Administration to certify the safety. The conference committee proposal would allow reimportation from Canada only, and allows the Secretary of the Department of Health and Human Services to block the reimportation of medicines from Canada. Some call this "safety certification" or reimported drugs a "poison pill" that blocks low-cost drugs for U.S. consumers.

**Discount Drug Cards.** The conference committee agreement would establish a drug discount card program aimed at helping beneficiaries get discounts during 2004 and 2005, before the new Medicare program is implemented. The policy issues involved even in this limited effort are huge, [13]and the potential savings are relatively modest at best. Consumer Reports has concluded that for the most part, consumers can save more money by careful comparison shopping for low prices for their medicines than they can through existing discount drug cards. It is unclear whether the cards that develop will make use of formularies that meet consumers' needs. Modest discounts, even at the optimistic levels (10 percent to 25 percent) projected by the Administration, are no substitute for the federal government putting its purchasing power to work for consumers.

**In sum: The conference committee proposal is premised on a private marketplace model that precludes the benefit of deep discounts possible through the pooled**

**purchasing power of the federal government. Growth of prescription drug expenditures is likely to continue at double-digit rates, with U.S. consumers continuing to pay prices higher than those in Canada and Europe. The Secretary of Health and Human Services can block the reimportation of medicines from Canada.**

### 3. Undermining the Universality of Medicare

During consideration of the Medicare legislation, proposals have surfaced that would undermine the universality of the Medicare program in various ways. The Senate bill would have prevented "dual eligibles" (those eligible for both Medicare and Medicaid) to get their coverage through Medicaid, not Medicare. (See section 6 below). Another very troubling proposal (in the House bill) would have linked benefits to income. The conference committee proposal includes a provision to link Part B premiums to income.

**Part B premiums**. Our understanding of the conference committee proposal is to relate Part B premiums to income, with individuals with income of $80,000 or higher to pay a larger share of the Part B premium, regardless of whether they sign up for the new prescription drug benefit. It is important to consider whether the additional revenue (which is not likely to be substantial in light of the relatively low income of most seniors) is worth the extra administrative costs and possible privacy incursions that will be necessary to implement it. It is critical that all beneficiaries continue to have an incentive to remain in Part B, so as not to fragment the risk pool. Any means-testing of premiums should be administered through the IRS and federal taxes, in order to reduce the potential for privacy incursions. It is important to consider this in the context of the progressivity that already exists in the financing of Medicare benefits: during working years, higher income taxpayers pay Medicare taxes proportional to their income (hence those with high incomes pay more); in addition, general revenues, which fund 75 percent of Part B and all of Part A are collected progressively across income, both earned income and unearned income. Finally, another consideration is whether income-relating the Part B premium will open the door to the slippery slope of means-testing the Medicare benefits, would violate the principle of Medicare as a universal program.[14]

**Means-testing of benefits.** H.R. 1 would have curtailed catastrophic benefits for individuals with income above $80,000 and couples with income above $160,000. This proposal would have severely compromised the universality of the Medicare program; fortunately, the conference committee proposal does not include this provision.

**In sum: The conference committee proposal rejected the most dangerous provisions that would have eroded the universality of the Medicare program (means-testing of benefits, coverage of dual eligibles through Medicaid), but has opened the door to reduced participation in Medicare of those with high incomes by relating Part B premiums to income, thereby reducing their Part B subsidy. The administrative complexity and potential for privacy incursion may be a high price to pay for very**

**little additional revenue for the Medicare program which already has relatively progressive financing.**[15]

## 4. Role of the Private Marketplace

Ever since the establishment of Medicare, people who prefer a larger role for the private sector and a smaller role for the public sector have sought to expand the role of private health plans in Medicare. They often frame the issue as "freedom of choice," without recognizing that most consumers value freedom of choice of doctors and hospitals more than freedom of choice of different health plans. A Kaiser Family Foundation/Harvard School of Public Health poll found that 68 percent of people 65 and over said that having choice of doctors and hospitals was most important to them personally, while 19 percent indicated choice of different health plans was most important.[16]

It is important to understand the history of subsidies to private plans as well as several of the proposals under consideration in order to have the context in which the conference committee proposal should be considered.

**History of subsidies to private plans.** Since the early days of encouraging participation of Medicare HMO's, the government has overpaid private plans, failing to recognize that private plans tend to experience favorable selection, by attracting relatively healthy enrollees and thereby paying out less costly benefits.

Both H.R. 1 and S.1 would continue the practice of overpaying private health plans that participate in Medicare, with the hope of providing financial incentives for private health plans to offer coverage. The Congressional Budget Office estimated that subsidies to private health plans such as health maintenance organizations (HMO's) and preferred provider organizations (PPO's), "Medicare Advantage and Enhanced Fee-For-Service" plans under the House bill and "MedicareAdvantage" plans under the Senate bill) and other plans would increase direct spending by $7.5 billion in H.R. 1 and $18 billion in S. 1.[17] The approach adopted by the conference, consistent with both the House and the Senate bill, is to in effect "bribe" private plans to participate, by paying them subsidies that far exceed what the cost of covering these beneficiaries would be under Medicare. CBO has not yet scored the subsidies in the conference report, but they are likely to be substantial (perhaps between the figures in the House and Senate bills). These extra payments to private plans are unlikely to improve health care quality, and perpetuate the congressionally sanctioned bias in favor of the private marketplace, even when the private sector has proven an unreliable partner by discontinuing plans and cutting back benefits.

