The Bush Framework for Medicare “Reform” Undermines the Medicare Program

The Bush administration’s framework for “reforming” Medicare, unveiled on March 4, 2003, has several critical flaws. Its most significant flaw is that it would require seniors and people with disabilities to leave the traditional Medicare program and join unreliable private managed care plans in order to get coverage for a significant portion of their outpatient prescription drug costs. In essence, the framework would establish two classes of Medicare beneficiaries. Those willing to give up the reliability of traditional Medicare, with its free choice of doctor at a known price, would have to join private insurance plans to become eligible for subsidized prescription drug coverage. Those opting to stay in traditional Medicare would get a “discount” card promising limited discounts, and no coverage for the high cost of prescription drugs until they had spent thousands of dollars out-of-pocket. By making more generous coverage available through private plans, the administration hopes to force people to leave traditional Medicare, undermining the viability of that program.

The President’s Framework

The President’s proposal makes three options available to Medicare beneficiaries. They could:

1. **Remain in the traditional Medicare program.** Those remaining in traditional Medicare would receive token assistance to cope with the high cost of prescription drugs. Assistance would come in the form of a drug “discount” card with very limited savings and unspecified coverage for their catastrophic drug costs.

2. **Join an HMO through the “Medicare Advantage” program.** Enrollees participating in the “Medicare Advantage” program would receive their health care coverage through HMOs in an arrangement similar to the existing Medicare+Choice (M+C) program. The only significant difference would be that taxpayer subsidies would be available to reduce the premiums they would otherwise be charged for drug coverage.

3. **Join a preferred provider organization (PPO) through the “Enhanced Medicare” program.** Beneficiaries who enrolled in a new “Enhanced Medicare” option would be joining a program similar to the Federal Employees Health Benefits Program (FEHBP). Instead of enjoying free choice of doctor as they do under Medicare they would be joining a private plan offering coverage for a more limited network of doctors. While they could see doctors not in their plan’s network, they would have to pay more for that privilege. Some PPO plans would offer taxpayer-subsidized coverage for prescription drugs.
Flaws in the President’s Framework

- Forces seniors to choose between coverage for their prescription drug costs and the ability to see the doctor of their choice at a guaranteed price. Since the administration’s framework would not make coverage for a significant portion of seniors’ drug costs available under traditional Medicare, beneficiaries who want coverage will be forced to join a private plan through the “Medicare Advantage” or “Enhanced Medicare” programs. The administration acknowledges that HMOs offering drug coverage through the Medicare Advantage program will restrict beneficiaries’ choice of doctor and other providers. However, it claims that under Enhanced Medicare beneficiaries will be able to get drug coverage and continue to receive care from the doctor or hospital of their choice. This is only half-true. PPOs would give them the ability to see any doctor, but they would face higher out-of-pocket costs for seeing doctors who are not in their plan’s network.

The President’s proposal describes the Enhanced Medicare option as modeled after the Federal Employees Health Benefits Program (FEHBP). While it is technically correct to say that enrollees in FEHBP have free choice of doctor and other health care providers, they may not enjoy the same level of coverage for the doctor of their choice that an enrollee in traditional Medicare enjoys. The administration is mischaracterizing the plans in FEHBP that offer enrollees the greatest choice of provider as fee-for-service plans with no restrictions on beneficiaries’ choice of doctor. In fact, they are not fee-for-service plans. They are preferred provider organizations (PPOs) in which enrollees can face high out-of-pocket costs if their provider of choice is not in their plan’s network. The Office of Personnel Management, which runs the FEHBP program, estimates that enrollees seek care out-of-network about 10-20 percent of the time.\(^1\) The Congressional Research Service (CRS) has found that enrollees who seek care out-of-network often will not know until they are billed by the doctor what their costs will be for seeing their provider of choice.\(^2\)

- Fails to make adequate choices available to Medicare beneficiaries. Proponents of FEHBP-like reforms to Medicare generally criticize the current Medicare program for offering beneficiaries insufficient choice of plan. While the President’s plan could result in more choice of plan beneficiaries can enroll in, it also clearly limits beneficiary freedom of choice in an area that is much more important to them – their ability to see the doctor of their choice.\(^3\) Those who support choice ought to support a proposal in which one of the options available to beneficiaries is the opportunity to maintain their choice of doctor by staying in the traditional Medicare program and get coverage for the high cost of prescription drugs. This is clearly the option that most beneficiaries would choose. Unfortunately, it is a choice that is not available to them now. Nor would it be available to them if a proposal following the president’s outline were enacted into law. Only a comprehensive drug benefit available through the traditional Medicare program will make this option a reality.

- Forces beneficiaries wanting drug coverage to depend on unreliable private plans. Existing private insurance plans in Medicare have offered unreliable coverage to beneficiaries. Since 1999 there have been 2.4 million occasions when beneficiaries have been dropped by an HMO that was pulling out of the program or reducing the area it served. In
one year, 22 percent of enrollees in Medicare HMOs were forced to look for new providers when their HMO stopped providing service in their area.\textsuperscript{4} When beneficiaries are dropped they must scramble to find alternative coverage and, according to one major study, in 22 percent of cases beneficiaries affected by a plan withdrawal were forced to give up their relationship with their doctor.\textsuperscript{5} Changing doctors can be especially traumatic for seniors who have developed a long-term bond of trust with a particular provider.

