

Testimony of Edmund F. Haislmaier

Before the Subcommittee on Human Rights & Wellness of the Committee on Government Reform of the U. S. House of Representatives

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Mr. Chairman and Members of the Committee:

My name is Edmund F. Haislmaier. I am a Visiting Research Fellow in the Center for Health Policy Studies at The Heritage Foundation. The views expressed in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

I appreciate your invitation to appear and discuss the effects of the prescription drug provisions in H.R. 1 and S. 1. As you know, a conference committee is currently working to resolve the difference between those two bills.

I will focus my remarks today principally on the likely effects that the new Medicare outpatient prescription drug benefit contained in the legislation will have on existing retiree coverage for prescription drugs.

Background

Mr. Chairman, in discussing any proposal for outpatient prescription drug coverage for the Medicare population it is necessary to begin with an understanding of current drug coverage among that population.

To start with, of the just over 40 million current Medicare beneficiaries, almost half (46 percent) already have fairly comprehensive drug coverage. They are the 16 percent of beneficiaries (about 6.4 million) who have drug coverage through Medicaid, plus another 30 percent (about 12 million) who have drug coverage through an employer-sponsored retirement plan.¹

Another 29 percent of Medicare beneficiaries have some drug coverage from another private or public source. They include the 12 percent (about 4.8 million) who have individually purchased Medicare supplemental insurance (Medigap) policies with limited, front-end drug coverage as well as about 17 percent (about 6.8 million) who have limited coverage through a Medicare HMO, or through a state or federal program other than Medicaid.

¹ See: Douglas Holtz-Eakin, Director, Congressional Budget Office, *Prescription Drug Coverage and Medicare's Fiscal Challenges*, Testimony before the Committee on Ways and Means, U.S. House of Representatives, April 9, 2003.

Finally, the remaining 25 percent of Medicare beneficiaries (about 10 million) have no drug coverage. Some of them have high drug expenditures, while others have average or low drug expenditures. Logically, it is the subset of this group with high drug costs that most desires a new Medicare drug benefit.

As these coverage disparities show, the challenge facing Congress is to design reforms that provide outpatient prescription drug coverage for Medicare beneficiaries who currently lack coverage and improve the coverage of those beneficiaries who currently have limited benefits, without at the same time diminishing the benefits of those who currently have more comprehensive coverage.

The danger for Congress is that, in taking a “one-size-fits-all” approach, it runs the risk of creating as many or more “losers” as it does “winners” and thus generating the kind of retiree opposition that it experienced with the 1988 Medicare Catastrophic legislation. Regrettably, that is the approach both the House and the Senate have again taken in the pending Medicare legislation

Standard Benefit Design

Both the H.R. 1 and S. 1 would create a new Part D Medicare drug benefit, with a standard benefit design. Both bills also have provisions designed to induce private insurers to offer the new coverage, and both would subsidize the cost of coverage for enrollees. Table 1 shows how the coverage structure for the drug benefit differs in the two bills.

Table 1

Comparison of Coverage Under Standard Prescription Drug Plan for First Year (2006) in S. 1 and H.R. 1

	S. 1	H.R. 1
Deductible	\$275	\$250
Initial Cost-Sharing	50% up to initial coverage limit of \$4,500 in total drug spending.	20% up to initial coverage limit of \$2,000 in total drug spending.
Coverage Gap	Beneficiary pays 100% of the cost of the next \$1,312.50 in drug spending.	Beneficiary pays 100% of the cost of the next \$2,900 in drug spending.
Stop-Loss on Out-of-Pocket Spending	\$3,700 in beneficiary deductibles and co-pays (reached at \$5,182.50 in total drug spending).	\$3,500 in beneficiary deductibles and co-pays (reached at \$4,900 in total drug spending).
Cost-Sharing Above Stop- Loss	Beneficiary pays 10% of each additional dollar of drug spending after reaching the \$3,700 stop-loss.	No beneficiary cost-sharing above the \$3,500 stop-loss.
Income-Related Stop-loss Threshold	No provision.	Stop-loss threshold is higher for enrollees with incomes above \$60,000/individuals and \$120,000/couples.