Ever since the early days of Medicare, there has been pressure to introduce private health plan participation. A recent report by the National Academy of Social Insurance[18] documents how expanded reliance on private health insurance plans resulted in

overpayments by taxpayers without improvements in quality of care. Private Medicare+Choice plans have a history of shifting costs to enrollees, cutting benefits, and increasing premiums.[19] The Medicare Payment Advisory Commission recently found that as a result of enrollment of relatively healthy beneficiaries, private Medicare + Choice plans have costs 16 percent lower than those in traditional Medicare.[20] Time after time, providers and health plans have come to Congress with requests for more money, even when the General Accounting Office was reporting overpayments to HMOs. For example:

- 1972 legislation set payment rates to Medicare HMO's at 95 percent of the adjusted average per capita cost. Studies in the 1980's showed "favorable selection" that resulted in Medicare paying 15 to 33 percent more than it would have had the private plan enrollees been in fee-for-service plans.[21]
- In 1998, the GAO reported to Congress that spent about $1,000 more per beneficiary enrolled in Medicare + Choice than it would have if they had been in fee-for-service. Yet lobbying by health plans and providers led to increased payment concessions ("give-backs") to the private health plans.[22]
- In 2000, the GAO concluded: "The Medicare +Choice program has already been expensive for taxpayers…the vast majority of plans have gotten paid more for their Medicare enrollees than the government would have paid had these enrollees remained in the traditional fee-for-service program. ... In our view, efforts to protect the viability of Medicare+Choice plans comes at the expense of ensuring Medicare's financial sustainability in the long term."[23]

**Premium support proposals:** It is important to understand the underlying House bill's premium support proposal, because the conference committee agreement has a similar impact, albeit on a smaller scale initially. The House bill would not only increase the role of private companies in Medicare by increased subsidies for private health plans, but it would also set up competition between private plans and traditional Medicare in the year 2010. Because people who are chronically ill or at high–risk of illness tend to value the freedom of choice of doctor allowed in traditional fee-for-service Medicare, this proposal will lead to a fragmentation of Medicare beneficiaries, with devastating impact on premiums for those who wish to remain covered by traditional Medicare. The Health and Human Services actuaries estimated that seniors and disabled in traditional Medicare could face premiums increases of 88 percent or more in 2013 if the premium support competition proposal in H.R. 1 were enacted.[24]

In addition, premiums would vary considerably across the country, undermining the universality of the Medicare program. For example, monthly Medicare premiums would range from a low of $56 in Davidson County, North Carolina to $200 in Jefferson Parish, Louisiana. Premiums could even vary within a state, e.g., from $65 in Yolo County, California to $142 in Los Angeles County, California.[25]

With the type of premium increase projected for traditional Medicare, many beneficiaries will be forced for financial reasons to switch to the private plans. The "cherry-picking" of the relatively healthy will continue, and the "death spiral" is likely to continue. The financial viability and survival of traditional Medicare – the coverage that provides beneficiaries with the maximum freedom of choice of doctor – will be threatened.

**Provision relating to percent of Medicare funding from general revenues.** A new proposal surfaced from conferees, reported in the press on November 12, 2003. If it turned out that expenditures from the Medicare prescription drug plan exceeded projections (which are estimated to total $400 billion between 2004 and 2013), then the premium support competition system would begin, starting with the regions of the country in which at least 30 percent of beneficiaries is enrolled in private plans. This proposal is flawed for several reasons:

- The cost estimates are likely to be exceeded because the legislation has inadequate provisions to contain costs.
- It has all of the disadvantages of full premium support, including large increases in premiums for those who wish to remain in traditional fee-for-service Medicare.
- It will result in unfair variation in Part B premiums, both within and between different states.
- Starting with regions in which there a significant percent of beneficiaries enrolled in private plans may mean that "cherry-picking" and adverse selection will result in very large increases in premiums for those wishing to remain in traditional coverage.

**Conference committee proposal.** As we understand the conference committee proposal, the premium support competition model would begin in four to six metropolitan statistical areas (MSA's) and possibly one region in which Medicare enrollment is at least 30 percent (MSA's) or 20 percent (regional). There are areas in California, Arizona, Florida, Oregon, and New York that are likely to qualify for this competition. This is a dangerous first-step toward full-scale competition between private carriers and traditional Medicare. It is likely to result in the fragmentation of the healthy from the sick, and substantially higher premiums for those who wish to remain in traditional Medicare. This proposal threatens the freedom of choice of doctor for millions of Medicare beneficiaries. The agreement includes the provision to create a Medicare "crisis" if the percent of Medicare costs from general revenues are projected to exceed 45 percent.

**In sum: By calling for competition between private health plans and traditional fee-for-service Medicare in 2010 in four to six metropolitan areas and possibly one region, the conference committee proposal takes a dangerous step toward privatization of Medicare, which could ultimately result in widely varying premiums across the country, financial pressure on beneficiaries to enroll in private plans that severely restrict choice of doctor, and burdensome premium increases for**

**beneficiaries who value freedom of choice of doctor and wish to remain in traditional fee-for-service Medicare. Instead of requiring private plans to demonstrate cost savings that result from efficiency, the proposal provides additional subsidies to private plans and even allows them to benefit financially from cherry-picking the healthy, perpetuating the shameful history of overpayments that have existed for many years.**

### 5. Millions will lose employer-provided coverage and end up with skimpier coverage

As noted earlier (see section 1), Medicare beneficiaries covered by employer-based retiree plans tend to have prescription drug coverage that is more comprehensive than the coverage in the conference committee proposal: typically, they have no deductible, 75 percent coverage, no gap in coverage (doughnut). The Congressional Budget Office has estimated that if the House or the Senate bills were enacted, four million retirees would lose their employer-based coverage, ending up with far less generous coverage than they now have. This is because the benefit structure would not count costs reimbursed by retiree plans toward the catastrophic limit. In response, many employers are expected to drop drug coverage from their retiree health plan. While the conference proposal has made slight adjustments, it is anticipated that millions of beneficiaries could be in the sad position of losing employer coverage and having to settle for less comprehensive prescription drug coverage.

**In sum: The conference committee proposal could cause millions of Medicare beneficiaries to lose generous retiree sponsored prescription drug coverage and will end up with considerably less generous coverage than they currently have.**

### 6. Those Eligible for Medicaid and Medicare

The conference committee has adopted the House provision to cover "dual eligibles" (more than 7 million people who are eligible both for Medicare and Medicaid benefits) through the Medicare program. This is significant because it helps to preserve the universality of the Medicare program, and assures that those with the lowest-incomes will benefit from "first-class" treatment, not second-rate care in a means-tested program.

