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POLICY BRIEF ▪ MEDICARE

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THE WINNERS AND LOSERS IN THE NEW MEDICARE SWEEPSTAKES

President Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 in December following a divided and mostly partisan vote in the House of Representatives (220-215) and the Senate (55-44). The new Medicare act offers drug coverage to all Medicare beneficiaries who choose to enroll, helps low-income seniors with costs associated with the benefit, and encourages greater participation by private insurance companies. Even as it makes these contributions, however, the new Medicare legislation also presents new challenges for the country and the Upper Midwest where two million beneficiaries live.

Breaking new legislative ground

The new drug legislation makes four principal changes in the Medicare program. First, it adds a drug benefit in 2006, with an interim drug discount card to be available by June of this year. Second, it will deliver the drug benefit through new, free-standing drug insurance plans or through private health plans called Medicare Advantage (previously known as Medicare+Choice). Third, the legislation expands the role of private insurance delivery models as a challenge to traditional fee-for-service (FFS) Medicare. In particular, it provides immediate and substantial increases in payments to Medicare Advantage HMOs and other private health insurers to participate and announces a demonstration project where FFS Medicare will compete directly against private insurers beginning in 2010.

Finally, the law includes income tests for beneficiaries for the first time. When Medicare was created in 1965, a fundamental tenet was to provide the same coverage for all beneficiaries regardless of income. Low-income seniors, known as "dual eligibles," received additional assistance through state Medicaid programs. Now, low-income seniors will get subsidies through the Medicare program; higher-income seniors will pay more in premiums based on a means-tested sliding scale.

Before the ink was dry, Democrats, senior groups, and long-time advocates of health care reform (including Families USA and the Minnesota Senior Federation) urged improvements in drug coverage, an end to billions of dollars of subsidies to health insurers, and changes to the prohibition on government negotiation for lower drug prices. Because many of the key provisions begin after 2006, there is ample time for amendments or a partial repeal.

States, health organizations, and consumer groups still are sorting through the 678-page bill to assess its impact. Many critical issues still are being discussed as regulations are prepared to implement the new program. Other issues have been forwarded for further study to advisory groups, such as the Medicare Payment Advisory Commission (MedPAC) and the Institute of Medicine (IOM). Early analysis points to several hurdles for the country and the Upper Midwest.

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The new fiscal hurdle

During the congressional debate, the Congressional Budget Office (CBO) estimated that the bill fell within the $400 billion over 10 years that the President and Congress authorized in the budget. Since the passage of the act, however, the Office of Management and Budget (OMB) has adjusted the assumptions and its estimate of the cost ballooned to $530 billion. Future costs could rapidly rise far higher due to the doubling in the number of beneficiaries (from 41 million today to 80 million in 2030), generous subsidies, and the skyrocketing costs of drugs.

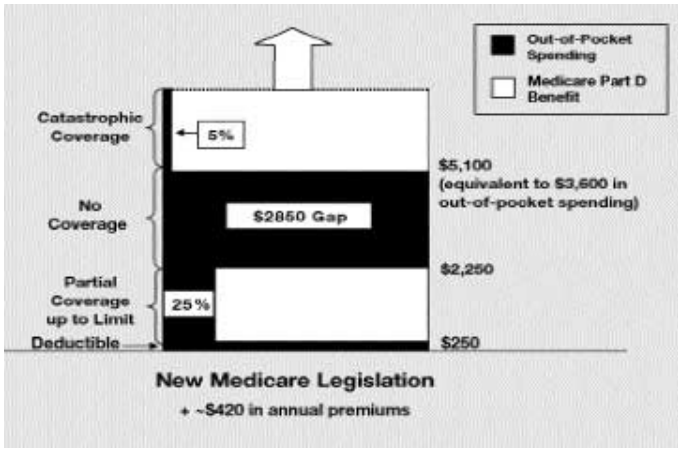
Some of the increased costs will benefit the Upper Midwest because of special payments for certain categories of rural hospitals and reductions in payment disparities between rural and urban providers. The larger question, though, is whether the new financial commitments are sustainable. If costs spiral out of control, the financial stability of Medicare will be undermined and dramatic legislative actions may be required.

