

Testimony of

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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.

Mr. Chairman, thank you for the opportunity to testify today. As today's hearing illustrates, even after passing H.R. 1 and S. 1 this summer, Congress is still wrestling with the challenge of constructing a Medicare drug benefit that helps those beneficiaries currently without coverage, while not unduly displacing the existing coverage that millions of other seniors currently receive.

It is becoming increasingly clear that a significant number of Medicare beneficiaries are unhappy with Congress's first draft of a drug benefit design, as embodied in H.R. 1 and S. 1.

The two major objections voiced by seniors are the odd benefit design that includes a "coverage gap" or "doughnut hole," and the concern that beneficiaries with employer-provided retiree drug coverage will see that coverage diminished or even eliminated as a result of the legislation.

Adverse Impact on Existing Retiree Coverage.

Let me address the second objection first, since it is a matter of some dispute.

About 30 percent of Medicare beneficiaries, or about 12 million individuals, currently receive prescription drug coverage through employer-provided retiree health benefits plans. The Congressional Budget Office (CBO) estimates, "that 32 percent of the Medicare beneficiaries who would have employer drug coverage under current law would not have their employer provide coverage to supplement the Part D benefit under

H.R. 1; under S. 1, that share is estimated to be 37 percent.”¹ Thus, CBO estimates that between 3.8 and 4.4 million Medicare beneficiaries would lose employer-provided prescription drug coverage under the pending legislation.

In contrast, the Employee Benefit Research Institute (EBRI) estimates a much lower likely coverage loss among this group; in the range of 2 percent to 9 percent, or between 240,000 and 1 million.² However, the EBRI study also notes that, “We believe most employers will choose to ‘wrap-around’ Medicare for current retirees, as they generally do today.”³

These substantial differences in estimates of coverage loss are attributable to different interpretations of the rather limited and imprecise existing survey data on employer-provided retiree benefits.

However, my analysis of the pending legislation leads me to agree with EBRI that the principle effect will be that those employers that don’t drop retiree drug coverage will scale-back the coverage they offer to the level of front-end, wrap around coverage for the new Part D benefit.

While I can’t offer the Committee a better estimate of how many beneficiaries will lose coverage completely, I am fairly confident that the vast majority of beneficiaries with current employer-provided drug coverage will see the scope of their drug coverage at least diminished as a result of employer responses to this legislation.

Under H.R. 1 and S. 1, an employer that currently offers retiree coverage would be faced with four options:

- 1) Drop coverage entirely and have its retirees enroll in the new Part D benefit.
- 2) Keep its existing retiree drug coverage plan as is, and ignore the new Medicare drug benefit.
- 3) Conform its existing plan to the new law by modifying the plan to make it a “Qualified Retiree Prescription Drug Plan.”
- 4) Scale-back its existing plan to provide retirees with front-end “wrap-around” coverage to supplement the new Part D benefit. The employer might also pay its retirees’ share of the premium for the new Part D benefit.

¹ Congressional Budget Office, “Cost Estimate: H.R. 1, Medicare Prescription Drug and Modernization Act of 2003 and S. 1, Prescription Drug and Medicare Improvement Act of 2003,” July 22, 2003.

² Dallas L. Salisbury and Paul Fronstin, “How Many Medicare Beneficiaries Will Lose Employment-Based Retiree Health Benefits if Medicare Covers Outpatient Prescription Drugs?” Employee Benefit Research Institute, *EBRI Special Analysis*, July 18, 2003.

³ *Ibid.*, footnote 5.

Options two and three are not particularly attractive to employers. Ignoring the legislation and maintaining the status quo does nothing for an employer seeking to lower its unfunded retiree health care liabilities. While an employer who pursued option three and conformed its existing plan to the new law would receive new subsidies from Medicare, the employer would still be at risk for much of the costs of the benefit and would still need to administer the benefit. In addition, because the legislation rigidly defines actuarial equivalence, the newly conformed plan would need to look much like the benefit structure of the new Part D benefit. Thus, even if the employer did conform its plan, the retirees would likely see some diminution of coverage relative to what they currently enjoy.

For employers, options one and four are by far the most attractive. Thus it is reasonable to assume that those employers willing and able to discontinue coverage altogether will do so. For the remainder, enrolling their retirees in the new Part D benefit and then providing front-end, wrap-around coverage is both the simplest and cheapest choice.