However, as we understand the proposal, it includes language that would prohibit states from providing "wrap-around" coverage to the drug benefit. Currently, Medicaid provides "wrap-around" coverage that pays cost-sharing for dual eligibles. Many of the most vulnerable seniors and disabled will end up therefore with less drug coverage than they have today. This represents an erosion of our country's safety net, and is a fundamental change in Medicaid policy.[26]

States would experience budget relief if Congress were to shift all of the prescription drug spending for dual eligibles from the states to the federal government. If the entire responsibility for dual eligibles' prescription drugs were shifted, states would save an average 6 percent of their total Medicaid budget, totaling $40 billion in 2002.[27] The "clawback" proposal (a provision that requires state governments to pay a substantial share of the dual eligible drug costs), intended to assure that most new federal funding provides *new* prescription drug coverage, will substantially limit this relief. States will face increased administrative costs since they will be responsible for determining eligibility for the new low-income subsidy.[28]

**In sum: The conference committee proposal helps to preserve the universality of the Medicare program by covering dual eligibles in Medicare, not Medicaid. However, many Medicaid enrollees will find they have *less* coverage than they do now because the proposal prohibits states from providing "wrap around" coverage. ("Wrap around" coverage would fill in the gaps not covered by the Medicare benefit). The clawback provision (a provision that requires state governments to pay a substantial share of the dual eligible drug costs) limits the fiscal relief to states; with limited relief and additional administrative responsibilities, states may be forced to cut back health coverage for children and others under 65, under Medicaid and the state children's health program (SCHIP).**

### 7. People with Low-Income

Medicare beneficiaries with incomes too high to qualify for Medicaid eligibility, but still lower than 150 percent of the federal poverty level[29] (about $13,000 for a single person, about $16,300 for a couple, 2002 figures) will receive a substantial premium and cost-sharing subsidy under this proposal.[30] The reduction (from the Senate bill) of eligibility from 160 percent to 150 percent of poverty will mean that approximately 1.1 million seniors and disabled will lose eligibility for subsidies.

They will receive their benefit through the Medicare program. Like others, therefore, if a private plan is available where they live, their benefit (e.g., which drugs will be on the formulary) will depend on the secret decisions and deal-making made by the PBM selected by their insurance company. Their premiums, cost-sharing, and doughnut gaps will be subsidized; they will experience genuine relief from out-of-pocket costs, provided their drugs are on their PBM's formulary[31]. If they formerly had subsidized coverage through pharmaceutical companies or state programs, they will in the future get their coverage through the Medicare program.

Individuals with income above $13,000 (individual) and $16,300 (couple) will not receive any additional subsidies through the new Medicare program. Families with modest incomes will be hard pressed to pay the premiums for this coverage. If they do

enroll, they will get help with drug expenditures between $275 and $2,200, but they will be hard hit by the doughnut (for expenditures between $2,200 and $5,000).

The conference agreement uses a strict assets test that poses a barrier to receiving the low-income subsidy. The strict assets test is likely to perpetuate the long-standing problem that the most vulnerable seniors and disabled – those with the lowest income – will be deprived of the assistance that they desperately need due to "documentation and bureaucratic obstacles" that make qualifying for assistance extremely challenging.[32] An estimated 3 million beneficiaries will lose eligibility for subsidies due to the combination of the change in income level eligibility and the assets test.[33]

**In sum: While the conference committee proposal provides comprehensive subsidies to people with income below 150 percent of poverty, its failure to adopt the Senate bill's more generous eligibility limit of 160 percent combined with its strict asset test will preclude several million low-income beneficiaries from getting the financial relief that they need. Individuals with income above about $13,000 and couples with income above about $16,300 (2002 figures) will be unlikely to afford the coverage and are ineligible for additional subsidies.**

## 8. Federal Fallback

The conference committee proposal provides for fallback Medicare coverage under a fairly restrictive test: it would preclude a federal fallback in the event that there is one drug-only plan along with one preferred provider organization (PPO) Under S.1, there would be a federal fallback if there were less than two prescription drug plans available. The Congressional Budget Office estimates demonstrated the significance of the different approaches: It estimated that under the House bill, about 5 percent of participants would be enrolled in a fallback plan (and this percent would decrease over time). Under the Senate bill, the CBO estimates that one-third of Part D (drug benefit) participants would be enrolled in a fallback plan, a percentage that remains constant through 2013.[34] The absence of real competition under the conference (and House) approach make it very likely that people who live in these areas will be facing very high (in many cases unaffordable) premiums for the drug-only coverage (with no competition from other drug-only plans). Many beneficiaries in these areas may feel financial pressure to enroll in PPO's which will require them to pick a doctor they might not think is best, or pay a high price in terms of extra unreimbursed health care costs. The CBO has not released estimates of the number of beneficiaries likely to be enrolled in Medicare fallback plans, but it is likely to fall somewhere between the estimates for H.R. 1 and S. 1.

**In sum: The conference committee proposal includes a fallback provision that is likely to leave many beneficiaries facing very limited competition and choices for their prescription drug coverage. People in rural areas, in particular, are likely to have a choice between *one* high-priced drug-only plan and one preferred provider**

**organization which restricts choice of doctor and imposes high costs for out-of-network care.**

## 9. Cap on Use of General Revenues[35]

During the course of conference negotiations, several proposals were put forward in the name of curbing the long-term Medicare expenditures. One proposal would challenge the fundamental premise established when Medicare began in 1965: that relatively progressive income taxes should be a major source of funding of Medicare benefits. Currently, the payroll tax, a proportional tax on earned income, funds Medicare's Part A hospital benefits, while Part B care is financed 75 percent by general revenues and 25 percent by premiums. The conference committee proposal would trigger certain events the second time that the percent of the general revenue fund of Medicare expenditures were projected to exceed 45 percent in any of the next seven years. Were this to occur, the President would be required to recommend legislation that would bring down this percentage, and a new Senate Rule would automatically be activated that would require full budgetary offsets for any improvements to Medicare. The 45 percent point is likely to be reached between 2015 and 2020, hence the "trigger" would go into effect between 2008 and 2013.

The Center on Budget and Policy Priorities has outlined key concerns about this misguided approach:[36]

- This proposal that is termed "Medicare cost containment" does not actually contain Medicare drug costs or total Medicare costs, but merely limits the funding that will come from the relatively progressive general-revenue financing.
- It is likely to shift the financing of Medicare away from relatively progressive income taxes and toward relatively regressive payroll taxes.
- It would limit improvements in Medicare with budget rules (in particular, required offsets) that do not apply to other types of spending, including tax cuts.
- The 45 percent threshold is likely to result in reductions in provider reimbursements, increases in premiums, deductibles and co-payments, reduced participation (and restricted access) of doctors in Medicare. Ultimately, it could lead Congress to increase the age of eligibility for Medicare.
- The required Medicare Trustees' reports, in particular the findings on "insolvency" and "unfunded liability" will make the financial status of Medicare look much worse than it is because of the arbitrary 45 percent limit, and is likely to fuel fear that Medicare will not be able to continue.