Who benefits

Early analysis indicates that many low-income seniors will benefit from the new coverage, although others struggling with high drug costs may lose more than they gain.

The new legislation requires beneficiaries to make substantial payments before receiving assistance. Put simply, recipients need to pay before they can play. In particular, they need to clear three financial hurdles, as shown in Figure 1. First, Americans already receiving Medicare can only qualify for the program if they pay a $35 monthly premium. Second, the first $250 of drug costs have to be paid before the new benefit kicks in. Even after paying the monthly premium and the first $250, beneficiaries are required to pick up 25% of the costs up to $2,250. Third, Medicare recipients with drug expenses that exceed $2,250 are completely on their own to cover the next $1,350. Only after they have spent $3,600 does the new benefit pay most of the remainder. Because benefits are indexed to growth in per capita expenditures, the deductible is projected to increase to $445 in 2013 and the catastrophic threshold to rise to $9,066 in the same year. The program is voluntary, but those who don't sign up will face financial penalties in the form of higher premiums when they enroll.

Figure 1. Out-of-Pocket Drug Spending in 2006 for Medicare Beneficiaries Under New Medicare Legislation

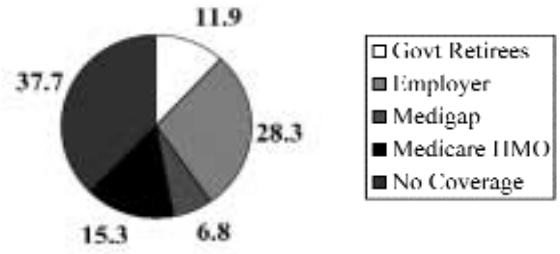


Note: Benefit levels are indexed to growth in per capita expenditures for covered Part D drugs. As a result the Part D deductible is projected to increase from $250 in 2006 to $445 in 2013; the catastrophic threshold is projected to increase from $5,100 in 2006 to $9,066 in 2013.

Source: Kaiser Family Foundation.

The value of the drug benefit depends on a beneficiary's anticipated drug costs and whether he or she has better drug coverage through other programs. Figure 2 shows that 37.7% of Medicare beneficiaries currently have no drug coverage at all; two-thirds have coverage through public or private retiree benefits, Medicaid, Medicare HMOs, or individually purchased Medigap plans.

Figure 2. Source of Prescription Drug Coverage for Non-Institutional Medicare Beneficiaries in the U.S.



The biggest winners are beneficiaries who currently have no prescription drug coverage. Even with its monthly premium, deductible, gaps, and co-pays, this plan will provide benefits for many with high medication expenditures. The "dual eligibles" (i.e., individuals eligible for both Medicare and Medicaid) will retain their drug benefit and will qualify for subsidies to cover out-of-pocket costs. The number of winners is likely to grow in the future because private employers have been dropping retiree drug benefits and are likely to continue shedding these benefits (despite provisions in the bill to discourage this development). While the Medicare drug benefit may not be as generous as employer plans, it may be a retiree's only option.

The Upper Midwest may benefit compared to other regions, though its advantage may be short-lived. States in the Upper Midwest have higher percentages of individuals without any drug coverage. In Minnesota, for instance, nearly half of the population has no prescription drug coverage. Chart 1 shows that Upper Midwest enrollment in Medicare managed care (which often provides drug benefits) is unusually low: compared to the national average of 12%, Iowa has less than 1%, Wisconsin has a mere 1%, and Minnesota only 6%. (Medicare managed care declined sharply within the region: Minnesota's enrollment fell by a third, from 59,000 in 1999 to 40,500 in 2004.)