Note: In both bills the deductible, initial coverage limit, and stop-loss are indexed for years after 2006.

Both designs have similar deductibles. The House benefit structure imposes lower total cost-sharing on beneficiaries than the Senate benefit structure. While the “coverage gap” in the House bill design is more than twice the size of the gap in the Senate bill design, the House bill provides for a true beneficiary “stop-loss.” Insurance “stop-loss” refers to the level beyond which the coverage pays 100 percent of the additional claims, and thus the losses stop for the policyholder. However, the “stop-loss” in the House bill would be increased, on a sliding scale, for upper-income beneficiaries. In contrast, while the Senate bill does not vary the benefit by income, it also places no limit on beneficiary cost sharing, and thus lacks a true beneficiary “stop-loss.”

Interaction With Other Coverage

These benefit structures are unlike any that can be found in a normal, private health insurance market and are largely the product of political and budgetary constraints. But the benefit design is only one part of the equation in determining how a new Medicare drug benefit will affect existing retiree drug coverage. Just as important are the provisions that govern how the new Medicare drug benefit will interact with existing employer-provided coverage and existing Medigap coverage.

I will first address the issue of coverage interaction among the larger group, those with employer-sponsored retiree drug coverage.

It has been reported that the Congressional Budget Office (CBO) estimates that if S. 1 became law, 37 percent, or about 4.4 million, of the 12 million seniors who currently have prescription drug coverage through plans sponsored by their previous employers would lose their private drug coverage. CBO’s equivalent estimate for coverage loss among this population under H.R. 1 is estimated to be 33 percent, or about 3.8 million retirees.²

However, the legislation would not simply create a binary choice of coverage versus no coverage for employers. Rather there are three other options implicit in the legislation that would also be available to employers who currently provide retiree drug coverage. Those options would be to: 1) keep the status quo; 2) conform their existing plan to the new law; or 3) drop their existing plan but provide retirees with “wrap-around” coverage to supplement the new Medicare plan.

Each option has trade-offs for both the employers and the retired workers who are covered by those plans, which I will outline here.

Option 1: Keep the status quo.

In this option the employer keeps its existing retiree drug coverage plan as is, and essentially ignores the new Medicare drug benefit.

² Robin Toner and Robert Pear, “House Committee Approves Drug Benefits for Medicare,” *The New York Times*, June 18, 2003.

Employer Pro: The employer would retain the flexibility to set and adjust the benefit design (within the context of any negotiated labor agreements) of its retiree drug plan. The employer could continue to offer a plan with different deductibles, co-pays and out-of-pocket limits than the new Medicare standard plan. The employer's plan could be either more or less generous than the Medicare standard plan. Also, the employer would avoid the burden of having its plan subject to Medicare audits.

Employer Con: The employer would forgo receiving a subsidy from Medicare. In the case of S. 1 the subsidy would equal to 70 percent of the average national premium for standard coverage (about \$840 in 2006) for each qualified enrollee in its plan. Under the Senate bill the employer would also lose the option to claim additional "reinsurance" payments from Medicare for its high-cost retirees, (those whose annual drug costs exceed \$5,813 a year.) In the case of H.R. 1 the foregone subsidy would be 28 percent of the cost of drugs in excess of the \$250 annual deductible for each qualified beneficiary, up to a maximum of \$5,000 per year.³ This subsidy to employers is less generous for beneficiaries with low drug costs and more generous for beneficiaries with high drug costs than the subsidies in the Senate bill. Also the employer would forego the opportunity to cap its plan losses.