**In sum: The conference committee proposal establishes an arbitrary ceiling on the percent of Medicare funding that should come from relatively progressive revenue**

**sources and will create an artificial crisis when this trigger calling for Presidential and Congressional action is reached, probably in about 2010. It will probably lead to cutbacks in Medicare benefits (hospital care, doctor care, and prescription drug coverage), increased cost-sharing for Medicare beneficiaries, and a shift to less progressive sources of Medicare financing.**

### 10. Health Savings Accounts

The conference committee proposal includes a scaled back version of ill-advised new tax policies that were included in H.R. 1. The proposal would expand Medical Savings Accounts and change their name to Health Savings Accounts. Many of the restrictions that currently apply to MSA's will be removed. Consumers Union has long-opposed MSA's[37] (which combine high deductible health insurance with tax advantaged savings accounts for health spending) for several key reasons: (1) they will separate the healthy from the sick in the risk pool, and ultimately *dramatically increase* premiums for those who remain covered by relatively low-deductible, traditional policies; (2) they can not exist side-by-side in the marketplace with traditional low-deductible coverage, and the long-run result will be a marketplace where very high deductibles are the norm (and many have no choice of a low-deductible plan); (3) they are bad tax policy, costing billions of federal revenue dollars without making the health care finance system more equitable or making health coverage more affordable.

The tax-advantaged savings account in the conference committee proposal could be used only by people with a high-deductible health insurance policy. The Center on Budget Policy and Priorities has criticized this provision (in which contributions are taxed neither when put in *nor* when withdrawn) as a new tax shelter that will benefit the affluent.[38]

This provision is estimated to cost $7 billion over 10 years**.**

**In sum: The conference committee proposal will rename (and expand) medical savings accounts, calling them Health Savings Accounts. These tax-advantaged savings accounts are likely to erode comprehensive employer-based health insurance for people under 65, substantially increase premiums paid by those who want to buy comprehensive health insurance, shift out-of-pocket costs to the sick, and provide an inappropriate and expensive tax shelter for the wealthy.**

## Conclusion

Medicare beneficiaries have waited for a long-time for relief from the financial burden of high prescription drug costs, and are desperate for some relief. **When Congress set**

**aside $400 billion (over ten years) to address the problem, we understood that whatever proposal emerged would be able to address only a fraction of the problem. Because the Conferees failed to adopt a plan that curbs prescription drug expenditures, and instead developed a model that relies on an insurance industry eager to see Medicare privatized while collecting more government subsidies, Consumers Union reluctantly concludes that, on balance, Medicare beneficiaries will be severely harmed by this proposal**. We urge consumers to request their Representatives and Senators go back to the drawing board to enact legislation that meets consumers' needs, not legislation that is shaped by special interests and those who favor privatization without recognizing the crucial role that government should play in assuring that Medicare meets the needs of the seniors and the disabled.

## APPENDIX A
## Methodology:
## Calculating Out-of-Pocket Drug Costs

First, we assumed that the distribution of prescription drug expenditures in 2003 is correct as reported in the Kaiser Family Foundation's Medicare and Prescription Drug Fact Sheet, April 2003, using Congressional Budget Office figures. Next, we estimated how fast prescription drug costs will increase between 2003 and 2007. We assumed that, since the tentative conference agreement lacks adequate provisions to rein in costs, costs will continue to increase at the rate that they have grown since 1997.

The key reasons that expenditures are increasing are price increases, an increase in the number of prescriptions, and a shift to higher cost drugs.[39] The National Institute of Health Care Management estimate of the increase in retail spending on prescription drugs ranged from 17.1 percent to 18.9 percent per year between 1997 and 2001, with the average annual increase 18.3 percent.[40] The Center for Studying Health System Change calculates the annual increase in prescription drug spending to range between 13.2 and 18.4 percent between 1998 and 2002. The average annual rate of increase of the average of these two studies is 17 percent. We also made estimates for average prescription drug users at an average annual rate of increase of 12 percent, far lower than the recent historical increase. A 12 percent increase is the average rate of increase in expenditures projected by the Congressional Budget Office over the next 10 years. We used the higher rate for the primary analysis because we believe that the recent experience is likely to be the best predictor of the future. The absence of tough measures to rein in growth of expenditures are likely to result in continued high increases in prescription drug prices, which in 2002 increased at five times the rate of growth of the gross domestic product.[41]

We estimated the impact of the benefit structure under consideration by the conference committee bill for a range of prescription drug expenditures at various points along the distribution of expenditures.

For each spending level, the 2003 spending level was used to estimate spending in 2007, using the 17 percent average annual increase. The next step was to adjust the nominal dollars in 2007 to the equivalent spending in 2003 dollars, to adjust for overall inflation. The average rate of increase in the consumer price index (CPI) between 1999 and 2003 (projection) was 2.5 percent. We deflated the 2007 numbers with the assumption that the average CPI increase will be 2.5 percent annually over the next 4 years.[42]

### Changing the Assumptions

We tested the results by changing the assumption about the rate of growth of prescription drug expenditures. For the average beneficiary, we estimated out-of-pocket costs in 2007 if the average annual increase in expenditures were 12 percent, the average number

projected by the Congressional Budget Office. Tables showing the breakdown of out-of-pocket costs and benefits at different drug expenditure levels, at drug expenditure growth rates of 17 percent and 12 percent follow.

## Calculator

The drug calculator (See Appendix B and the section on adequate benefits above) allows individuals to determine the impact of the proposal on their own out-of-pocket drug costs in 2007. Individuals can enter (1) their own drug expenditures and (2) their prediction of the annual national rate of growth of prescription drug expenditures, in order to project their own out-of-pocket drug costs (with coverage under this plan) in 2007. The calculator was prepared be Ven Neralla, legislative assistant for Congressman Peter DeFazio.

