

**THE MEDICARE PRESCRIPTION
DRUG, IMPROVEMENT, AND
MODERNIZATION ACT OF 2003:
WILL IT BE GOOD MEDICINE FOR
U.S. HEALTH POLICY?**

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The Medicare Prescription Drug, Improvement, and Modernization Act (MMA), passed by Congress in 2003, took effect on January 1, 2006. The Act created a Part D for Medicare that includes coverage of outpatient prescription drugs. This expansion of Medicare will have far-reaching effects for seniors, nearly all of whom are eligible for this new coverage, as well as for the general population of taxpayers. Professor Channick argues that despite the MMA's appearance as a legislative commitment to social insurance, it actually hinders progress toward universal health insurance. The MMA also shows a clear commitment to the private market to solve social problems, and it will ultimately shift costs from the government and employers to individual citizens and employees, particularly the elderly. Moreover, the cost of implementing the MMA is prohibitive at a time when the financial demands of national emergencies such as the war in Iraq and the Katrina disaster make it difficult to finance other programs. As a result, Professor Channick concludes that the MMA may prove to be bad medicine for the future of U.S. health policy.

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I. Introduction

In November 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) passed both the House of Representatives and the Senate, and it was signed into law by President George W. Bush on December 8, 2003.¹ The Act establishes a new voluntary Medicare Part D for outpatient prescription drug coverage effective January 1, 2006.² To pay for an outpatient prescription drug benefit for all Medicare beneficiaries, Congress had originally pledged \$400 billion over ten years.³ Although this seems like a huge price tag, Senator Edward Kennedy (D-Mass.) freely admitted that the \$400 billion is merely a down payment on the cost of providing a prescription drug benefit to Medicare beneficiaries.⁴ If his prediction is only partially accurate, the cost of providing this admittedly medically necessary Medicare benefit could cost trillions of dollars, raising the cost of health care in the United States well above the current 15% of the nation's gross domestic product (GDP).⁵ In fact, one study predicts that health

1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

2. Prior to implementation of the MMA, Medicare will offer certain beneficiaries drug discount cards. See 42 U.S.C.S. § 1395W-141 (LexisNexis 2006).

3. Since the MMA's passage, however, the cost of providing prescription drug coverage has gone from \$395 billion to \$534 billion. Robert Pear, *New White House Estimate Lifts Drug Benefit Cost to \$720 Billion*, N.Y. TIMES, Feb. 9, 2005, at A1. In February 2005, Mark McClellan, the administrator of the Centers for Medicare and Medicaid Services (CMS), acknowledged that the cumulative cost of the program between 2006 and 2015 will gross \$1.2 trillion dollars, which nets out at \$720 million after factoring in savings and offsets. *Id.*

4. Interview by Judy Woodruff with Senator Edward Kennedy (D-Mass.) (June 18, 2003), available at <http://transcripts.cnn.com/transcripts/0306/18/ip.00.html>. The Congressional Budget Office has estimated that in the second decade of its existence, Part D of Medicare will cost in excess of \$1 trillion. EDWIN PARK ET AL., CTR. ON BUDGET & POLICY PRIORITIES, THE TROUBLING MEDICARE LEGISLATION (2003), available at <http://www.cbpp.org/11-18-03health2.pdf>.

5. Thomas Saving and Andrew Rettenmaier estimate that the MMA would create a new, unfunded liability of \$7.5 trillion. Andrew J. Rettenmaier & Thomas R. Saving, *Another Medicare Monster*, WALL ST. J., June 24, 2003, at A.16. A study issued on February 23, 2005, by economists and actuaries at the Centers for Medicare and Medicaid Services estimates that by 2014, public sector spending on health care will account for almost 50% of all spending for health care in the United States, up from 45.7% in 2004, and that the MMA will be the reason for this shift from the private sector to the public sector. Steve Teske, *Cost with Drug Benefit, Taxpayers to Pay Half of U.S. Health Care Bill by 2014, CMS Says*, Health Care Daily Rep. (BNA) (Feb. 24, 2005).

spending in 2015 will be 20% of GDP, growing from about \$2 trillion in 2005 to \$4 trillion by 2015.⁶

This allocation of resources to the over-sixty-five cohort, while providing an important benefit to one segment of the population, further attenuates access to health care for the approximately fifty million Americans under the age of sixty-five who are uninsured or underinsured. Without an increase in the percentage of GDP dedicated to health care, the dollars spent providing a prescription drug benefit to seniors will be dollars that are unavailable to provide health care coverage to the under-sixty-five cohort.⁷ A recent report by the economists and actuaries of the Centers for Medicare and Medicaid Services (CMS) found that public sector programs such as Medicare and Medicaid will account for 47.5% of total U.S. health care spending by 2015, up from 45.1% in 2005.⁸ This shift in source of payment is due largely to the MMA: in 2005, Medicare was projected to pay for 2% of total prescription drug costs; in 2006, CMS predicted that Medicare's share of the costs would be 28%.⁹

The retirement of the baby boomers over the next thirty years is likely to further exacerbate the public sector's share of health care costs.¹⁰ In the words of Eugene Steuerle, "[t]he legacy we are about to leave our children is a government whose almost sole purpose is to

6. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH CARE EXPENDITURES PROJECTIONS: 2005–2015 (2005), <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf>.

7. In the United States, rationing as applied to health care, is an anathema. For the insured, this is surely true. Health insurance, even in a managed-care model, provides coverage that is both broad and deep. Even when insurers refuse to provide coverage by invoking language in the contract that excludes coverage for certain treatments, courts are inclined to interpret the contract in favor of the insured particularly where failure of coverage threatens the health of the insured. See, e.g., *Bradley v. Empire Blue Cross & Blue Shield*, 149 Misc. 2d 20 (1990). So, for the insured, there is little if any rationing of health care. For the uninsured, however, health care is heavily rationed. Unless people who lack health insurance can pay out of pocket, they must have access to some alternative form of health care subsidization, such as hospitals required by federal law to admit into their emergency departments anyone whose health problem is emergent and at least provide sufficient care to stabilize. Otherwise, the uninsured may simply be unable to afford to obtain non-emergent, chronic, or preventive care.

8. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 6.

9. Press Release, Ctrs. for Medicare & Medicaid Servs., Overall Health Care Cost Growth Projections Slow from 2003: Medicare Drug Coverage Expected to Lower Prices (Feb. 23, 2005), <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1356>.

10. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 6.

finance our own consumption in retirement.”¹¹ Adding a prescription drug benefit to Medicare that helps only one segment of the population, however deserving, raises a question not only of disproportionate resource allocation but also of intergenerational inequity. Even if the children of today are fortunate enough to be employed and have access to health insurance when they grow up, the propriety of an ever-growing portion of their income allocated to subsidizing the health insurance and income replacement of their parents is at least arguable. For the portion of the so-called working generation who do not have access to health care for themselves or for their children, the projected cost of the MMA may be literally life-threatening.

Myriad questions remain about the efficacy of the Act from both sides of the political spectrum. Advocates on the left argue that the MMA does not provide an adequate drug benefit to seniors.¹² They talk about the so-called doughnut hole in coverage that shifts the entire cost of prescription drugs to the beneficiary after out-of-pocket drug costs reach the initial benefit cap of \$2250, and the shift continues until the beneficiary's costs reach \$3600, the amount that the Act defines as catastrophic.¹³ Advocates on the right argue that the Act does little to “reform” Medicare to curb its ever-increasing costs and, in fact, gives health care providers, particularly providers of prescription drugs, a virtual blank check from the federal government.¹⁴ Thus,

11. C. Eugene Steuerle, Senior Fellow, Urban Inst., Social Security—A Labor Force Issue: Statement Before the Subcomm. on Social Security of the H. Comm. on Ways & Means, available at http://www.urban.org/UploadedPDF/900819_Steuerle_061405.pdf.

12. Currently, traditional fee-for-service Medicare covers only slightly more than half of the health care costs of its beneficiaries, making it look like a skimpy health insurance plan when compared with private health insurance plans often enjoyed by the under-sixty-five cohort. UWE REINHARDT, A PRIMER FOR JOURNALISTS ON MEDICARE REFORM PROPOSALS (2003), available at http://www.www.princeton.edu/pubaff/publications/primer_MedicareReform.pdf.

13. See MARILYN MOON, THE COMMONWEALTH FUND, MEDICARE PRESCRIPTION DRUG LEGISLATION: HOW WOULD IT AFFECT BENEFICIARIES? 2 (2003), available at http://www.cmwf.org/usr_doc/Moon_rxlegislation_678.pdf (discussing how the bill would affect low-income Medicare beneficiaries).