To compensate for this lack of drug benefits, residents of Iowa, Wisconsin, and Minnesota purchase supplemental insurance programs in larger numbers than the national average: more than 40% of Minnesotans and Iowans have Medigap coverage, compared with 25% nationally. About one-third of those with Medigap purchase a plan that includes a drug benefit. The Medigap drug benefit carries higher monthly premiums than the new law but allows for much more generous benefits and significantly fewer restrictions on drug choice. The new Medicare legislation, however, prohibits Medigap drug plans after 2006, forcing seniors to opt for the new plan.

Chart 1. Medicare Facts

	# Beneficiaries	% of State Population	Medicare +Choice	Medigap	Dual Eligible
IA	478,063	16%	0%	42%	54,690 (11%)
MN	660,399	13%	6%	44%	70,804 (11%)
WI	787,442	15%	1%	27%	75,310 (10%)
U.S.	41,000,000	14%	12%	25%	5,830,000 (14%)

Source: The Henry J. Kaiser Family Foundation State Health Facts Online, www.statehealthfacts.kff.org.

New challenges for government

The new Medicare drug program puts national and state government officials in a tight spot. The Medicare program has long set fees for services to hospitals and doctors in order to control rapidly rising expenditures. In the new drug program, government purchasing is delegated to private prescription drug plans (PDP) and the national government is explicitly prohibited from negotiating prices with drug manufacturers. Moreover, the government has committed itself to providing additional financing for PDPs to ensure that their future participation is financially rewarded; "risk corridors" have been established to help drug plans that can't manage expenditures.

The bottom line is clear: the national government is likely to find itself handcuffed in the near future as Medicare drug costs spin out of control.

A further challenge will be monitoring the quality of the PDPs and policing against fraud. The new law allows PDPs to vary benefits, such as coverage of classes or brands of drugs, as long as the benefit is "actuarially equivalent" to the requirement. If the past is any guide, beneficiaries and their representatives in Congress are likely to turn to the federal government for help.

In addition, the government is taking on the new responsibility of ensuring at least two competing plans in each region of the country (regional lines have yet to be drawn). If no plans enter these regions, the new law promises "fallback plans" defined as non-risk bearing entities with substantially limited financial risks. PDPs cannot serve as fallbacks. It is unclear what type of entity, if any, will provide this service.

Moreover, state governments are mandated to take on substantial new regulations and audits (and the costs associated with these responsibilities). They will be required to administer the income tests for subsidy eligibility. They also must calculate the "savings" from the transfer of drug coverage to the federal program as part of what are known as "clawback" provisions. Existing Medicaid programs will be disrupted because the drug benefit will be administered by a PDP while Medicaid coordinates all other benefits. State officials worry that they will lack data and information to manage care. Put simply, states face more bureaucracy, less control of their Medicaid program, and the prospect of paying a "clawback" to Washington. The precise costs of the new financial and regulatory burden remain unclear because state Medicaid programs differ substantially from state to state and many regulations are not yet written.

Regional inequities in Medicare advantage increased

The new law helps health maintenance organizations (HMOs), preferred providers organizations (PPOs), and other health insurers by immediately increasing their monthly payments to offer Medicare benefits through a health plan. It also promises substantial incentives to enter the Medicare marketplace in the future.

However, the new law does not address the regional inequity in monthly payments per enrollee that has plagued the program throughout its history. The inequities reward inefficiency and discourage high enrollment in Medicare managed care.

Since the 1980s, HMOs have received a monthly payment from Medicare to deliver benefits. Payment has been tied to per capita spending in more than 3,000 counties participating in the traditional fee-for-service Medicare program. The per capital spending has varied significantly across these counties for a number of reasons, including inefficiency and the overutilization of services. Areas in Florida and California, for example, are known for excessive and often wasteful use of Medicare services, while Minneapolis, Milwaukee, and other Upper Midwest cities have efficient and conservative utilization. All rural areas, including those in the Upper Midwest, have low utilization due to access challenges.