# OUT-OF-POCKET COSTS, MEDICARE BENEFIT, 17% GROWTH, 2007

| 17% growth | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 2003 drug expenditures | 2007 drug expenditures | 2007 inflation adjusted | premium | deductible | base for basic benefit | basic co-insurance | co-insurance on catas-J45trophic | doughnut | total OOP | basic benefit | base for catas-trophic | catas-trophic benefit | total benefit | 2007 OOP as % of 2003 OOP |
| | Row C x1.87391 7%/year | div. by 1.104 (2/5) or mult. By .906 | 420 | 275 | | 0 | 5% | 2200-5000 | | | | | | |
| 0 | 0 | 0 | 420 | 0 | 0 | 0 | 0 | 0 | 420 | 0 | 0 | 0 | **0** | |
| 500 | 937 | 849 | 420 | 275 | 574 | 143 | 0 | 0 | 838 | 430 | 0 | 0 | 430 | 168% |
| 1000 | 1874 | 1697 | 420 | 275 | 1422 | 356 | 0 | 0 | 1051 | 1067 | 0 | 0 | 1067 | 105% |
| 1296 | 2429 | 2200 | 420 | 275 | 1925 | 481 | 0 | 0 | 1176 | 1444 | 0 | 0 | 1444 | 91% |
| 1500 | 2811 | 2546 | 420 | 275 | 1925 | 481 | 0 | 346 | 1522 | 1444 | 0 | 0 | 1444 | 101% |
| 2000 | 3748 | 3395 | 420 | 275 | 1925 | 481 | 0 | 1195 | 2371 | 1444 | 0 | 0 | 1444 | 119% |
| 2200 | 4123 | 3734 | 420 | 275 | 1925 | 481 | 0 | 1534 | 2710 | 1444 | 0 | 0 | 1444 | 123% |
| 2318 | 4344 | 3935 | 420 | 275 | 1925 | 481 | 0 | 1735 | 2911 | 1444 | 0 | 0 | 1444 | 126% |
| 2500 | 4685 | 4243 | 420 | 275 | 1925 | 481 | 0 | 2043 | 3219 | 1444 | 0 | 0 | 1444 | 129% |
| 2946 | 5520 | 5000 | 420 | 275 | 1925 | 481 | 0 | 2800 | 3976 | 1444 | 0 | 0 | 1444 | 135% |
| 3000 | 5622 | 5092 | 420 | 275 | 1925 | 481 | 5 | 2800 | 3981 | 1444 | 92 | 88 | 1532 | 133% |
| 3500 | 6559 | 5941 | 420 | 275 | 1925 | 481 | 47 | 2800 | 4023 | 1444 | 941 | 894 | 2338 | 115% |
| 4000 | 7496 | 6790 | 420 | 275 | 1925 | 481 | 89 | 2800 | 4065 | 1444 | 1790 | 1700 | 3144 | 102% |
| 5000 | 9370 | 8487 | 420 | 275 | 1925 | 481 | 174 | 2800 | 4150 | 1444 | 3487 | 3313 | 4757 | 83% |
| 6000 | 11243 | 10184 | 420 | 275 | 1925 | 481 | 259 | 2800 | 4235 | 1444 | 5184 | 4925 | 6369 | 71% |
| 8000 | 14991 | 13579 | 420 | 275 | 1925 | 481 | 429 | 2800 | 4405 | 1444 | 8579 | 8150 | 9594 | 55% |

# OUT-OF-POCKET COSTS, MEDICARE BENEFIT, 12% GROWTH, 2007

| 12% growth | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 2003 drug expenditures | 2007 drug expenditures 12% | 2007 inflation adjusted | premium | deductible | base for basic benefit | basic co-insurance | co-insur., catas-trophic | doughnut | total OOP | basic benefit | base for catas-trophic | catas-trophic benefit | total benefit | 2007 OOP as percent of 2003 OOP |
| | x 1.5735 | div. by 1.1 | 420 | 275 | | 0.25 | 0.05 | 2200-5000 | | | | | | |
| 0 | 0 | 0 | 420 | 0 | 0 | 0 | 0 | 0 | 420 | 0 | 0 | 0 | 0 | |
| 500 | 787 | 713 | 420 | 275 | 438 | 109 | 0 | 0 | 804 | 328 | 0 | 0 | 328 | 161 |
| 1000 | 1574 | 1426 | 420 | 275 | 1151 | 288 | 0 | 0 | 983 | 863 | 0 | 0 | 863 | 98 |
| 1296 | 2039 | 1848 | 420 | 275 | 1573 | 393 | 0 | 0 | 1088 | 1179 | 0 | 0 | 1179 | 84 |
| 1500 | 2360 | 2138 | 420 | 275 | 1863 | 466 | 0 | 0 | 1161 | 1398 | 0 | 0 | 1398 | 77 |
| 1544 | 2429 | 2200 | 420 | 275 | 1925 | 481 | 0 | 0 | 1176 | 1444 | 0 | 0 | 1444 | 76 |
| 2000 | 3147 | 2851 | 420 | 275 | 1925 | 481 | 0 | 651 | 1827 | 1444 | 0 | 0 | 1444 | 91 |
| 2200 | 3462 | 3136 | 420 | 275 | 1925 | 481 | 0 | 936 | 2112 | 1444 | 0 | 0 | 1444 | 96 |
| 2318 | 3647 | 3305 | 420 | 275 | 1925 | 481 | 0 | 1105 | 2281 | 1444 | 0 | 0 | 1444 | 98 |
| 2500 | 3934 | 3564 | 420 | 275 | 1925 | 481 | 0 | 1364 | 2540 | 1444 | 0 | 0 | 1444 | 102 |
| 2946 | 4636 | 4200 | 420 | 275 | 1925 | 481 | 0 | 2000 | 3176 | 1444 | 0 | 0 | 1444 | 108 |
| 3000 | 4721 | 4277 | 420 | 275 | 1925 | 481 | 0 | 2077 | 3253 | 1444 | 0 | 0 | 1444 | 108 |
| 3500 | 5507 | 4990 | 420 | 275 | 1925 | 481 | 0 | 2790 | 3966 | 1444 | 0 | 0 | 1444 | 113 |
| 3508 | 5520 | 5000 | 420 | 275 | 1925 | 481 | 0 | 2800 | 3976 | 1444 | 0 | 0 | 1444 | 113 |
| 4000 | 6294 | 5702 | 420 | 275 | 1925 | 481 | 35 | 2800 | 4011 | 1444 | 702 | 667 | 2111 | 100 |
| 5000 | 7868 | 7128 | 420 | 275 | 1925 | 481 | 106 | 2800 | 4082 | 1444 | 2128 | 2022 | 3466 | 82 |
| 6000 | 9441 | 8554 | 420 | 275 | 1925 | 481 | 178 | 2800 | 4154 | 1444 | 3554 | 3376 | 4820 | 69 |
| 8000 | 12588 | 11405 | 420 | 275 | 1925 | 481 | 320 | 2800 | 4296 | 1444 | 6405 | 6084 | 7528 | 54 |
| | | | | | | | | | | | | | | |