Retiree Pro: The retirees in the plan would keep the drug benefit structure they currently have, since it would not need to meet the new Medicare standard. This would be advantageous to them if, and as long as, their employer plan is more generous than the Medicare standard, (e.g., a lower deductible and/or costs sharing requirements.) Also, the retirees would not have to pay the new Medicare drug coverage premiums (about \$420 a year in 2006).

Retiree Con: The employer would be free to change the design of the drug benefit in future years or to eliminate it altogether. However, because the plan was not a "qualified" one, if the employer later dropped the plan and the retiree sought to join the Medicare Part D program, he or she would be subject to the much higher premiums imposed for delayed enrollment.

Option 2: Conform the existing plan to the new law.

In this option, the employer modifies its existing retiree drug coverage plan to make it a "Qualified Retiree Prescription Drug Plan" under the new Medicare drug benefit. A "qualified" plan is either one that offers the same standard coverage structure specified in the legislation, with or without reduced beneficiary cost sharing, or a coverage structure that Medicare approves as "actuarially equivalent" to the standard coverage structure.

Employer Pro: The employer gains several advantages by conforming its existing plan to the new standard benefit design. First, if the employer's plan is

³H.R.1 Section 1860D-8(f)(3)

more generous (e.g., lower deductibles and co-pays) than the standard design it will be able to reduce plan costs by scaling back the benefits to meet the standard design (e.g., raising the deductible and/or co-pays). Second, Medicare will pay the employer a subsidy for each qualified enrollee in its plan. Third, in the case of S. 1, Medicare will pick up 80 percent of the additional costs of drugs for retirees in the plan who reach their annual out-of-pocket limit. Under the standard plan, in 2006 the \$3,700 out-of-pocket limit is reached once total drug spending exceeds \$5,813. Thus, for the 5,814th dollar, and all subsequent dollars spent on drugs for the beneficiary, Medicare will pay 80 cents and the employer and the retiree will pay 10 cents each.

Employer Con: In the future, the employer could not scale-back its plan to anything less than the standard coverage design, without its plan ceasing to be a “qualified plan.” The employer would need to get Medicare approval for its “qualified plan” and once the plan became a “qualified plan,” the employer would be subject to Medicare reporting requirements and plan audits. Also the employer would forego the opportunity to cap its plan losses, since to be a “qualified” plan, the employers plan would have to include catastrophic drug cost coverage that is at least actuarially equivalent to that in the Medicare standard plan design.

Retiree Pro: The employer would likely go through the trouble of getting its plan certified as a qualified plan only if it intended to keep the plan for the foreseeable future. Also, if or when the employer did discontinue its plan the retiree would be able to buy one of the standard Medicare plans without being hit with the much higher premium for delayed enrollment. Thus, the retiree would be protected against losing coverage.

Retiree Con: If the current employer plan is a generous one, it is likely that the employer will be forced to scale back the benefits offered to meet the new Medicare standard coverage design or the actuarial equivalence standard. Also, if the employer did get approval for a plan that was more generous than the Medicare standard plan, it could always scale the plan back to the Medicare standard at any time. Indeed, given the complexity and restrictions associated with the actuarial equivalence standard in the Senate bill, plus the general desire of employers to scale back, if not eliminate coverage, it is most likely that any employer electing to keep its plan and make it a “qualified” one would simply adopt the Medicare standard coverage structure into its new plan and blame Congress for forcing it to scale back coverage.

Option 3: Drop the existing plan but provide “wrap-around” coverage.

In this option, the employer discontinues its existing retiree drug coverage plan and has its retirees enroll in the new standard Part D Medicare drug plans. The employer compensates its retirees by providing “wrap-around” drug coverage that pays the out-of-pocket costs its retirees incur with the standard Part D Medicare drug plans. The

employer might also pay the retirees' share of the premium for the Medicare drug coverage.