Payments to deliver the same set of Medicare benefits can vary by more than two-fold from one county to another. Chart 2 illustrates the payment inequities. A health plan in Des Moines, Iowa, for example, will receive $555.42 per month to offer benefits, while a health plan in Dade County, Florida, will receive $904.51—nearly twice as much. The additional dollars allow plans to add extra benefits and more profits to their bottom line. Payments in 2003 and 2004 remain 30% to over 50% lower in the three largest population centers in the Upper Midwest compared to the large concentrations of seniors in Florida, California, and New York. These discrepancies far exceed differences owing to cost of living.

The discrepancies in payments generate substantial regional differences in enrollment in Medicare managed care. There were 4.6 million beneficiaries enrolled nationally in Medicare+Choice in 2003, down from a high of 6.3 million in 1999. Enrollment in Medicare+Choice has stayed high in areas with high payments as many plans compete by offering drug benefits and other attractive options. (California has enrolled 1.28 million or 33% of the state's beneficiaries in the program and Florida has enrolled 19% or 535,600 individuals.) By contrast, the lower payments in the Upper Midwest correspond with far lower Medicare+Choice enrollment in Iowa (below 1%), Wisconsin (1%), and Minnesota (6%) (see Chart 1). Low payment areas have fewer plan choices and those plans cannot offer richer benefits and lower co-pays like the plans in high pay regions.

The Upper Midwest will continue to be victimized by unjustified regional discrepancies under the new Medicare legislation. If the law's goal is to encourage enrollment in private plans, it will not succeed without better efforts to set premiums that reflect the cost of providing care and are not tied to historic and highly varied utilization patterns.

Chart 2. Regional Payments to Medicare Managed Care Plans in Upper Midwest and Selected Regions

County	2003 Monthly Payment Per Beneficiary	2004 Monthly Payment Per Beneficiary
Des Moines, IA	**$510.38**	**$555.42**
Hennepin, MN	**$564.10**	**$613.89**
Milwaukee, WI	**$564.10**	**$613.89**
Dade County, FL	**$850.88**	**$904.51**
Los Angeles, CA	**$707.96**	**$752.58**
Bronx, NY	**$828.15**	**$880.34**

Source: The Henry J. Kaiser Family Foundation State Health Facts Online, www.statehealthfacts.kff.org.

Impacts of the Medicare law beyond the new drug benefit

The media's preoccupation with the new drug benefit in the Medicare legislation distracted attention from numerous significant changes that alter arrangements for Medicare contractors, incentives for quality reporting by hospitals, and health savings accounts, to name a few. The law also includes increases in the physician fee schedule and payments for hospitals, both applauded by their trade associations as necessary to assure access to beneficiaries.

Summary

The Medicare drug benefit helps poorer Americans but has initiated a number of significant new financial and statutory responsibilities that are likely to grow in the future. It also has introduced untried concepts, such as freestanding PDPs, handcuffs the government for future management of drug expenditures, and does not address the regional challenges in the private health plan marketplace. The Upper Midwest will continue to be discriminated against for its efficiency and control over medical care usage and expenditures, which limits the choices of local beneficiaries.

Far from evoking confident predictions of consistent improvement, the new drug benefit and program restructuring has introduced new complexity, uncertainty about implementation, and reasonable concerns about unsustainable cost escalations.

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• *2004 Elections Project* •

Recent polls in the Upper Midwest show early signs that the 2004 elections may follow the electoral map of past elections—reelection of Senate incumbents in Iowa and Wisconsin and a presidential race that delivers South Dakota for the Republicans and Iowa and possibly Minnesota for the Democrats. One early surprise is that Democrats appear poised to pick up the U.S. House of Representative seat vacated by the recently convicted Republican Bill Jenklow.

Go online for the 2004 Elections Project's "Poll Roundup" (**www.hhh.umn.edu/centers/csp/elections**) to find the most recent regional information from leading polling organizations and look for the forthcoming Humphrey Institute survey on political attitudes in the region and, especially, in suburban areas.

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