# APPENDIX B

Calculate your costs under the tentative conference committee proposal

## What you'll still have to pay

### *Calculate your costs under the tentative conference committee proposal*

**(1)** How fast do you think prescription drug expenditures will increase (annually, on average) over the next four years? 17 percent

**or** enter your own estimate: percent

*hints: recent annual increase has been 17 percent; CBO projects annual increase of 12 percent; recent annual increase in overall inflation (Consumer Price Index) has been 2.5 percent; enter "0" if you don't think drug prices will increase*

**(2)**Enter your total yearly drug costs:

Clear

Your projected drug expenditures in 2007 ($):

Your projected drug expenditures in 2007 (inflation adjusted) ($):

**Your yearly out-of-pocket drug costs under conference committee proposal ($):**

*Your cost under the tentative conference committee agreement includes the cost of the annual deductible ($275), the estimated average yearly premium ($35/month = $420/year; but this could vary since the proposal leaves the premium up to private insurers), the 25 percent co-insurance on drug expenses between $275 and $2,200 and the 5 percent co-insurance on expenses over $5000, and the out-of-pocket costs you'll have to bear between $2200 and $5000 (the "doughnut").*

Note: Seniors and disabled with retirement income greater than $80,000 (or $160,000 per couple) will have to pay higher Medicare Part B premiums. Low-income seniors with retirement income below 150 percent of the federal poverty level will receive additional subsidies.

# Medicare Rx Scorecard
# Consumers Union Urges Congress to
# Understand What's in the Medicare Rx Bill Before the Vote that Could Change Medicare Forever

| Feature | Conference Agreement (***based on preliminary reports and press reports***) | Good for Consumers | Bad for Consumers |
|---|---|---|---|
| **Will the drug benefit be adequate?** | The overall benefit is INADEQUATE and is substantially less than what Members of Congress get through FEHBP | | |
| Is coinsurance higher than 20%? | Coinsurance will be 25% | OK<br>(20% would be better) | |
| Is there a doughnut in coverage? | Doughnut for drug expenditures between $2,200 and about $5,000 | | Benefit "shutdown" will hit consumers with expenditures between $2200 and $5000 |
| Is there relief for those with moderate expenses and true catastrophic protection? | 5% coinsurance, 95% benefit after expenditures reach about $5,000 | Catastrophic protection is good: those with expenditures greater than about $5,000 will get substantial benefit | Relief for those with moderate expenditures will be modest, especially with continued price inflation |
| **Will the government negotiate fair prices for U.S. consumers?** | The bill does not create a model that allows the federal government to use its purchasing power to benefit beneficiaries and consumers. | | The entire structure of the new prescription drug program precludes effective containment of prescription drug expenditures. |
| Is there a prohibition on the government seeking fairer prices? | We expect the conference report to prohibit the federal government from negotiating lower drug prices for beneficiaries, a provision in both HR 1 and S 1 | | Prescription drug price inflation can be expected to continue unchecked, since the federal government is precluded from using its purchasing power to negotiate fair prices for consumers |
| Are loopholes that delay generics closed? | Both HR 1 and S1 closed loopholes that delay generics: the fine print in the bill should be studied carefully | May close the loopholes that delay generics, but language needs to be reviewed | |

| Feature | Conference Agreement (***based on preliminary reports and press reports***) | Good for Consumers | Bad for Consumers |
|---|---|---|---|
| Will U.S. consumers have access to safe drugs at prices comparable to those in Canada? | | | No. Secretary of HHS can block reimportation. No other provision assures access to fairly priced drugs. |
| **Will the universal nature of Medicare be preserved?** | | | |
| Will benefits be based on income, providing incentives for those with high-incomes to leave the Medicare program? | No means-testing of benefits | No: does not include means-testing of benefits, so preserves universality of Medicare | |
| Will Part B premiums vary substantially depending on where in the country you happen to live? | Premium support competition in three to six cities and possibly one region | | Yes. Premiums will vary by region and within regions |
| Will pharmacy benefit managers (PBM's) have total control (with limited accountability and transparency) meaning that benefits are not standard, but depend on where you live (and which PBM your plan uses)? | We expect that the conference committee bill to allow PBM's to determine what drugs are on the plan's formulary with minimal if any accountability to the public or transparency. | | Which drugs are covered will depend on where you live and which PBM your plan uses. Your drug benefits could change at the whim of your PBM. No transparency. No requirement that formulary be based on scientific evidence |
| **Does the bill ensure beneficiaries' freedom to choose their own doctor is not threatened by requiring "traditional" fee-for-service Medicare to compete with private HMO's and PPO's?** | | | Will restrict choice of doctor for millions by driving up premiums for fee-for-service Medicare; takes first steps toward privatization of Medicare |

| Feature | Conference Agreement (***based on preliminary reports and press reports***) | Good for Consumers | Bad for Consumers |
|---|---|---|---|
| Will those who wish to remain in traditional Medicare face increased premiums based on their choice? | | | Yes, much higher premiums |
| Are private HMO's and PPO's provided subsidies that unfairly favor them and drive up Medicare costs? | | | Substantial subsidies for HMO's and PPO's |
| **Will the legislation not provide incentives for employers to drop their retiree benefits that now provide comprehensive drug coverage?** | | | |
| Will an estimated four million beneficiaries end up with less prescription drug coverage than they have currently? | Details of tentative conference agreement not yet available; impact is unclear | | Millions could lose retiree coverage |
| **Will those eligible for both Medicaid and Medicare not be forced to get their prescription drug benefits through Medicaid?** | Preliminary reports indicate that dual eligibles will get there drug benefits through Medicare | This preserves the universality of the Medicare benefit, but it also means that that states may lose their leverage in getting better value for prescription drug dollar achieved in the Medicaid program. | |