Employer Pro: The employer can reduce and cap its retiree prescription drug liability and greatly simplify its plan. In exchange for eliminating coverage, the employer simply agrees to pay its retirees' co-payments for their Medicare drug coverage up to a fixed annual amount. Thus, the employer shifts the majority of the price and volume risk for drug coverage onto Medicare and its own retirees. The employer also effectively creates a stop-loss for itself. Furthermore, the employer no longer needs to contract with an insurer or a pharmacy benefit manager (PBM) to manage its retiree drug benefit. Instead, it just hires a contractor to process reimbursements for employee cost sharing. Nor is the employer plan subject to Medicare oversight as it would be if the employer sought to make its plan a "qualified" one. Of course, the employer is free to further scale-back or eliminate this wrap-around coverage at any time.

Employer Con: There really is no employer downside to this option other than the fact that some of its retirees (those with high drug costs) will not be happy with the new arrangement. However, the employer can blame it on Congress, while pointing out that the above alternatives are not very attractive for the retirees either. Also, the employer would forgo the subsidies offered for making its plan a qualified plan. But if the savings from substituting wrap-around coverage are worth more than the subsidies for converting its plan to "qualified" coverage, the smart move will be for the employer to shift to wrap-around coverage.

Retiree Pro: Depending on the generosity of the employer, the retiree still gets fairly comprehensive drug coverage. However, the coverage would now come in two parts. The Medicare drug plan would be the primary insurer and the employer would pay the deductible and the initial coinsurance with wrap-around coverage up to some employer set limit. This is the same arrangement as currently exists with employer-paid wrap-around coverage for Medicare Parts A and B.

Retiree Con: As long as the retiree does not incur substantial drug costs, there is little to complain about in this arrangement. The retiree is still getting comprehensive drug coverage, coming, as noted, in two parts. The problem with this option will be for those retirees with the highest drug costs. If the employer sets any limit, (and most employers likely will set some limit) on the total amount of co-pays it will reimburse the retiree, then any retiree who exceeds the employer's cost-sharing limit will first need to spend \$3,700 under S. 1 or \$3,500 under H.R. 1 out-of-pocket before Medicare again kicks in and pays 90 percent of the costs under S. 1 or 100 percent of the costs under H.R.1. This is because, according to provisions in both bills, none of the payments from the employer wrap-around coverage would count toward the retiree's "out-of-pocket" spending limit. Indeed, under the provisions of S. 1, Section 1860D-6(c)(4)(D), enrollees who are found to have claimed out-of-pocket expenses that were actually

reimbursed by private insurance, would have their Medicare Drug coverage terminated.

The most likely result will be that those employers, who currently offer coverage, if they don't drop it entirely, will adopt either the second or third option. They will either make their plan a "qualified plan," and scale-back current coverage, or substitute "wrap-around" coverage for their current plan.

The lower front-end cost-sharing structure in the House bill coverage design means that it will be less costly than the Senate bill for employers who decide to offer wrap-around coverage. Under the Senate bill, an employer offering wrap-around coverage would spend \$2,387.50 in paying the deductible and initial cost sharing on the first \$4,500 in drug expenses, or \$2,807.50 if the employer also reimbursed the retiree for the estimated \$420 annual premium. In contrast, under the House bill an employer offering wrap-around coverage would spend only \$600 in paying the deductible and initial cost sharing on the first \$2,000 in drug expenses, or \$1,020 if the employer also reimbursed the retiree for the estimated \$420 annual premium.

The Effects Of Employer Wrap-Around Drug Coverage

Of the different options that either bill would present to employers, the simplest and most attractive one for them is the option of substituting wrap-around coverage for their current plans. With that approach, the employer off-loads most of the cost and risk of retiree drug coverage, while still pleasing the majority of its retirees who have relatively low annual drug bills. Although some employers may drop their existing coverage entirely, the more likely scenario is that most employers will sooner or later substitute wrap-around coverage for their existing, more comprehensive plans.