14. Cf. *Does CMS Have the Right Prescription? Implementing the Medicare Prescription Drug Program: Hearing Before the S. Comm. on Governmental Affairs*, 108th Cong. 19–23 (2004) (statement of Gail Wilensky, Senior Fellow, Project HOPE) (discussing challenges involved in the regulation and implementation phase of the Medicare prescription drug program). See generally JOSEPH ANTOS & JAGADEESH GOKHALE, CATO INST., BRIEFING PAPER NO. 91: MEDICARE PRESCRIPTION DRUGS: MEDICAL NECESSITY MEETS FISCAL INSANITY (2005), available at <http://www.cato.org/pubs/briefs/bp91.pdf>; Robert E. Moffit, *Fixing the New Medicare Law #1: An Agenda for Constructive Change*, BACKGROUND, Apr. 26, 2004, at 2.

instead of reining in the cost of the Medicare entitlement, the MMA authorizes additional large expenditures with little limitation.¹⁵ The American Association of Retired Persons (AARP) endorsed the legislation notwithstanding its apparent deficiencies.¹⁶ As one commentator stated, seniors were not about to leave a \$400 billion budgetary commitment on the table.¹⁷

Since its passage in 1965, Medicare has lacked, among other things, an outpatient prescription drug benefit.¹⁸ In fact, the validity of the Medicare benefit structure for a population whose primary health concerns are due to chronic disease is questionable.¹⁹ Although there is certainly consensus that adequate health insurance for people sixty-five and older must include prescription drug coverage, there has been little consensus on how to provide this benefit through Medicare. In 2003, almost 76% of Medicare beneficiaries had drug insurance “through pensions, Medicaid or private policies.”²⁰ This left approximately 24% of Medicare beneficiaries with no prescription drug coverage at all.²¹ At the same time, approximately forty-five million, or 15.6%, of noninstitutionalized Americans under the age of sixty-five were completely uninsured during the whole of 2003.²²

This article addresses several health policy issues implicitly raised by the passage of the MMA. First, the MMA makes it impossible for true universal health insurance to happen. If the Congressional Budget Office’s and Medicare trustees’ prediction that the MMA will

15. One common wisdom is that the legislation would not have passed but for the inclusion in the MMA of universal medical savings accounts for those younger than sixty-five. John Berlau, *The Two Faces of Medicare Reform*, INSIGHT ON THE NEWS, Dec. 23, 2003.

16. Jane Bryant Quinn, *The Drug Bill’s Hidden Costs*, NEWSWEEK, Dec. 22, 2003, at 37, available at <http://www.msnbc.msn.com/id/3704899/site/newsweek/from/RL4/>.

17. *Id.*

18. Originally, Medicare was modeled on private insurance which, in 1965, was primarily the province of Blue Cross and Blue Shield. At that time, private insurance did not include prescription drug coverage, so it is hardly surprising that Medicare did not cover outpatient prescription drugs.

19. See generally Henry J. Aaron & Robert D. Reischauer, *The Medicare Reform Debate: What Is the Next Step?*, 14 HEALTH AFF. 8, 10–11, 27 (1996), available at <http://content.healthaffairs.org/cgi/reprint/14/4/8>; Marilyn Moon, *Modernizing Medicare’s Benefit Structure*, 60 WASH. & LEE L. REV. 1207 (2003).

20. Deroy Murdock, *Medicare Drug Plan Promotes Dependence on Government*, INST. FOR HEALTH FREEDOM, July 10, 2003, available at <http://www.forhealthfreedom.org/Publications/MedicareMedicaid/murdock070903.html>.

21. *Id.*

22. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2003, at 14 (2004).

create an unfunded liability in the trillions of dollars is correct,²³ the opportunity to fund universal health insurance has been effectively short-circuited. Recently there has been a surge of scholarly interest and a spate of literature exploring the viability of universal health insurance in the United States.²⁴ As the number of uninsured persons continues to rise,²⁵ making serious inroads into middle-class employed America,²⁶ speculation has increased about the existence of a political mandate for some form of universal health coverage. But the decision to increase the Medicare benefit package and to make the benefit available to every Medicare beneficiary regardless of income or need makes universal coverage much less likely if only as an economic reality.

Second, while the MMA appears to be a legislative commitment to health care coverage as social insurance,²⁷ this conclusion is anything but certain. Many skeptics proffer their own contradictory the-

23. In February 2005, the White House released budget figures indicating that the Medicare prescription drug benefit will cost more than \$1.2 trillion in the coming decade. Ceci Connolly & Mike Allan, *Medicare Drug Benefit May Cost \$1.2 Trillion; Estimate Dwarfs Bush's Original Price Tag*, WASH. POST, Feb. 9, 2005, at A1.

24. See, e.g., THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (2d ed. 2000); RICK MAYES, *UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH INSURANCE* (Univ. of Mich. Press 2004) (2001).

25. It is now estimated that forty-five million Americans are uninsured for the entire year and approximately double that number are uninsured for some part of the year. U.S. CENSUS BUREAU, *supra* note 22, at 14.

26. Since the 1950s, "health insurance as an employment benefit has been the norm" due to the "favorable income tax treatment accorded to employers who offer this benefit to their employees." Susan A. Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?*, 39 CAL. W. L. REV. 303, 304 (2003). "As long as health insurance costs remained relatively low, these tax preferences were perceived as beneficial to employers who were able to give their employees a tax-subsidized increase in compensation." *Id.* at 305 n.8. However, as health insurance costs continue to rise, the value of this benefit to the employer has substantially decreased (while the value to the employee has correlatively increased). *Id.*

27. All insurance operates on the principle of pooling risk, which often requires redistributing funds from healthy premium payers to sick ones. Social insurance guarantees that participants receive the benefit, such as health care, in accordance with their need for it rather than their ability to pay for it. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287, 291 (1993). Commercial insurance, on the other hand, operates according to the principle of actuarial fairness, holding that premium rates should be differentiated so that each individual pays in accordance with the probability that he or she will incur the insured risk. Commercial insurers, therefore, are interested in factors that can help to predict the amount of use that the insured will make of his or her health insurance, factors such as family medical history, personal medical history, and any medical information that may be predictive of disease such as genetic information. *Id.* at 293.

sis: rather than providing additional health care benefits to seniors as social insurance, the MMA is really a thinly disguised commitment to the private market as a model for health care coverage for both the over- and under-sixty-five populations.²⁸ Considering that not long ago President Bush baldly stated that outpatient prescription drug coverage would be available to only those seniors who elected private plan coverage, a position from which he hastily retreated,²⁹ it should not be surprising that the current legislation more discretely shifts Medicare from publicly administered health insurance to privately administered health insurance. However, the inclusion in the MMA of a provision authorizing universal health savings accounts (HSAs)³⁰ both for Medicare beneficiaries and for those under the age of sixty-five—without which the legislation would probably not have been successful³¹—suggests that this administration and Congress are

28. There seems to be little question that this administration believes in the efficacy of private markets as the solution to federal spending for big budget items, most particularly big budget items that create entitlements for certain segments of the population. While Medicare is a very popular program, particularly among the benefited segment, it is also an expensive program. Currently, Medicare costs the federal government approximately \$271 billion annually. See CONG. BUDGET OFFICE, CBO'S ANALYSIS OF REGIONAL PREFERRED PROVIDER ORGANIZATIONS UNDER THE MEDICARE MODERNIZATION ACT 1 (2004), available at <http://www.cbo.gov/ftpdocs/59xx/doc5997/10-27-PPOUnderMedicare.pdf>. On the assumption that the private competitive market can lower those costs to the federal government, the MMA authorizes a large subsidy to private insurers who are willing to come into the Medicare marketplace to provide insurance coverage and negotiate with providers to care for the Medicare population. CTR. FOR AM. PROGRESS, BETTER BENEFITS, LOWER COSTS: THREE STEPS TO IMPROVING MEDICARE 3-5 (2005), available at <http://www.americanprogress.org/kf/medicare.pdf>. Health savings accounts, authorized by the MMA, appear to be the ultimate device for shifting the cost of health care from the public sector to the private sector. See *id.* at 6.

29. *Online NewsHour Update: Pres. Bush Outlines Plan to Add Drug Coverage to Medicare*, PBS.COM, Mar. 4, 2003, http://www.pbs.org/newshour/updates/medicare_03-04-03.html.

30. Under the MMA, favored tax treatment is extended to money paid into health savings accounts (previously known as medical savings accounts). CTR. FOR AM. PROGRESS, *supra* note 28, at 5. Participants pay into these accounts, which must be accompanied by a high-deductible, catastrophic insurance policy. *Id.* The plan owner may use the contributed amounts to pay for qualified medical expenses, and any amount not used in any tax year may be rolled over into the next tax year with no forfeiture or penalty, thus making HSAs more desirable than the currently authorized flexible spending accounts. Advantage Benefit Serv., Learn More About HSAs, <http://www.abs-insurance.com/HSA.aspx?PageID=6> (last visited Apr. 17, 2006).