Unfortunately for retirees, the effect of their employers choosing option four will be to aggregate together all of the cost sharing into a bigger “doughnut hole.” This is because under both bills employer insurance payments for cost sharing do not count in calculating the retiree’s cost sharing requirements. Thus, under H.R.1 a beneficiary with employer wrap-around coverage that paid the deductible and initial cost sharing would spend nothing out-of-pocket on the first \$2,000 of drugs, but would then have to spend the next \$3,500 out-of-pocket before the Part D catastrophic benefit kicks in. The employer, however, under this arrangement would be able to cap its retiree drug spending at a maximum of \$600 per retiree, or at \$1,020 per retiree if the employer also elected to reimburse its retirees for the cost of the Part D premium. The effects under S.1 would be similar.⁴

Coverage Gap.

The second major objection to the pending legislation is the substantial coverage gap or “doughnut hole” in the Part D benefit design.

A basic problem that Congress faces in designing any Medicare drug benefit is that the principles of good insurance collide head on with the principles of good politics. Essentially, any real insurance program collects a little in premium from everybody and pays out a lot in benefits to those few with the greatest need. In contrast, to be popular a government program needs to meet the political demands of giving something to everybody. So Congress has to figure out how to help those with the greatest needs while still giving something to everybody -- or more accurately, giving everybody at least as much -- and preferably more -- than they have now.

⁴ For a more detailed discussion, see Edmund F. Haislmaier, “How Congress’s Medicare Drug Provision Would Reduce Seniors’ Existing Private Coverage,” Heritage Foundation *Backgrounder* No. 1668, July 17, 2003.

It was the attempt to square this circle, while still staying even within the generous budget parameter of \$400 billion dollars, which produced the coverage gap design of the Part D benefit in H.R. 1 and S. 1.

An Alternative Approach.

Can Congress still come up with a better drug plan? Yes, I think so, and I am glad, Mr. Chairman, that you are pursuing that option by holding this hearing.

The first step in designing a better plan is to start by admitting to ourselves the basic reality that when it comes to the first thousand dollars or so of a retiree's drug spending we need to think of any subsidies as basically a cash-equivalent. We can all do ourselves a big favor and greatly simplify things if we start by admitting that anyone taking a daily dose of one or more medications for one or more chronic conditions (i.e., many of the elderly), has ongoing drug expenses that in no proper sense of the word can be considered "insurable." Indeed, for many retirees their monthly prescription drug expenses are probably more predictable than their monthly electric bills.

Thus, I believe we should start by figuring out how much cash we want to give each retiree. Next, let's make sure some of that cash is used to buy them insurance coverage for the share of their future drug spending that is less predictable and thus somewhat more insurable. That would be insurance against catastrophic drug expenses. A relatively small number of beneficiaries have very high drug expenses that are unaffordable to the individual, but constitute only a portion of the total program cost. Finally, let's give the beneficiaries the rest of the money in a form that is administratively simple, can only be used on drugs and encourages the appropriate use of generics and the seeking of discounts.

My recommendation is to give Medicare beneficiaries the option of a getting a subsidy for their prescription drugs through a combined debit card and discount card. To get the subsidy they would have to enroll in a private plan that provided catastrophic drug expense insurance. It could be any kind of plan -- existing employer-sponsored plans, Medigap, the new comprehensive Medicare Advantage plans or stand-alone drug plans. Every plan would have a natural incentive to hire a Pharmacy Benefit Manager (PBM) to manage the drug benefit and get discounts. Each plan would give its enrollees a PBM discount card with the debit card feature added on. The first thing deducted from the debit card would be the premium for the catastrophic insurance. The beneficiary could then apply the remaining funds toward the deductibles and copays.

The per-beneficiary subsidy amount could be varied based on income and indexed for inflation. The benefit structure would be a high deductible with a catastrophic stop loss and cost sharing in between – i.e., real insurance. For example, a \$1,000 deductible with a \$6,000 stop-loss and 50/50 cost sharing in between, would ensure that the beneficiary paid no more than \$3,500 out-of-pocket – the same as the House bill, which has a lower total out-of-pocket cost than the Senate bill.

All of the plans providing the coverage would also participate in a national reinsurance pool. The pool would pay any claims above the per-beneficiary stop loss level. Those costs of the pool would then be passed back to all plans as a fixed amount per-enrollee, which in turn would be added on to the premiums. Thus, the selection effects that the plans fear would be adjusted for and everyone would pay an even share of the extra cost of the small minority with high drug spending.

The result would be that Congress could give all seniors essentially low cost, subsidized catastrophic drug insurance, access to discounts on all of their drug purchases (including the share paid for out-of-pocket) and some money left over toward out-of-pocket costs (with more for the low-income).

One advantage of this approach is that more assistance could be targeted to low-income beneficiaries by simply increasing the contribution to their debit cards. Another advantage is that there would be minimal disruption of employer-provided drug coverage for those retirees with such coverage, as those plans would easily qualify to participate and enrollees could spend their subsidy on payments to maintain their existing coverage.

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.

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