The problem with this approach for the retiree is that, under both bills, none of the amounts paid by employer wrap-around benefits to cover the deductible and initial cost sharing would count toward the out-of-pocket limits. This means that employer wrap-around coverage would have the effect of aggregating together all of the cost sharing in one large coverage gap or "doughnut hole," which would then kick-in at the point at which the employer's wrap-around coverage ended.

Senate Bill Effect

In practice, the Senate bill would set in motion the following dynamics. The retiree enrolls in one of the new Medicare drug plans and pays about \$420 a year in premiums. Under the Senate version, the employer reimburses the retiree for the premiums plus pays the \$275 deductible as well as the 50 percent coinsurance on the next \$4,225 in drug expenses (or \$2112.50). At that point the retiree has consumed \$4,500 in drugs and not paid a single penny in either premiums or out-of-pocket cost sharing. The employer has paid the \$420 in premiums, the \$275 deductible and the \$2,112.50 in coinsurance, for a total cost of \$2,807.50. Medicare has paid the remaining \$1,692.50 in drug spending. From that point on Medicare pays nothing. If the employer also caps its program at that

level, then the retiree must pay 100 percent of the cost of the next \$3,700 in drug expenses, after which Medicare will then start paying 90 cents of each additional dollar with the retiree paying the remaining 10 percent.

Chart 1 shows how, under the Senate bill, this scenario will result in retiree drug spending being distributed among employers, retirees, and Medicare. It also shows how employers will be able to create a stop-loss limit for themselves by converting their exiting retiree drug plans into wrap-around coverage.



As can be seen in the chart, under S. 1 an employer is able to effectively create a stop-loss for itself at the level of \$2,387.50 of the first \$4,500 per year in drug spending per retiree. However, neither Medicare nor the retirees have a true stop loss. The indexing of the deductible and the “initial coverage limit” for the coinsurance means that the employer’s per-retiree drug spending stop-loss will rise over time, but it will still remain a true stop-loss for the employer.

However, thanks to the generosity of the employer in providing wrap-around coverage, the point at which the program’s “catastrophic level” co-pay of only 10 percent kicks in for the retiree has been pushed up from \$5,812.50 in total drug spending to \$8,200 in total drug spending. At that point, of the total \$8,200 in drug spending, the employer will have paid \$2,387.50, or 29 percent; Medicare will have paid \$2112.50, or 26 percent; and the retiree will have paid \$3,700, or 45 percent.

Thus, the effect of the employer offering wrap-around coverage will be to increase the burden on those retirees with higher drug costs. This can be seen in Chart 2, which shows the percentage share of drug spending for the employer, the retiree, and Medicare at each level using the same data as in Chart 1.



Under the Senate bill, due to the employer creating an effective stop-loss, the proportionate share paid by the employer declines as the level of drug spending increases. In contrast, the retiree's proportionate share of the spending increases dramatically once the employer's wrap-around coverage stops, and only starts to decline once the retiree has spent an additional \$3,700 and met Medicare's "out-of-pocket limit."

House Bill Effect

A similar, though somewhat different, effect occurs under H.R. 1. Under the House bill, the employer reimburses the retiree for the premiums and pays the \$250 deductible as well as the 20 percent coinsurance on the next \$1,750 in drug expenses (or \$350). At that point the retiree has consumed \$2,000 in drugs and not paid a single penny in either premiums or out-of-pocket cost sharing. The employer has paid the \$420 in premiums, the \$250 deductible and the \$350 in coinsurance, for a total cost of \$1,020. Medicare has paid the remaining \$1,400 in drug spending. From that point on Medicare pays nothing. If the employer also caps its program at that level, then the retiree must pay 100 percent of the cost of the next \$3,500 in drug expenses, after which Medicare will then pay all additional costs.