31. Many wavering Republicans were induced to vote for the legislation by the inclusion of HSAs. "We would have never gotten MSAs so pure through an ordinary tax bill," said Republican Rep. Paul Ryan (R-Wis.), referring to the widely held belief that there was no other way to get the sixty votes necessary to over-

poised for a paradigm shift in financing health care from a perspective that embraces the value of mutual support to one that values the financial ability of consumers to choose.³²

Third, and closely related to the debate about whether Medicare is social insurance or a segmented health insurance model, the MMA may have a profound effect on how all health care in the United States is financed. While the legislation was purportedly enacted to finance a much-needed drug benefit for seniors, its collateral effects may be much more far-reaching. Employers who have been subsidizing employee health insurance for decades³³ are looking for ways to reduce their cost share or simply to avoid offering health insurance as an employment benefit.³⁴ One way to accomplish this is for employers to shift their health insurance offerings from relatively rich defined-benefit plans to more meager defined-contribution plans.³⁵ In such a system, employees would receive a premium subsidy from their employers and a choice of health plans of varying costs and benefits. The MMA's universal health savings account provision is an attractive alternative for employers who feel economically burdened by the incessant rise in the cost of health care.

Health savings accounts, which shift much of the cost of at least first-dollar insurance from the employer to the employee, may be just the answer for employers who want to continue to provide health insurance benefits for their employees without the attendant cost. For healthier, younger, or more highly compensated employees, HSAs

come a Senate filibuster in order to pass MSAs as comprehensive as the ones included in the MMA. Berlau, *supra* note 15.

32. There is rampant, even impassioned, disagreement about whether the MMA advances the cause for socialized health care or is, as Senator Edward Kennedy (D-Mass.) declaims, "a Trojan horse to reshape Medicare. . . . [.] a calculated program to unravel Medicare, to privatize it." *Id.*

33. In many ways, the employment based health insurance system is an artifact of the tax code. Since WWII, employers have received a tax deduction for their payments toward employee health insurance and such payments are excluded from the employees' taxable income. As long as health insurance costs remained relatively low, these tax preferences were perceived as beneficial to employers who were able to give their employees a tax-subsidized increase in compensation. As health insurance costs have risen, the value of this employee benefit to employees has gone up while its value to employers has fallen.

Channick, *supra* note 26, at 305 n.8.

34. *But see* 42 U.S.C.S. § 1395W-132 (LexisNexis 2006) (providing subsidies for employers who continue to provide health insurance to retirees as part of their retirement benefits package).

35. Timothy S. Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433 (2004).

may present a more acceptable tax-friendly alternative to other cost-sharing arrangements. For such employees, health care is a consumer product they can either afford to use or choose not to. But for employees with higher medical expenses, especially those earning lower wages, HSAs require employers to absorb much higher deductibles. For this cohort, first-dollar health insurance, with its more traditional deductibles and co-payments, may be the only choice until the adverse selection death spiral also makes this choice too expensive to afford.³⁶ When employees who have been relying on their employers to provide affordable health insurance can no longer afford either rising premiums or high deductibles, they will join the already swelling ranks of the employed who are uninsured or underinsured.

Last, but certainly not least, is the question of how Medicare Part D will be financed, particularly with regard to low-income seniors who have qualified as so-called dual eligibles under state Medicaid programs. Prior to 2006, the prescription drug needs of dual eligibles have been covered under state Medicaid programs and cofunded by federal and state Medicaid allocations. But under the MMA, all Medicare beneficiaries, including dual eligibles, are eligible to enroll in Medicare Part D. Dual eligibles, unlike other Medicare beneficiaries, are automatically enrolled in a Part D plan if they have not voluntarily enrolled, and they will no longer be able to receive their prescription drug coverage under Medicaid. Presumably, one of the goals of the federal legislation is to relieve the states of the fiscal burden of providing more and more expensive prescription drug coverage to their most vulnerable elderly.

An issue of great contention of late is the states' understanding that while the purpose of the MMA is to add a prescription drug benefit for all Medicare beneficiaries that presumably would be paid for with general tax revenue and beneficiary co-payments, the states would not be relieved of the fiscal burden of providing prescription

36. See SHERMAN FOLLAND ET AL., *THE ECONOMICS OF HEALTH AND HEALTH CARE* 159–61 (3d ed. 2001). Adverse selection is the phenomenon that occurs in health insurance when younger, healthier enrollees choose a less expensive insurance option such as health savings accounts, leaving the older, sicker enrollees in the first-dollar group and effectively segmenting the insurance pool. *See id.* Those in the first-dollar segment will inevitably incur higher health care costs, and without the lower-cost enrollees to offset these costs, premiums for this segment will rise to a point where employers will either refuse to pay or pass the increased costs to employees. *See id.* In a defined-contribution insurance world, employees may simply be unable to afford the cost of health insurance. *See id.*

drug coverage to their dual eligible population. The MMA contains a provision, colloquially known as the “clawback,” that essentially requires the states to subsidize a benefit granted to Medicare beneficiaries by federal legislation, administered by federal agencies, and operated by private-sector entities. Before 2006, state Medicaid agencies had the flexibility to design and operate the prescription drug programs they were subsidizing, but their post-2006 role will purely be one of financing Medicare Part D. States are taking a dim view of this new reverse federalism raised by the financing structure of the MMA.

Section II of this article describes the structure of the MMA, including benefit design, coverage parameters, and reimbursement formulae. Section III examines how, if at all, the health care marketplace for the over-sixty-five population differs from the health care marketplace for the under-sixty-five population. Section IV addresses the related question of whether the MMA is really good medicine for the population it covers. Section V asks whether drug costs simply trump all other issues related to prescription drug coverage. Section VI explores who is really paying for the MMA, a problem that is just now being recognized. Federal legislation that requires states to pay a significant portion of its cost is unprecedented in the history of federalism, and it comes at a time when the states are incurring losses of future Medicaid funding as a central feature of federal budget reconciliation legislation percolating in Congress. Finally, Section VII concludes that the MMA may turn out to be bad medicine for future U.S. health policy.

II. Inside the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

A. The Basics of the MMA

The MMA provides insurance for outpatient prescription drugs to all Medicare beneficiaries on a voluntary basis. Beneficiaries can choose the Part D benefit or may continue to be otherwise insured for outpatient prescription drugs through individual policies such as Medigap that have, for years, supplemented Medicare.³⁷ The Con-

37. The MMA prohibits the sale of supplemental insurance policies for prescription drug coverage to Medicare beneficiaries. Bruce Stuart et al., *Riding the Rollercoaster: The Ups and Downs in Out-of-Pocket Spending Under the Standard Medicare Drug Benefit*, 24 HEALTH AFF. 1022, 1023 (2005).

gressional Budget Office (CBO) had estimated that twenty-nine million of the 42.6 million Medicare beneficiaries, including 8.7 million participants who are projected to receive low-income subsidies, would enroll in Part D in 2006.³⁸ The CBO further assumes that 13.6 million Medicare beneficiaries will not participate in Part D.³⁹ This figure includes 8.2 million beneficiaries who are expected to receive drug coverage through qualified employer-sponsored plans and 5.4 million who receive drug coverage from either the Federal Employees Health Benefits Program or the TRICARE military health plan, who do not receive any drug coverage, or who have only Medicare Part A and not Medicare Part B.⁴⁰

Under the MMA, private risk-bearing entities known as Prescription Drug Plans (PDPs) administer the Part D drug benefit for Medicare beneficiaries who wish to remain in traditional fee-for-service Medicare in order to receive their Part A and Part B coverage.⁴¹ Alternatively, beneficiaries may choose to enroll in Medicare Part C Medicare Advantage (MA) plans, which more comprehensively provide Part A and Part B benefits as well as the Part D benefit.⁴² The MA plans include a number of insurance and delivery options, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and private fee-for-service plans.⁴³ The Medicare Advantage option was added to Medicare by the MMA as a substitute for Medicare + Choice.⁴⁴

38. JIM MAYS & MONICA BRENNER, ACTUARIAL RESEARCH CORP. & TRICIA NEUMAN ET AL., THE HENRY J. KAISER FAMILY FOUND., ESTIMATES OF MEDICARE BENEFICIARIES' OUT-OF-POCKET DRUG SPENDING IN 2006, at 6 (2004), available at <http://www.kff.org/medicare/upload/Report-Estimates-of-Medicare-Beneficiaries-Out-Of-Pocket-Drug-Spending-in-2006-Modeling-the-Impact-of-the-MMA.pdf> [hereinafter ARC & KAISER FAMILY FOUND.].