| Feature | Conference Agreement (***based on preliminary reports and press reports***) | Good for Consumers | Bad for Consumers |
|---|---|---|---|
| Will states' budgets get some relief that will keep them from cutting health benefits for children and those with low-income? | "Clawback" proposals are on the table that require states to continue to make substantial contributions for dual eligibles prescription drug costs, in perpetuity. | | Apparently, the bill contains minimal relief for states; this could mean that states will reduce coverage of children in Medicaid and CHIP due to continued budget pressures. |
| **Will those with low-income get meaningful relief?** | | | |
| Will there be an assets test that means low-income alone is not sufficient to qualify for subsidies? | | | Strict assets test restricts access to low-income subsidy |
| Will low-income beneficiaries (i.e., those with income below 160% of the federal poverty level) have coverage for the doughnut? | | Subsidies, but only up to 150 percent of the poverty level. Coverage for doughnut | |
| Will low-income beneficiaries whose income is just above the cut-off for deep subsidies get meaningful relief? | | | No low-income subsidies above income of about $13,000 for individual |
| **Will there be a *real* federal fallback?** | | | |
| Will the federal fallback apply when there is just one private plan (plus one PPO) in a region? | | | Yes: in many areas (especially rural), very limited choice and probably high premiums. |
| Is the federal fallback expected to be available to at least one third of Medicare beneficiaries? | | | No, probably about 18 percent because requires just one drug plan and one PPO |

| Feature | Conference Agreement (***based on preliminary reports and press reports***) | Good for Consumers | Bad for Consumers |
|---|---|---|---|
| Will there be any guarantee of premium level | Our expectation is that there will be no guarantee that beneficiaries will have access to prescription drug coverage at a set premium. Estimates of premiums in the range of $35 per month are just estimates, not guarantees. | | Premiums are not guaranteed. Beneficiaries in regions with limited competition will likely face high premiums. |
| **Will new cost containment provisions (such as a global cap on spending) threaten the availability of Medicare benefits to all?** | There are proposals under consideration that would triggered if combined general tax revenue spending on Medicare accounted for more than 45% of Medicare spending. The President would be required to propose policies that would reduce the reliance on general revenues (i.e. income tax revenues instead of payroll tax/premium revenues) | | This "cap" proposal is likely to lead to higher beneficiary premiums; higher coinsurance; possibly cut-backs in benefits. It is likely to shift the financing of Medicare from progressive income taxes to more regressive payroll taxes, increasing the burden on those with modest incomes. |
| **Will costly provisions such as expanded medical savings accounts (e.g., health savings accounts) that threaten to erode employer-based coverage for those under 65 be tacked on?** (This could drive up the number of uninsured and make it harder for those with pre-existing conditions to get coverage) | Preliminary reports indicate that while provisions for health security savings accounts (HSSA's) have been dropped, the bill is likely to include health savings accounts (HSA's) which allow individuals and employers to contribute (up to the amount of a deductible) into a tax-favored savings account to be used for health care. This provision is flawed tax policy, favors those in higher tax brackets, is likely to make premiums higher for those who remain in traditional low-deductible policies. | | Bad tax policy; bad health policy that divides the healthy from the sick and drives up premiums for those who wish to be covered with relatively low-deductible protection. Likely to shift costs to the sick. A tax benefit that helps those with higher incomes. |

# Endnotes

[1] Part A of Medicare is financed through a payroll tax that is proportional in incidence over earned income (since there is no cap on contributions); Part B is financed (1) progressively through general revenues, mostly income taxes, for 75 percent and (2) regressively through premiums for 25 percent of revenues.
[2] The Congressional Budget Office projects that Medicare beneficiaries will spend $1.839 trillion on prescription drugs between 2004 and 2013. Memorandum to Interested Parties, from Tom Bradley, Congressional Budget Office, Projected spending for prescription drug by and on behalf of Medicare Enrollees, February 3, 2003.
[3] Gail Shearer, Prescription Drugs for Medicare Beneficiaries: 10 Important Facts, Consumers Union, April 14, 2000. http://www.consumersunion.org/health/drugdc400.htm#3
[4] For an explanation of the how we calculated the 17 percent annual growth rate, see the Appendix.
[5] James Langenfeld and Robert Maness, "The Cost of PBM 'Self-Dealing' Under a Medicare Prescription Drug Benefit," September 9, 2003.
[6] Levit, Katharine et.al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, vol. 22, no. 1, January/February 2003, p. 155-156; Steinbrook, Robert, M.D. "The Prescription Drug Problem," *New England Journal of Medicine*, vol. 346, no. 11, March 14, 2002, p. 790.
[7] NONINTERFERENCE- In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs. S. 1, Sec. 301. Similar language is in section 301 of H.R. 1.
[8] Savings from Multi-State Pools Described in Presentation to Legislative Drug Group," BNA's Health Care Policy Report, July 7, 2003.
[9] Vernon Smith, Sandy Kramer, and Jocelyn Guyer, *Coordinating Medicaid and Medicare Prescription Drug Coverage*, Kaiser Commission on Medicaid and the Uninsured, November 2003, p. 6-7.
[10] The Congressional Budget Office estimates that the changes to the Hatch-Waxman Act by the House and the Senate bills would save $7 billion between 2004 and 2013, for the provisions that "reach beyond" the effect of the new Food and Drug Administration rule relating to Hatch-Waxman. *H.R. 1 Medicare Prescription Drug and Modernization Act of 2003 and S.1 Prescription Drug and Medicare Improvement Act of 2003*, Congressional Budget Office Cost Estimate, July 22, 2003, p. 50-51.
[11] Sarah Lueck and David Rogers, *Wall Street Journal*, November 14, 2003.
[12] CNBC, November 14, 2003 story on Medicare prescription drug legislation.
[13] The Health Strategies Consultancy LLC for the Henry J. Kaiser Family Foundation, *Designing a Medicare Drug Discount Card: Implications of Policy Choices for Medicare Beneficiaries and Card Sponsors*, November 2003/
[14] Medicare+Choice, as it exists today, was one of the first steps that eroded the universality of the Medicare program. Eligibility for prescription drug benefits through Medicare varies based on where a person lives and what private plans are available.
[15] Part A of Medicare is financed through a payroll tax that is proportional in incidence over earned income (since there is no cap on contributions); Part B is financed (1) progressively through general revenues, mostly income taxes, for 75 percent and (2) regressively through premiums for 25 percent of revenues.
[16] Chart 8, The Kaiser Family Foundation/Harvard School of Public Health National Survey of the Public's Views on Medicare, June 2003.
[17] $12 billion of S. 1 $18 billion figure is for spending on PPOs and fee-for-service demonstration projects from 2009 through 2013. *H.R. 1 Medicare Prescription Drug and Modernization Act of 2003 and S.1 Prescription Drug and Medicare Improvement Act of 2003*, Congressional Budget Office Cost Estimate, July 22, 2003, p. 33.
[18] *The Role of Private Health Plans in Medicare: Lessons From the Past, Looking to the Future*, National Academy of Social Insurance, November 2003.
[19] Lori Achman and Marsha Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999-2002*. New York: The Commonwealth Fund, 2002 and Lori Achman and Marsha Gold, *Medicare+Choice Plans Continue to Shift More Costs to Enrollees.* New York: The Commonwealth Fund, 2003.
[20] Medicare Payment Advisory Commission, Transcript from Public Meeting, October 9, 2003 http://www.medpac.gov/public_meetings/transcripts/100903_M percent20C_SH_transc.pdf. See also discussion in *House Republican Proposal Leads to Inequities in Medicare Premiums*, House Budget Committee Democratic Caucus, November 2003, p. 3.
[21] NASI, p. 8-11.