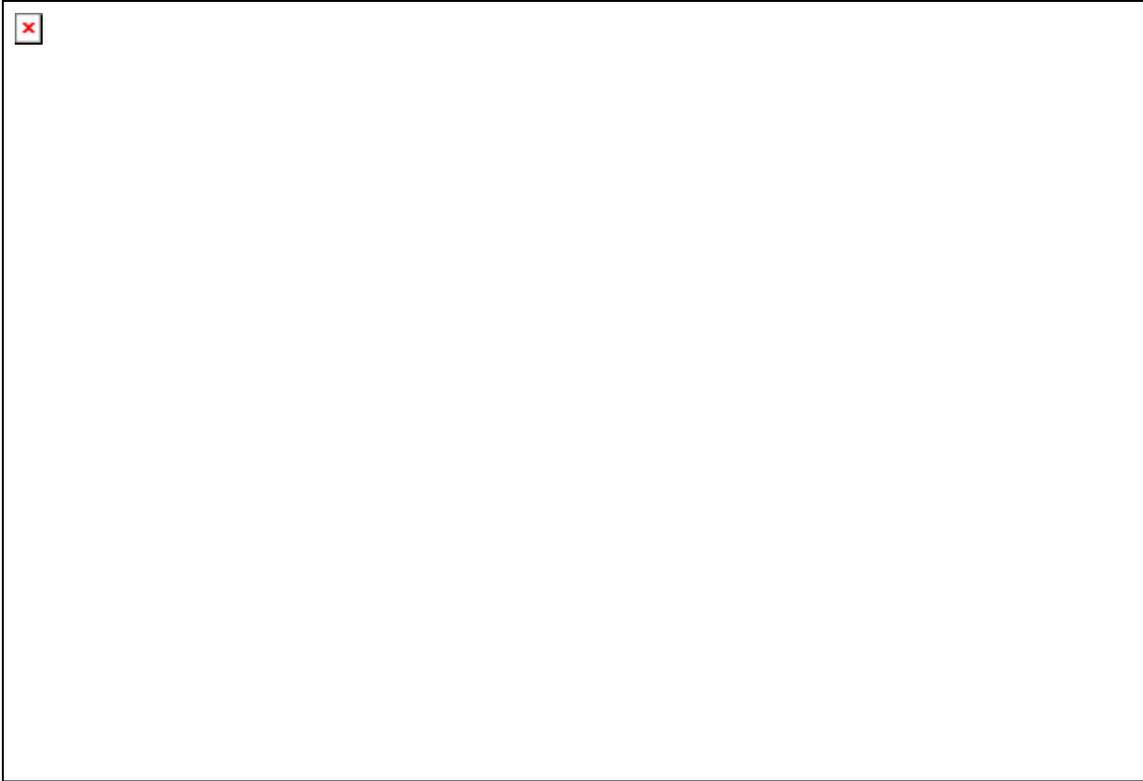
Chart 3 shows how, under the House bill, this scenario will result in retiree drug spending being distributed among employers, retirees, and Medicare.



Once again, the chart shows how under H.R. 1 the employer is able to effectively create a stop-loss for itself. The difference in this case is that the employer can set that level as low as \$600 of the first \$2,000 per year in drug spending per retiree. However, in the House bill, after the retiree has spent \$3,500 out-of-pocket, he or she also reaches a true stop-loss. The indexing of the deductible, the “initial coverage limit” for the coinsurance and the retiree stop-loss means that both the employer’s and the retiree’s stop-loss levels will rise over time, but they will still remain true stop-losses.

Again, thanks to the generosity of the employer, the point at which the program’s stop-loss kicks in for the retiree has been pushed up from \$4,900 in total drug spending to \$5,500 in total drug spending. At that point, of the total \$5,500 in drug spending the employer will have paid \$600, or 11 percent, Medicare will have paid \$1,400, or 25 percent, and the retiree will have paid \$3,500, or 64 percent.

Thus, the effect of the employer offering wrap-around coverage will again be to increase the burden on those retirees with higher drug costs, though not as much as in the Senate bill. This can be seen in Chart 4, which shows the percentage share of drug spending for the employer, the retiree, and Medicare at each level using the same data as in Chart 3.