39. *Id.*

40. *Id.* Medicare Part A is available without an additional premium to all individuals sixty-five and older who qualify for Social Security; Part B is available only to those who pay a monthly premium, which in 2006 was \$88.50. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & YOU 6, 8 (2006), available at <http://www.medicare.gov/publications/pubs/pdf/10050.pdf> [hereinafter MEDICARE & YOU].

41. See ARC & KAISER FAMILY FOUND., *supra* note 38, at 3.

42. See MEDICARE & YOU, *supra* note 40, at 3.

43. *Id.* at 36, 37.

44. THE HENRY J. KAISER FAMILY FOUND., MEDICARE ADVANTAGE, FACT SHEET 1 (Sept. 2005), <http://kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf>.

Both of the above-described plans must offer at least the “standard drug coverage” or its actuarial equivalent.⁴⁵ Guidelines for the private risk-bearing entities released by the U.S. Pharmacopoeia⁴⁶ in January 2005, specified 146 types of medications that Medicare private plans must cover under a model formulary.⁴⁷ The guidelines include forty-one categories, such as antidepressants, cholesterol, and hypertension medications that private plans must provide in their formularies.⁴⁸ Without formularies, the cost of Medicare Part D would far exceed even its most pessimistic projections. Because Part D formularies are expected to be more restricted than state Medicaid formularies have been, it is unclear how Part D enrollees, particularly dual eligibles,⁴⁹ will cope with these limitations on their drug choices.

Part D insurance administered through a PDP will cost the average beneficiary approximately \$35 for a monthly premium,⁵⁰ and CMS

45. “Actuarial equivalent” refers to the minimum amount of coverage a drug plan sponsor may offer. CTRS. FOR MEDICARE & MEDICAID SERVS., CMS GUIDANCE ON THE ACTUARIAL EQUIVALENCE STANDARD FOR THE RETIREE DRUG SUBSIDY (2005), available at <http://www.cms.hhs.gov/EmployerRetireeDrugSubsid/Downloads/ActrlEqvIncStdforRDS.pdf>.

46. The United States Pharmacopoeia (USP) is the official public standard-setting authority for all prescription and over-the-counter medicines, dietary supplements, and other health care products manufactured and sold in the United States. USP sets standards for the quality of these products and works with health care providers to help them reach the standards. USP was designated by Congress under the MMA to develop a model formulary for PDPs and other private plans contracting with Medicare under Part D.

47. U. S. PHARMACOPEIAL CONVENTION, CMS COOP. AGREEMENT NO. 18-C-92305/3-01, MEDICARE PRESCRIPTION DRUG BENEFIT: MODEL GUIDELINES: DRUG CLASSES AND CATEGORIES IN PART D 13 (2004), available at <http://www.usp.org/pdf/EN/mmg/finalModelGuidelines2004-12-31.pdf>.

48. Drug formularies are an important tool in the cost-containment arsenal of risk-bearing entities. Insurers try to motivate beneficiaries to use those drugs for which the insurer has negotiated a good price with the manufacturer by making the insurer’s share of cost greater and the beneficiary’s share of cost correlatively less. Prescription drugs that are not part of an insurer’s formulary are available to the beneficiary at 100% of the share of cost. Haiden A. Huskamp et al., *The Impact of a National Prescription Drug Formulary on Prices, Market Share, and Spending: Lessons for Medicare?*, HEALTH AFF., May/June 2003, at 149–50.

49. A “dual eligible” is an elderly or disabled person whose income is low enough to qualify for the federal Supplemental Security Income (SSI) program which, in 2005, is \$579 per month for an individual. See *infra* note 63 and accompanying text.

50. The Centers for Medicare and Medicaid Services recently said that premiums for the drug benefit will average \$5 per month less than originally predicted, a reduction from \$37.37 to \$32.20. *CMS Says Premiums for Drug Benefit Will Average \$5 Less Than Predicted*, Health Care Daily Rep. (BNA) (Aug. 10, 2005). In addition, in every region except Alaska, at least one PDP will be available that will offer Medicare beneficiaries drug coverage for \$20 a month or less in 2006. *Administra-*

recently announced that 70% of Medicare Advantage plan enrollees will have access to zero-premium plans.⁵¹ Under the MMA, beneficiaries bear the first \$250 of prescription drug cost.⁵² The next \$2000 is shared by Medicare, which pays 75% (\$1500), and the beneficiary, who pays 25% (\$500).⁵³ The beneficiary then bears 100% of the prescription drug cost (\$2850) until total out-of-pocket spending reaches \$3600,⁵⁴ the so-called MMA doughnut hole.⁵⁵ At \$3600 of beneficiary spending (or \$5100 in total drug costs), the beneficiary's share is considered catastrophic, and Medicare pays for 95% of the cost of any additional prescription drugs.⁵⁶ Thus, for enrollees with covered drug costs of \$2200 annually, Medicare bears approximately two-thirds of the share of cost, and the beneficiary must pay one-third.⁵⁷ However, the beneficiary with high drug costs, \$5100 for example, pays approximately 70% of the cost, while Medicare's share of cost is approximately 30%.⁵⁸ Predictably, as the cost of prescription drugs rises above \$5100 and is deemed catastrophic, Medicare's share of cost rises as well, so that the cost of a \$7500 prescription drug bill will be shared equally between the beneficiary and Medicare.

B. The MMA and Low-Income Beneficiaries

In addition to catastrophic coverage for prescription drugs, the MMA is designed to provide premium and cost-sharing assistance to

tion Says Medicare Drug Options to Be Available for \$20 or Less Per Month, Health Care Daily Rep. (BNA) (Aug. 30, 2005).

51. *CMS Issues Drug Benefit Details as Marketing to Seniors Is Set to Start*, Health Care Daily Rep. (BNA) (Oct. 3, 2005) [hereinafter *Drug Benefit Details*].

52. See 42 U.S.C.S. § 1395w-102(b)(1)(A)(i) (LexisNexis 2006).

53. See *id.* § 1395w-102(b)(2), (3)(A)(i).

54. See *id.* § 1395w-102(b)(4)(B)(i)(I).

55. The doughnut hole is a term describing insurance that has a deductible in the middle of the insurance. Meredith B. Rosenthal, *Donut-Hole Economics*, 23 HEALTH AFF. 129, 129 (2004). The Medicare doughnut hole starts at \$2250, which is roughly Medicare enrollees' mean spending for prescription drugs in 2003. The statistics for 2003 prescription drug spending for Medicare enrollees show that the probability of annual spending in excess of \$2250 was about 25% and that the probability of spending in excess of \$5100 was about 10%. *Id.* at 132. Recently, CMS announced that some plans in each state will offer doughnut hole insurance which, in most cases, would cover only generic drugs. *Drug Benefit Details*, *supra* note 51.

56. See 42 U.S.C.S. § 1395w-102(b)(4)(A)(i)(II).

57. At a total drug cost of \$2200, the beneficiary pays \$250 + (\$1950 * 25%) or \$737.50; Medicare pays \$0 + (\$1950 * 75%) or \$1462.50.

58. At a total drug cost of \$5100, the beneficiary pays \$250 + (\$2000 * 25%) + \$2850 or \$3600; Medicare pays \$0 + (\$2000 * 75%) + 0 or \$1500.

8.7 million low-income beneficiaries,⁵⁹ defined as having incomes below 150% of the federal poverty level (\$13,965 annual income for an individual in 2004) and modest assets.⁶⁰ For these beneficiaries, the MMA will significantly reduce out-of-pocket prescription drug costs by an average of 83%, or \$584.⁶¹ This group includes the estimated 6.4 million dual eligibles⁶²—people who are seniors, disabled, or sometimes both, whose income and assets qualify them for both Medicare and Medicaid, and who have had prescription drug coverage under their state Medicaid program.⁶³

Although federal legislation does not require states to provide Medicaid assistance to anyone but citizens with incomes and assets that qualify them for the federal Supplemental Security Income (SSI) program, twenty-one states and the District of Columbia, had, as of the date of the MMA's enactment, raised the low-income bar and offered Medicaid to elderly and disabled people whose incomes exceed SSI.⁶⁴ In these states, the numbers of elderly on the Medicaid rolls is higher than in states with strictly SSI income qualification.

59. ARC & KAISER FAMILY FOUND., *supra* note 38, at i.

60. *Id.*

61. *Id.* at iii.

62. FAMILIES USA, SPECIAL REPORT: TROUBLE BREWING? NEW MEDICARE DRUG LAW PUTS LOW-INCOME PEOPLE AT RISK 1 (2005), available at http://www.familiesusa.org/assets/pdfs/Trouble_Brewing.pdf [hereinafter FAMILIES USA: TROUBLE BREWING?].