[22] NASI, p. 23.
[23] NASI, p. 39, citing General Accounting Office, 2000, *Medicare + Choice: Payments Exceed Costs of Fee for Service Benefits, Adding Billions to Spending.* GAO/HEHS-00-161. Washington, DC: Government Printing Office.
[24] *House Republican Proposal Leads to Inequities in Medicare Premiums,* House Budget Committee Democratic Caucus, November 2003, citing: *Comparison of Annual Beneficiary Premium Under H.R. 1 for Medicare Advantage, Enhanced Fee-For-Service and Traditional Fee-For Service Plans,* U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, Office of the Actuary, August 9, 2003. "Note: all estimates cited are for premiums in 2013 and are a best approximation of HHS's graphs." (House Budget Committee footnote).
[25] *Ibid.*, p. ii.
[26] For more information, see *Medicare Drug Conference Considering Provisions That Threaten Drug Benefits and Other Coverage for Millions of Low-Income Medicare and Medicaid Beneficiaries,* Office of Senator Jeff Bingaman, October 24, 2003. See also Vernon Smith, Sandy Kramer, and Jocelyn Guyer, *Coordinating Medicaid and Medicare Prescription Drug Coverage,* Kaiser Commission on Medicaid and the Uninsured, November 2003.
[27] Brian Bruen and John Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government,* Kaiser Commission on Medicaid and the Uninsured, November 2003, p. 15.
[28] Vernon Smith, Sandy Kramer, and Jocelyn Guyer, *Coordinating Medicaid and Medicare Prescription Drug Coverage,* Kaiser Commission on Medicaid and the Uninsured, November 2003.
[29]

| Federal Poverty Level (2002): | 100 percent | 135 percent | 150 percent | 160 percent |
|---|---|---|---|---|
| Single person over 65: | $8,628 | 11,648 | $12,942 | $13,805 |
| Couple, over 65 | $10,874 | 14,680 | $16,311 | $17,398 |

For more information about the federal poverty level, see Poverty in the United States: 2002, U.S. Census Bureau, http://www.census.gov/prod/2003pubs/p60-222.pdf
[30] Beneficiaries with income up to 135 percent of the federal poverty level would pay no premiums or deductibles, and would pay co-payments of $2 on generics and $5 on brand name drugs, including doughnut coverage. Assets of $6,000 ($9,000 for couples) would disqualify a beneficiary for this low income subsidy. They would not pay any cost-sharing after the stop-loss was reached. For those with income between 135 percent and 150 percent of poverty, the deductible would be $50 per year; there would be sliding scale premium subsidies; and they would pay 15 percent coinsurance for their drugs, including through the doughnut hole. They would pay the 5 percent cost-share on the catastrophic benefit. (BNA Health Policy Report, October 27, 2003, p. 1341.
[31] Medicaid beneficiaries with severe mental illness could face new challenges: many states have assured open access to needed medicines. Private PBM formularies may not be as flexible. *See:* Medicare Drug Conference Conferees Considering Provisions that Threaten Drug Benefits and Other Coverage for Millions of Low-Income Medicare and Medicaid Beneficiaries, Office of Senator Jeff Bingaman, October 24, 2003.
[32] Medicare Drug Conference Conferees Considering Provisions that Threaten Drug Benefits and Other Coverage for Millions of Low-Income Medicare and Medicaid Beneficiaries, Office of Senator Jeff Bingaman, October 24, 2003.
[33] Medicare Drug Conference Conferees Considering Provisions that Threaten Drug Benefits and Other Coverage for Millions of Low-Income Medicare and Medicaid Beneficiaries, Office of Senator Jeff Bingaman, October 24, 2003.
[34] *H.R. 1 Medicare Prescription Drug and Modernization Act of 2003 and S.1 Prescription Drug and Medicare Improvement Act of 2003*, Congressional Budget Office Cost Estimate, July 22, 2003, p. 12-13.
[35] For more information about how the proposed budget caps that single-out Medicare beneficiaries can threaten Medicare benefits and make the tax system more regressive, see Richard Kogan and Robert Greenstein, *The Administration's Misguided proposal to Apply 'Pay-as-you-go Rules' Only to Medicare Benefits,* Center on Budget and Policy Priorities, November 3, 2003 and Richard Kogan and Edwin Park, *Administration Proposal to Combine the Accounting of Medicare Part A, Medicare Part B, and Prescription Drugs is Unsound,* Center on Budget and Policy Priorities, November 3, 2003.
[36] Richard Kogan, Edwin Park, and Robert Greenstein, *Medicare "Cost Containment" Proposal Includes Ideologically Loaded Provisions*, Center on Budget and Policy Priorities, November 7, 2003.
[37] Gail Shearer, *The Health Care Divide: Unfair Financial Burdens*, Consumers Union, August 10, 2000. http://www.consumersunion.org/health/divide/divide6.htm
See also: http://www.consumersunion.org/i/Health_Care/Medical_Savings_Accounts/index.html

[38] Robert Greenstein and Edwin Park, *Health Tax Provision Being Pushed in Medicare Conference Poses Threats Both to Long-Term Fiscal Policy and to the Employer-Based Health Insurance System,* October 27, 2003.
[39] *Prescription Drug Expenditures in 2001: Another Year of Escalating Costs*, National Institute for Health Care Management, May 6, 2002, p. 6.
[40] *Ibid*, p. 2.
[41] Data Bulletin: Tracking Health Care Costs, Center for Studying Health System Change, June 2003.
[42] Consumer Price Index, 1913-, Federal Reserve Bank of Minneapolis.
http://minneapolisfed.org/research/data/us/calc/hist1913.cfm