As with the Senate bill, the effect under the House bill is that, since the employer can create a stop-loss, the proportionate share paid by the employer declines as the level of drug spending increases. In contrast, the retiree's proportionate share of the spending increases dramatically once the employer's wrap-around coverage stops, and starts to decline only after the retiree has spent an additional \$3,500 and met Medicare's stop-loss. However, because the House bill includes a true stop-loss for the retiree, his or her share of the total cost declines more rapidly than in the Senate bill as the level of drug spending increases.

Impact of S.1 and H.R. 1 on Existing Medigap Coverage

Medicare enrollees without employer-provided Medicare supplemental coverage are able to buy supplemental coverage on their own. Such plans are commonly called Medigap plans. Federal law permits insurers to sell 10 different types of standardized Medigap plans. Three of the plans, (plans H, I, and J) provide "front-end" prescription drug coverage. In all three of those plans the beneficiary pays a \$250 deductible, and the plan reimburses the beneficiary 50 percent of the cost of drugs up to an annual maximum amount. In the case of plans H and I, the maximum amount is \$1,250 and in the case of plan J, the maximum amount is \$3,000. Thus, the beneficiary pays all of the first \$250 a year in drugs plus half of the next \$2,500 or \$6,000 (depending on the plan), plus any drug costs beyond those limits.

An estimated 4.8 million Medicare beneficiaries currently have additional coverage for drugs through one of the three standard Medigap plans.

Impact of Senate Bill on Medigap

Section 103 of S. 1 would ban the sale or renewal of Medigap plans with prescription drug coverage after January 1, 2006, to any Medicare enrollee who is enrolled in a new Medicare Part D prescription drug plan. Beneficiaries with coverage under one of those Medigap plans would be allowed to switch to any other Medigap plan that did not include drug coverage. Thus, beneficiaries with those plans would be forced to choose between their existing drug coverage and the new Medicare drug coverage. If they opted to keep their existing Medigap coverage, they would be penalized with higher premiums if they tried to enroll later in the Medicare Part D drug benefit.

The Senate bill in effect would all but eliminate Medigap plans with prescription drug coverage. The result would be that retirees would have no way of obtaining insurance, other than employer-sponsored wrap-around coverage, to pay the cost sharing under the Senate version of the Medicare drug benefit.

Impact of House Bill on Medigap

The House bill differs from the Senate bill in that, while it eliminates current Medigap plans with drug coverage in the future, it “grandfathers” enrollees who already have such coverage and allows them to keep it. Under the House bill, any Medicare enrollee with an H, I, or J Medigap policy in force on January 1, 2006, would be able to keep that policy or switch to a new policy of the same type. Also, the House bill instructs the National Association of Insurance Commissioners (NAIC) to develop two new standard Medigap plans that include coverage for the cost sharing (other than the deductible) in the new Medicare Part D prescription drug plan.⁴

Thus, under H.R. 1, Medicare enrollees with Medigap plans that pay for prescription drugs could enroll in the new Medicare Part D drug benefit and keep their Medigap coverage to pay the cost sharing. Also, in the future, Medicare beneficiaries would be able to buy new Medigap plans that covered some of the cost sharing of the Part D drug benefit.

However, as with any payments made by employer wrap-around policies, any payments for drugs made by a Medigap plan would not count toward the beneficiary’s stop-loss under the new Medicare Part D prescription drug plan.⁵

The resulting effects are similar to those for employer wrap-around coverage. Combining Medigap drug coverage with the new Medicare Part D drug benefit only serves to push the beneficiary’s cost sharing up to a higher level of total annual drug spending. It does not buy what the beneficiary really wants – coverage for the initial cost sharing and the “doughnut hole” coverage gap in the Medicare drug benefit design. This means that the

⁴H.R. 1, Section 104.