63. THE HENRY J. KAISER FAMILY FOUND., DUAL ELIGIBLES: MEDICAID'S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES (July 2005), available at [http://www.kff.org/medicaid/upload/4091-04%20Final\(v2\).pdf](http://www.kff.org/medicaid/upload/4091-04%20Final(v2).pdf). The MMA requires that Medicare beneficiaries who have been receiving insurance for out-patient prescription drugs through their state Medicaid programs be enrolled in a Medicare PDP in order to get out-patient prescription drug coverage. Judith Stein et al., Testimony of the Center for Medicare Advocacy, Inc., Before the Health Subcomm., Comm. on Ways & Means, http://www.medicareadvocacy.org/PartD_05.2006.Testimony.htm. In exchange for transferring prescription drug coverage from Medicaid to Medicare, the MMA requires that the states reimburse the federal government for any savings from the transfer under the so-called clawback provision. Because the only aspect of the payback formula over which the states have control is the number of individuals who are enrolled in their Medicaid programs, the fear is that states will have incentive to disenroll those Medicaid beneficiaries for whom they are not legally required to enroll, leaving the disenrolled beneficiaries without access to certain services provided by Medicaid but not Medicare, services such as dental and vision care. FAMILIES USA: TROUBLE BREWING?, *supra* note 62; *Clawback Provision Could Give States Incentive to Cut Medicare Rolls, Study Finds*, Health Care Daily Rep. (BNA) (July 7, 2005).

64. FAMILIES USA: TROUBLE BREWING?, *supra* note 62. The states that have done so include Arizona, Arkansas, California, Florida, Hawaii, Illinois, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Virginia.

Notwithstanding the intent of Congress to provide subsidization for many low-income elderly, the intersection of state and federal law that makes Medicaid such an extremely complex program threatens to, at least partially, undermine this intent. The MMA requires the states to contribute to the prescription drug benefit for its seniors that have heretofore received prescription drug coverage through the Medicaid program. This provision, known as the “clawback” payment, establishes a complex formula for what the states must pay to the federal government.⁶⁵ Only one factor, the number of dual eligibles enrolled in Part D, is within the control of the states. Because federal law does not require states to insure dual eligibles, there has been speculation that this factor provides an incentive for states to cut these recipients from the Medicaid rolls.⁶⁶ Although such a decision would not threaten these seniors’ prescription drug coverage, it would cut off their qualification for other Medicaid benefits not also provided by Medicare, such as vision and dental coverage.

Florida, Mississippi, and Missouri recently announced plans “to reduce or eliminate Medicaid coverage for some or all elderly enrollees and people with disabilities” who have incomes of greater than \$579 per month.⁶⁷ North Carolina was considering similar cuts.⁶⁸ These cuts from the Medicaid rolls may affect as many as 215,660 low-income former Medicaid recipients.⁶⁹ If the remaining seventeen states and the District of Columbia follow suit, the number of low-income seniors disenrolled from Medicaid will be substantial and significant. With Medicaid spending continuing to squeeze state budgets, states will understandably have incentives to drop recipients,⁷⁰ and state budget directors⁷¹ may use the clawback provision of the MMA to trim their Medicaid rolls.

65. *Id.* at n.1 (“The clawback formula is based on multiplying four factors: (1) the amount the state spent per capita on Medicaid prescription drug benefits for dual eligibles in 2003 . . . ; (2) nationwide prescription drug price inflation; (3) the number of dual eligibles enrolled in Part D from that state; [and] (4) the year in which the payment is calculated—in 2006, states must pay 90% of their clawback amount to the federal government. The amount drops to 75% by 2013.”).

66. *Id.* at 1.

67. *Id.* at 2.

68. *Id.*

69. *Id.* at 3.

70. *Health Care Continues to Dominate State Spending, NGA/NASBO Survey Says*, Health Care Daily Rep. (BNA) (July 8, 2005).

71. NAT’L GOVERNORS ASS’N & NAT’L ASS’N OF STATE BUDGET OFFICERS, THE FISCAL SURVEY OF STATES 4 (June 2006), available at <http://www.nasbo.org/Publications/PDFs/FiscalSurveyJune06.pdf>.

For the 2.3 million low-income beneficiaries who were not receiving prescription drug coverage under their state Medicaid program but who qualify for low-income assistance under the MMA, the effect of the legislation is even more significant.⁷² These low-income beneficiaries are projected to spend approximately \$1400 less out-of-pocket under the MMA than they would without the law.⁷³ The CBO has projected that even unsubsidized Part D enrollees are expected to save 28% of out-of-pocket costs on prescription drugs.⁷⁴

For the 5.7 million low-income beneficiaries projected to enroll in Part D who do not qualify for low-income subsidies because either their assets exceed the low-income subsidy qualification or they did not apply for subsidy assistance,⁷⁵ the out-of-pocket costs under the MMA will be significantly higher than for enrollees receiving low-income subsidies—in some cases ten times higher.⁷⁶ The CBO projects that 6.9 million enrollees will have prescription drug spending that will put them in the doughnut hole, which occurs when the annual amount of prescription drug spending is between \$2250 and \$5100.⁷⁷ Of these enrollees, 1.9 million, or 28%, are people whose incomes are less than 150% of the poverty level; some of them will have low-income subsidies, while others will not receive any further assistance.⁷⁸ The burden of prescription drug costs will fall disproportionately on those without low-income subsidies.⁷⁹ However, once their prescription drug spending becomes catastrophic (more than \$3600 in out-of-pocket expenses), Medicare will cover 95% of such drug costs.⁸⁰

72. ARC & KAISER FAMILY FOUND., *supra* note 38.

73. *Id.*

74. *Id.*

75. The CBO estimates that almost two million Part D enrollees whose income falls below 150% of the poverty line will not qualify for low-income subsidies because they have assets that exceed the threshold defined by law. *Id.* The remaining four million otherwise eligible low-income beneficiaries will not apply for low-income assistance because of lack of knowledge, administrative burden, or fear of being stigmatized. *Id.*

76. *Id.* “For example, the 2 million beneficiaries with incomes below 100% of poverty (\$9,310 for an individual in 2004) who are *not* expected to receive low-income subsidies” will spend on average of \$943 versus \$90 for those enrollees who qualify for low-income subsidies. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

C. The MMA and Prescription Drug Reimbursement

In addition to means-testing beneficiaries to determine their out-of-pocket costs for prescription drugs, the MMA has completely changed how provider pharmaceutical companies are reimbursed by Medicare.⁸¹ Heretofore, reimbursement for hospitalization, physician services, and other benefits under Parts A and B was provided at prices that were set by CMS, the administrative agency within the U.S. Department of Health and Human Services (HHS) that is responsible for Medicare and Medicaid.⁸² In the early 1980s, Medicare began using administered payment systems to reimburse hospitals, ambulatory surgical centers, and outpatient labs; APS paid providers prospectively based on diagnosis-related groups (DRGs).⁸³ A DRG is a “means of categorizing patients to reflect relative intensity of use of services.”⁸⁴ A payments system based on DRGs “treats hospitals as coordinating services to produce particular products, such as the diagnosis and treatment of heart attacks, ulcers, or tumors.”⁸⁵ Prospective payment systems were adopted to stem the inflation of health care costs that caused Medicare hospital expenditures to increase from \$3 million to \$33 million between 1967 and 1983. This eleven-fold increase was largely attributed to a retrospective cost-based reimbursement system.⁸⁶

Reimbursement for Medicare Part D is not based on the prices for pharmaceuticals set by CMS. In fact, one of the most contentious pieces of the MMA is its direct prohibition of administered pricing or even negotiations of drug pricing by the director of CMS⁸⁷ or the Secretary of HHS.⁸⁸ Instead, the private MAs and PDPs that administer

81. See 42 U.S.C.S. § 1395W-101 (LexisNexis 2006).

82. BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 374, 384 (5th ed. 2004).

83. *Id.* at 383.

84. *Id.* at 384.

85. *Id.*

86. *Id.*

87. The current director of the CMS is Mark B. McClellan, the former director of the FDA. Ctrs. for Medicare & Medicaid Servs., *Organizational Chart* (2005), http://www.cms.hhs.gov/CMSLeadership/50_OrganizationalChartASP.asp.

88. The Social Security Act reads:

Noninterference. In order to promote competition under this part and in carrying out this part, the Secretary—(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs.