- \textbf{Administration plan cannot avoid the instability problems that have plagued the Medicare+Choice program.} There are several ways the new Enhanced Medicare program differs from the existing Medicare+Choice program that supporters may argue will make it better able to retain private plans. First, under Enhanced Medicare payments to plans will be determined based on market competition rather than through the existing system in which Medicare is able to pay providers a price lower than private plans because it represents so many beneficiaries. Second, under Enhanced Medicare plans will be forced to provide service to large regions of the country and will not be able to selectively withdraw from particular counties, as they could in the M+C program.

It is unclear if creating a more market competitive system would lead to more or less instability. If increased competitiveness were to lead to lower payments to plans, it could result in more instability. Requiring plans to cover a larger area than they do in the M+C program is likely to lead to more stability in the program. But private plans will never be as stable as the traditional Medicare program, which has never dropped a single enrollee. On average, HMOs offering coverage through the FEHBP program, in which payments to plans are set by a competitive process, drop 5 percent of the beneficiaries they are covering each year.\textsuperscript{6} Last year, Blue Cross Blue Shield, the single largest insurer in the FEHBP program, covering 49 percent of enrollees, threatened to withdraw from the program.\textsuperscript{7} Although it appears that nothing will come of the BCBS threat, this incident demonstrates the inherent instability of a program that relies on private plans to provide coverage. Therefore, if stability is a goal of reform efforts then Medicare should not rely on private plans to offer health care coverage, including coverage for prescription drugs, to our nation’s seniors. Instead it should be made available through the traditional Medicare program.

- \textbf{Proposed drug benefit is much less generous than FEHBP coverage.} The administration talks as if its framework will offer coverage similar to what members of Congress receive through FEHBP. The reality is that the level of funding the administration has proposed for its benefit means that it will be much less generous than the benefit available through FEHBP. The administration has proposed $400 billion towards Medicare reform over 10 years, only a portion of which would be available for adding prescription drug coverage. In 2002, the Congressional Budget Office and the Congressional Research Service found that dedicating $341 billion over 10 years to a Medicare drug benefit would provide coverage that is less than two-thirds the value of FEHBP coverage.\textsuperscript{8}

- \textbf{“Discounts” available from drug cards may be illusory.} The President’s proposal for reforming Medicare includes making a drug “discount” card available to all Medicare beneficiaries, including those who elect to remain in traditional Medicare. The administration claims that drug discount cards will save beneficiaries 10-25 percent off retail prescription
drug prices. However, there is no reason to believe the administration’s discount cards will result in savings any better than those offered by discount cards already widely available to seniors. According to a study by the General Accounting Office (GAO), the discounts these cards offer are limited, averaging about 10 percent off the prices of brand name drugs that seniors most often use.\textsuperscript{9} Ironically, many times the prices that pharmacies offer to any senior shopping at their store will be lower than the price available to those with a “discount” card.\textsuperscript{10}

- **Drug discount cards may not be honored in all pharmacies.** Organizations offering discount cards typically negotiate with pharmacies seeking to participate in their programs. If pharmacies are unwilling to accept lower payments for dispensing medications they may decline to honor a particular card. This will mean that beneficiaries who have enrolled in card programs are likely to find their cards of no use to them at some pharmacies.

- **Discount cards create formularies offering discounts only on certain prescription drugs.** Organizations offering drug cards generally use restricted formularies, which limits discounts only to those drugs listed on their formularies.\textsuperscript{11} This means that beneficiaries who must take drugs not on a card’s formulary will not benefit from any discounts a drug card company may have negotiated.

- **Enrollees in traditional Medicare would be forced to pay thousands of dollars out-of-pocket before they received any coverage for their drug costs.** The administration’s outline suggests that beneficiaries in traditional Medicare will receive coverage for catastrophic drug costs, but it does not specify at what level of out-of-pocket costs that coverage would become effective. Press accounts have suggested that coverage would be available only to those who spent over $5,500 a year on prescription drugs or perhaps only to those who spent over $7,000.\textsuperscript{12} If coverage were offered only to those who spent over $5,500 in a year this would benefit less than 18 percent of beneficiaries.\textsuperscript{13}

- **The only way the President’s proposal will save money for the Medicare program is if it forces beneficiaries to pay more.** In the past one of the rationales offered by those who support transforming the Medicare program into a system based on market competition between private plans is that it would result in greater efficiency and greater program savings.\textsuperscript{14} The administration does not make that claim in its Medicare reform background materials. This may be because cost increases in the private sector and FEHBP outpace those in Medicare.\textsuperscript{15} Close analysis of Medicare reforms based on the FEHBP model have found that the only way they are likely to save the program money is if they pass on more costs to beneficiaries, not by making the program more efficient.\textsuperscript{16} Not only has Ken Thorpe, an academic who worked with the Gore for President campaign in 2000, come to this conclusion, but in a recent policy paper on Medicare reform, the conservative Heritage Foundation—one of the original architects of plans to transform Medicare into a competitive market system—appears less certain of the claim they had made in earlier papers that competitive reforms would save the program money.\textsuperscript{17} Instead they advocate imposing greater costs on all but the lowest income beneficiaries of Medicare as a way of controlling costs.\textsuperscript{18}
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3Survey research has found that 85 percent of Medicare beneficiaries have not even considered choosing a different plan, generally because they like traditional Medicare. However, beneficiaries do care about maintaining their choice of doctor. See Medicare Payment Advisory Commission, “Report to the Congress,” March 2003, p. 205.
4Public Citizen Analysis of Centers for Medicare & Medicaid Services data.
10Ibid.