⁵H.R. 1, Section 1860D-2(b)(4)(C)(ii)

extra Medigap coverage is almost certainly not worth the much higher premiums beneficiaries must pay for plans H, I, and J. Consequently, under the House bill most retirees who currently have Medigap plans that cover drugs will likely chose to switch to a Medigap policy without drug coverage (and with a lower premium).

Thus, under either the House or Senate bill, retirees without employer coverage will in the future have no realistic way to obtain private insurance to cover the costs of the deductible, cost sharing, or coverage gap in the new Medicare Part D drug plan.

Conclusion

Mr. Chairman, to summarize, my analysis of the outpatient prescription drug benefit provisions in H.R. 1 and S. 1 leads me to concluded that the most likely results will be that employers who currently offer prescription drug coverage for their retirees will either scale back their coverage to the standard plan design or replace their existing coverage with wrap-around coverage.

After reviewing the legislation, I believe that the easiest and most cost effective course of action for employers under either bill will be to substitute wrap-around coverage for their existing retiree drug plans. Thus, most of those retirees will continue to have comprehensive, front-end drug coverage. However, the interaction of the new Medicare benefit with the wrap-around coverage and the legislated prohibitions on private insurance reimbursements counting toward beneficiary cost-sharing mean that those retirees with higher drug costs will be forced to spend much more out-of-pocket under that arrangement.

In addition, the provisions in both bills with respect to Medigap coverage effectively mean that retirees will not be able to purchase private supplemental insurance to cover the cost-sharing under the new Medicare drug benefit. Even if the conference committee adopts the House bill provision to instruct NAIC to develop two new standard Medigap plans that partly cover drug cost-sharing, the effect of the prohibition on those insurance payments counting toward the beneficiary cost-sharing limit will only serve to ensure that those beneficiaries with higher total drug costs face higher out-of-pocket expenditures.

Thus, the principle “winners” under either bill are those beneficiaries who currently have no public or private coverage for outpatient prescription drugs, while the principal “losers” are those beneficiaries who currently have private drug coverage, either through an employer plan or a Medigap plan, and also have high drug costs.

Notwithstanding the politically appealing and superficial rhetoric of universal drug coverage, it is the quality of the policy that will determine its reception among seniors and taxpayers alike. Based on the details of the Senate and House drug provisions, and the incentives and dynamics they are certain to set in motion, it is likely that a significant number of retirees will not be thanking their representatives for the new Medicare drug entitlement. Now, as in 1988, the danger for Congress is that if it legislates in haste, it could end up repenting at leisure.

If Congress wants to avoid the kind of retiree backlash that occurred in response to the 1988 Medicare Catastrophic Coverage Act, it should scrap the drug provisions in both the House and Senate bills and go back to the 1999 recommendations of the majority of the membership of the National Bipartisan Commission on the Future of Medicare and provide Medicare beneficiaries with a choice between the traditional Medicare program as it exists today and new, private plans offering comprehensive, integrated benefits including outpatient prescription drug coverage.

The goal of true Medicare reform is to help tomorrow's retirees escape the growing problems that beset the current Medicare program, problems that are rooted in the absence of integrated, quality care. Congress should instead give retirees the option of choosing between the existing Medicare system and a set of new, private plans, with comprehensive drug coverage, subsidized by the government.

Only by covering outpatient prescription drugs through an integrated, flexible package of privately delivered health care benefits can Medicare in fact realize the tremendous potential of modern pharmaceuticals to both reduce other health care costs and to improve the quality of health outcomes and the lives of America's current and future retirees.

Mr. Chairman, this concludes my prepared testimony. I will be glad to try to answer any questions you or the other members of the Committee may have. Thank you.

***Disclosure:** Neither Mr. Haislmaier nor The Heritage Foundation is, nor was during the previous fiscal year, the recipient of any Federal Government grant or contract.*