Medicare Part D through their sponsored pharmacy benefit managers (PBMs) negotiate prices for drugs with the pharmaceutical companies. Pharmacy benefit managers are a small group of private companies that “administer outpatient prescription drug benefits for most of the more than 160 million Americans with employer-based health care coverage”⁸⁹ as well as for some beneficiaries in the public sector, such as federal employees covered under the Federal Employees Health Benefits Program (FEHBP).⁹⁰

An important question that Congress considered regarding the structure of the MMA is whether the pricing model for prescription drugs under the MMA should be more like the private health care market or more like the public Veteran’s Affairs (VA) model. As noted above, in the private health care market, insurers negotiate with drug manufacturers for favorable drug prices through their sponsored PBMs, and competition among PBMs forces monopolistic drug manufacturers to sell their drugs for less than profit-maximizing prices.⁹¹ The more centralized public model permits the Secretary of VA, for example, to negotiate directly with drug manufacturers for discounted prices on behalf of VA beneficiaries.⁹² The U.S. General Accounting Office (GAO) has found that average VA-negotiated prices are less than 50% of the nonfederal average manufacturer’s price.⁹³

42 U.S.C.S. § 1395w-111 (LexisNexis 2006). The conference report adds that “[c]onferees expect PDPs to negotiate price concessions directly with manufacturers.” H.R. REP. NO. 108-391, at 461 (2003).

89. Robert F. Atlas, *The Role of PBMs in Implementing the Medicare Prescription Drug Benefit*, HEALTH AFF., Oct. 28, 2004, at W4-504, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.504v1>.

90. *Id.*

91. Monopolists can charge monopoly (profit-maximizing) prices when the purchaser has no choice but to buy from that monopolist or not to buy at all. Where alternative products or substitutes exist, the monopolists’ power to charge monopoly prices and to price discriminate disappears. In the pharmaceutical market, the ability to charge monopoly prices disappears when generic drugs are available or other patented brand name products can be considered therapeutic substitutes. JIM HAHN, CONG. RESEARCH SERV., CRS REPORT FOR CONGRESS: THE PROS AND CONS OF ALLOWING THE FEDERAL GOVERNMENT TO NEGOTIATE PRESCRIPTION DRUG PRICES 28 n.4 (2005), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2205902182005.pdf>.

92. See 38 U.S.C.S. § 8126(a)(2) (LexisNexis 2006). The Act authorizes the Veterans Affairs Secretary to negotiate prices for covered drugs on behalf of the Department of Defense, the Public Health Service (including the Indian Health Service), and the Coast Guard, in addition to Veterans Affairs. *Id.* § 8126(b).

93. U.S. GEN. ACCOUNTING OFFICE, DRUG PRICES: EFFECTS OF OPENING FEDERAL SUPPLY SCHEDULE FOR PHARMACEUTICALS ARE UNCERTAIN 7 (1997), available at <http://www.gao.gov/archive/1997/he97060.pdf>.

Notwithstanding the favorable prescription drug prices that the Secretary of VA is able to negotiate on behalf of VA beneficiaries, Congress chose the decentralized competitive pricing model for Medicare by specifically including in the MMA the noninterference provision that prohibits the Secretary of HHS from directly negotiating prices with drug manufacturers. A recent study by the Congressional Research Services (CRS) assessing this policy has concluded that the large PBMs already have significant market power and could negotiate prices similar to what the federal government could attain, a conclusion that echoes the views of the chief actuary for CMS and the CBO.⁹⁴ How much influence the pharmaceutical industry had on the choice of a decentralized, competitive pricing model over a centralized pricing model is anyone's guess, but there is no question that Medicare contractors, including drug manufacturers, have acquired a distaste for administered pricing.

Based on the reimbursement negotiated with the pharmaceutical companies by PBMs, health plans establish prescription drug formularies that categorize covered drugs into tiers that determine the beneficiaries' share of cost. Generic and other less expensive drugs have the lowest cost share for beneficiaries, preferred brand-name drugs have midlevel cost sharing, and nonpreferred drugs have high cost sharing.⁹⁵ The PBMs are required, as they are in the commercial context, to submit bids to CMS to be chosen as Medicare prescription drug providers.⁹⁶ Bids are required to include information about the drug coverage, including deductibles and cost sharing.⁹⁷ As health economist Joseph Newhouse recognizes in his *Health Affairs* article on drug reimbursement under Medicare, this system should work well enough when there is competition among drugs.⁹⁸ PBMs have incentives to negotiate low reimbursements with drug manufacturers, which Dr. Newhouse calls "low supply prices."⁹⁹ Low supply prices

94. HAHN, *supra* note 91, at 4. *But see* MARCIA ANGELL, THE TRUTH ABOUT THE DRUG COMPANIES 194–97 (2004).

95. *See, e.g.*, Wellmark Blue Cross & Blue Shield, Blue Rx 3-Tier Plans, http://www.wellmark.com/products/pharmacy/Blue_rx_3tier_plans.htm (last visited Oct. 4, 2006).

96. *Part Six: Medicare Prescription Drug Benefit (Title I)*, MEDICARE PRESCRIPTION DRUG LAW UPDATE (Epstein Becker & Green P.C., New York, N.Y.), Jan. 2004, at 6.

97. *Id.*

98. Joseph P. Newhouse, *How Much Should Medicare Pay for Drugs?*, 23 HEALTH AFF. 89, 98 (2004).

99. *Id.* at 91.

reduce the share of costs for Medicare beneficiaries and attract them to the plan.¹⁰⁰ In addition, a PBM can keep any difference between the bid price and the actual cost to the PBM.¹⁰¹ However, the bidding process cannot be effective when there is no competition among drugs, such as when a drug is patented, represents a major therapeutic advance, and has no close competitors.¹⁰² In such cases, Medicare must select another approach, which may include administered pricing, Medicare's traditional method of setting prices.

III. Is the Health Care Marketplace for Seniors Different?

An important question to consider is whether financing health care for Americans sixty-five and older is different enough from financing health care for the under-sixty-five crowd to justify the public/private dichotomy that is the hallmark of U.S. health care financing. Almost all of the forty million Americans sixty-five and older qualify for Medicare, although in some cases, Medicare is only the secondary payor.¹⁰³ Unlike private insurance carriers, Medicare cannot refuse coverage because of health status, including preexisting conditions. Medicare Part A has no premium, and Part B's premium has been relatively nominal until very recently.¹⁰⁴ In 2003, before

100. *Id.*

101. *Id.*

102. *Id.*

103. For Americans who qualify for Medicare health insurance but who also have other health insurance such as private employer-based insurance, Medicare will pay for health care only to the extent that it is covered by Medicare and that the beneficiary's other health insurance does not pay. I have a friend who, at the time of his illness at age sixty-seven, was employed and insured through his employer-provided insurance, which happened to be an HMO. He became acutely ill and required intensive care hospitalization for three months and subsequent rehabilitative hospitalization for another three months. The cost of his hospitalizations was approximately \$1.5 million, of which Medicare would have only covered a fraction due to the structure of Medicare Part A. The HMO had no ceiling on hospitalization coverage and covered the entire amount of his combined hospitalizations. While my friend might have had catastrophic supplementary coverage had he not been employed, it might have had a ceiling. In any case, his employment-based insurance was very fortuitous for him and his family, and Medicare picked up very little, if any, of the cost of his care.

104. Medicare Part B, the Supplemental Medicare Insurance program, covers physicians' services and a variety of other items and services including outpatient hospital services, physical therapy, diagnostic scans, and more laboratory testing. The Henry J. Kaiser Family Found., *Increase in Medicare Payments to Doctors This Year Will Raise Beneficiaries' Part B Premiums More Than Expected Next Year*, MED. NEWS TODAY, Apr. 2, 2005, <http://www.medicalnewstoday.com/medicalnews>.

MMA, Medicare accounted for about 20% of all U.S. health care spending, or \$320 billion.¹⁰⁵ Part D adds an important and expensive benefit to Medicare: universal prescription drug coverage.

As of 2003, approximately sixty-one million Americans were uninsured or underinsured.¹⁰⁶ Because essentially all Americans sixty-five and older are insured by Medicare, these sixty-one million must be below the age of sixty-five, so that approximately one in three Americans under the age of sixty-five does not have adequate health insurance. Is it possible that insuring elderly Americans is so much more important than insuring younger Americans to justify the kind of allocation of health care resources that Medicare, particularly Medicare enhanced by the MMA, requires? Of course, the very same questions can be asked of health care resource allocation between the under-sixty-five insured and uninsured.

As noted above, providing a universal prescription drug benefit under Medicare is an expensive proposition; how expensive depends on a number of factors. Conservative health policy analysts argue that the benefit must not be universal, thus supplanting the prescription drug coverage the majority of the elderly already had; rather, it should seek to provide coverage to those without prior prescription drug coverage so as to supplement already existing coverage with catastrophic insurance.¹⁰⁷ Because the costs of repair and rebuilding in the wake of Hurricane Katrina and the ongoing war in Iraq will strain an already tight federal budget, many have called for at least a one-year delay before phasing in the MMA. In addition, as health economists Patricia Danzon and Gail Wilensky point out, the MMA makes Medicare the nation's dominant consumer of pharmaceuticals, giving

php?newsid=22162. It is financed through beneficiary payments with the balance coming from the federal budget. *Id.* As the cost of Medicare rises, so does the cost to the beneficiary and the federal government. In 2005, Part B monthly premiums rose 17% to \$78.20, and in 2006, they rose 14% to \$89.20. *Id.* "Medicare chief actuary, Richard Foster, said that Medicare payments to doctors and other health care professionals increased from \$76.7 billion in 2003 to \$88.3 billion in 2004[.]" contributing to the rise in Part B premiums. *Id.*

105. Press Release, Ctrs. for Medicare & Medicaid Servs., Health Care Spending in the United States Slows for the First Time in Seven Years (Jan. 11, 2005), available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1314> [hereinafter CMS Press Release].

106. Cathy Schoen et al., *U.S. Health System Performance: A National Scorecard*, HEALTH AFF., Sept. 20, 2006, at w457, w466.

107. Moffit, *supra* note 14.

it the power to set health-financing policy for the rest of domestic payers and probably globally as well.¹⁰⁸

There is no question that the sixty-five-and-over cohort is especially susceptible to disease, particularly chronic disease. The elderly represent 12% of the U.S. population and consume about 40% of the pharmaceuticals sold nationally.¹⁰⁹ Furthermore, elderly people with multiple chronic diseases consume more health care resources than those with only a single chronic disease or no chronic disease at all. As a result, health care spending in Medicare is highly skewed, with 10% of Medicare beneficiaries accounting for 75% of the program's outlays each year.¹¹⁰ Not only does the higher prevalence of chronic disease make the cost of health care for seniors more expensive, but the cost of health care in the last year of life consumes more than one-quarter of annual Medicare costs.¹¹¹ In other words, dying is expensive because of the high cost of treating end-of-life illnesses.¹¹²

Medicare beneficiaries are often retired and receiving Social Security benefits, factors which also qualify them to receive Medicare.¹¹³ Prior to the enactment of Medicare, retired persons often had little or

108. Patricia Danzon et al., *Alternative Strategies for Medicare Payment of Outpatient Prescription Drugs—Part B and Beyond*, 11 AM. J. MANAGED CARE 173, 174 (2005).

109. *Id.*

110. Geoffrey F. Joyce et al., *The Lifetime Burden of Chronic Disease Among the Elderly*, HEALTH AFF., Sept. 26, 2005, at W5-R18.

111. *Healthcare Access and Affordability: Cost Containment Strategies: Special Hearing Before the Subcomm. on Departments of Labor, Health and Human Servs., and Education, and Related Agencies of the S. Comm. on Appropriations*, 108th Cong. 33–34 (2003) (statement of Dr. Donald R. Hoover, Professor, Department of Statistics, Rutgers University).

112. David M. Cutler, *The Potential for Cost Savings in Medicare's Future*, HEALTH AFF., Sept. 26, 2005, at W5-R78.

113. HHS policy makes it mandatory for persons applying for Social Security benefits and who are not covered by certain group health plans to enroll in Medicare Part A hospitalization insurance (HI). A Social Security beneficiary who wants to opt out of Medicare Part A can do so only if she forgoes her Social Security benefit. The policy, added by the Balanced Budget Act of 1997, states in pertinent part: "Individuals entitled to monthly benefits which confer eligibility for HI may not waive HI entitlement. The only way to avoid HI entitlement is through withdrawal of the monthly benefit application. Withdrawal requires repayment of all RSDI [Retirement, Survivors, Disability Insurance] and HI benefit payments made." SOC. SEC. ADMIN. POLICY POMS SECTION HI 00801.002, WAIVER OF HI ENTITLEMENT BY MONTHLY BENEFICIARY (1993), available at <http://www.forhealthfreedom.org/Publications/References/SocialSecurityPolicyHI00801-002.pdf>. Medicare Part B pays for some physician and outpatient services, but unlike Part A, it is voluntary, and individuals who enroll are prohibited from contracting privately with physicians participating in Medicare for Medicare-covered treatments. *Id.*

no access to private health insurance. Employers did not routinely provide health insurance coverage for their retirees, and retirees were unable to obtain private health insurance either because of age, preexisting condition, or prohibitive costs. Medicare was intended to ensure access to health insurance for the retired elderly who have few other options.¹¹⁴ Rather than use means tests to determine eligibility, legislators assumed that the elderly generally met the criterion of need. The public intuitively understood that the elderly were sicker, poorer, and less insured than other adult groups, making the accumulation of statistical data to prove the intuition unnecessary.¹¹⁵ Whether that intuition applies today is open to much debate.

Compulsory national health insurance had been considered by a number of presidents, including Franklin D. Roosevelt and Harry S. Truman, but both understood that universal coverage was unlikely to be successful. Too many constituencies opposed it, including the American Medical Association, and the enactment of Medicare in 1965 was intended only as a compromise to opponents of a more comprehensive national health insurance program. It was also meant to be a pilot program to demonstrate the likelihood of success of universal national health insurance. Forty years later, the nation is no closer to expanding Medicare to include all Americans and may be farther from it than in 1965. Entitlement has almost become a dirty eleven-letter word. With public dollars constituting more than 45% of health care spending in 2003,¹¹⁶ and an overwhelmingly Republican government in recent years, the political climate has been particularly unreceptive to expanding the financial claims on the budget that universal public health insurance would undoubtedly bring.

Rick Mayes, in his comprehensive examination of the elusive quest for universal health insurance, posits that the success of Medicare is the success of incrementalism.¹¹⁷ The success of Social Security provided the seminal event that proved that social insurance could work and work well. Tying public health insurance for the elderly to Social Security was an incremental change to an already successful

114. The selection of the elderly as first beneficiaries of a government health insurance is unique to the United States. The typical pattern has been to initially cover low-income workers with the coverage subsequently extending to dependents and then to higher-income groups. MARMOR, *supra* note 24, at 11.

115. *Id.*

116. See CMS Press Release, *supra* note 105.

117. See generally MAYES, *supra* note 24.

public program to benefit the elderly.¹¹⁸ The MMA is another incremental change to an already existing and popular institution to benefit a group towards whom most of the public is sympathetic. After all, we can all identify with Medicare beneficiaries; they are our parents, grandparents, uncles, aunts, and ourselves in the future.

Universal national health insurance, on the other hand, is not incremental, or at least not incremental enough. It is seminal. It requires a brand new infrastructure that is likely to be complex and controversial. President Clinton's Health Security Act foundered on exactly these issues. It is high irony that legislation intended to be inclusive was understood by so few. Universal national health insurance requires social welfare to be a cultural and social norm. Many scholars of the welfare state point to national attributes—such as rugged laissez-faire individualism, federalism and a weak national government, the lack of a genuine labor party in national politics, and the absence of a tradition of public provision—to explain the absence of national health insurance in the United States.¹¹⁹ Another relevant national attribute is a commitment to the private sector to solve social problems. The saturation of the health insurance market by the private sector, a movement that started in the late 1940s and continues today, is so institutionalized that employers who are not required by law to provide health insurance to their employees often continue to do so.¹²⁰ The MMA requirement that prescription drug coverage must be available only through private health plans even when the beneficiary is enrolled in public fee-for-service Medicare reaffirms a political commitment to the private sector and competition to solve health access problems, even though the lack of private sector success in the past decade in improving costs and access suggests this is not an effective approach.¹²¹

The most influential factor working against universal national health insurance is probably the perceived cost. Although health pol-

118. *Id.*

119. *Id.* at 4.

120. The private sector model for health insurance may be breaking down due to a number of factors, most prominently the cost of health insurance dictated by the ever-rising cost of health care. The trend toward shifting the cost of health care from the employer to the employee continues and is often the subject of contentious conflict between employers and employees. Saul Friedman, *The Crumbling Obstacle to Universal Health Care*, NEWSDAY, Nov. 26, 2005.

121. See generally Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095 (2003).

icy analysts have demonstrated that public dollars are already paying for the majority of health care and that the adoption of a universal health insurance system would not create huge additional public costs,¹²² projections of the cost of Part D of the MMA in the trillions of dollars understandably create significant barriers to the adoption of universal national health insurance. As the argument goes, if we cannot afford public health insurance for our growing population of seniors, how can we afford insurance for all Americans?¹²³ The cost of single-payer universal coverage is further exacerbated by a lack of commitment among Americans to further social insurance. Apparently, it is one thing to subsidize the cost of health care for seniors and the very poor with tax dollars; it is quite another to subsidize the cost of health care for other uninsured groups. According to Theodore Marmor and Jonathan Oberlander, both well-respected health policy experts, “universal health care boils down to a redistributive question: Are the insured willing to pay more taxes to fund medical care for the uninsured? Thus far, the insured public has yet to give an unqualified ‘yes’ to that question.”¹²⁴

IV. Is the MMA Really Good Medicine for Seniors?

Although seniors initially rejoiced over the passage of the MMA, there now seems to be an increasing amount of disillusionment with it.¹²⁵ In fact, as analysts struggle to deconstruct the legislation and the CMS attempts to clarify its fine points to beneficiaries, it becomes clearer that the MMA does not simply add a Part D to Medicare; in addition to its huge price tag (which may, in fact, be seriously understated) for an arguably inadequate drug benefit covering those who have the most serious need for comprehensive prescription drug in-

122. See Channick, *supra* note 26, at 317–18.

123. Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 205, 227.

124. *Id.* at 212.

125. Ironically, even the AARP, which initially heralded the program as a triumph for seniors, has been critical of many of the aspects of the program since its passage. This is, of course, not the first time that seniors have rethought legislation passed specifically to benefit them. In 1988, Congress passed the Medicare Catastrophic Coverage Act (MCCA), legislation designed to expand the benefits of Medicare to include insurance for long-term care and an outpatient prescription drug benefit. In order to be budget-neutral, the legislation imposed a surtax on high-income seniors. The uproar over this “senior only” tax is what impelled Congress to repeal the legislation before it ever became effective. MARMOR, *supra* note 24, at 112–13.

surance, the legislation creates a fundamental change in Medicare financing policy. Prior to the passage of the MMA, the vast majority of Medicare beneficiaries (87%) had health insurance that covered defined benefits and reimbursed providers prospectively according to a fee schedule established by HHS, the administrative agency that regulates Medicare.¹²⁶ The remaining 13% of Medicare beneficiaries belonged to private health plans that contracted with Medicare through its Part C, previously known as Medicare + Choice.¹²⁷

Medicare Part C, added to the Medicare statute by the 1997 Balanced Budget Act (BBA),¹²⁸ was intended to reduce the cost of the Medicare program by making more attractive its more cost-efficient managed-care option.¹²⁹ The MMA relies heavily on PDPs and private health plans in the now-renamed Medicare Advantage program to provide Medicare beneficiaries with the Part D outpatient prescription drug benefit, despite the apparent failure of the Medicare + Choice program. Congress (and the administration) seemed so persuaded that Medicare would benefit from privatization that it allocated between \$14 billion and \$46 billion to subsidize these private plans so that they would agree to contract with Medicare.¹³⁰ With this “upfront

126. *Strengthening and Improving the Medicare Program: Hearing Before the S. Comm. on Fin.*, 108th Cong. 86 (2003) (statement of Thomas A. Scully, Administrator, Centers for Medicare & Medicaid Services).

127. CRAIG CAPLAN, AARP PUBLIC POLICY INST., *THE MEDICARE PROGRAM: A BRIEF OVERVIEW (FACT SHEET) 2* (2005), http://assets.aarp.org/rgcenter/health/fs103_medicare.pdf.

128. Medicare has had an HMO option since 1974; this option was expanded by the 1997 BBA to include many more risk-contracting entities. Marsha Gold, *Can Managed Care and Competition Control Medicare Costs?*, HEALTH AFF., Apr. 2, 2003, at 176, 177, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.176v1>. Congress had hoped that Medicare Part C would reduce the cost of the Medicare program by making risk-bearing health plans attractive to Medicare beneficiaries who would join such a health plan because of the increased benefits offered for a much lower cost share. *See id.* at 183. When the BBA was adopted, the prediction was that enrollment in Medicare + Choice would reach 34% of the Medicare population by 2005. *Id.* at 177. The underlying premise was that private health plans utilizing the tools of managed care could provide such benefits more cost efficiently than traditional fee-for-service Medicare and that competition among health plans competing for Medicare beneficiaries would lower the costs of care to the federal government. *Id.* at 176.

129. There seems to be a consensus that Medicare Part C has failed both to lower the costs of Medicare and to attract a significant proportion of beneficiaries to its ranks. *Id.* at 177, 179. The real question, important to the success of Medicare Part D, is why.

130. One lesson that Medicare + Choice taught private insurers is that contracting with Medicare to provide managed-care health insurance to Medicare beneficiaries can be a very expensive and sometimes unprofitable business. *See id.* at 182, 184. As a result, many MCOs that initially had contracted with Medicare did not

investment to stabilize plan participation and increase beneficiary enrollment, ‘private plans and competition will help drive down the explosive growth of Medicare spending.’”¹³¹ This effect, however, will have to come in the long term because in the short term, the Commonwealth Fund estimates that the five million Medicare beneficiaries projected to be enrolled in private plans will cost taxpayers an additional \$552 per enrollee more than the cost per beneficiary enrolled in fee-for-service Medicare.¹³²

As President Bush’s proposed Social Security reforms indicate, a key theme of privatization is that private accounts will contribute to what the administration calls “an ownership society.”¹³³ The argument is that Americans are better off owning their retirement accounts than having them owned by the federal government, which then makes distributions to beneficiaries. Ownership is derogated both by the government’s authority to invest the beneficiaries’ contributions and by its authority to reallocate the distributions from higher-income contributors to lower-income contributors.¹³⁴ Redistribution from the wealthy and healthy to the poor and sick is the hallmark of a political system that values social insurance over private ownership. Indeed,

renew their contracts when it became clear that providing risk contracts for Medicare was less profitable than they had originally believed. *See id.* at 177, 184. In order to induce PDPs and MCOs to come into the Medicare marketplace, Congress agreed to this subsidization, which is projected to increase costs over ten years by \$14 billion, according to a CBO estimate, or \$46 billion, according to the Medicare Office of the Actuary. BRIAN BILES ET AL., THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS—2005 UPDATE, 1–2 (2004), available at http://www.cmwf.org/usr_doc/750_Biles_costofprivatization_update_ib_pdf.pdf.

131. BILES ET AL., *supra* note 130, at 1 (quoting E.M. Kennedy & B. Thomas, *Dramatic Improvement or Death Spiral—Two Members of Congress Assess the Medicare Bill*, 350 NEW ENG. J. MED. 747, 750 (2004)).

132. *Id.* at 1, 4.

133. *See generally* David Boaz, *Defining an Ownership Society*, CATO INST., available at http://www.cato.org/special/ownership_society/boaz.html (last visited Apr. 17, 2006).

134. One of the hallmarks of the Social Security system is that it is social insurance; workers’ contributions are intended both to replace income at retirement and to provide a safety net of replacement income for everyone eligible to receive Social Security. These two purposes are accomplished by using the contributions of high-income workers to subsidize the distributions of lower-income workers. *See Stone, supra* note 27. Because the second objective of social insurance can be accomplished only in a defined-benefit system, President Bush’s proposed defined-contribution or ownership system will accomplish only the income replacement objective. *See id.* at 293–94 (stating that in the context of health insurance, setting premiums based on individual risk eliminates the subsidy given to the sick by the healthy).

the inclusion in the MMA of a provision authorizing universal HSAs—an “ownership society” preference—is touted by some as the primary reason why many conservative members of Congress voted for legislation that will greatly increase the entitlement effect of Medicare.¹³⁵ A related issue is the apparent triumph of the Pharmaceutical Research and Manufacturers of America (PhRMA) with regard to prohibiting the federal government from acting as negotiator of drug prices for Medicare beneficiaries.

Under Medicare Part D, Medicare recipients receive the drug benefit only through risk-bearing private plans contracted with the government,¹³⁶ including PDPs offering only Part D coverage as well as integrated plans offering all of the Medicare benefits under Part C of Medicare, now renamed Medicare Advantage (MA).¹³⁷ If Medicare beneficiaries choose to remain in the traditional Medicare program, Medicare will continue to reimburse providers for all benefits to which they are entitled under Parts A and B, but beneficiaries will be able to receive Part D benefits only through separate stand-alone private risk-bearing drug plans, the PDPs.¹³⁸ Seniors who elect Medicare Part C, which is administering the Medicare Advantage plans, will receive their prescription drug coverage through private health plans that offer benefits under Parts A, B, and D.¹³⁹ Medicare beneficiaries may elect not to participate in Medicare Part D but rather stay with previously acquired Medicare supplemental insurance, such as employment-related health insurance or a Medigap policy that covers prescription drugs.¹⁴⁰ However, there is a late penalty for opting into Medicare Part D if the beneficiary later changes her mind or the supplementary insurance becomes unavailable.¹⁴¹

135. Berlau, *supra* note 15.

136. MARILYN MOON, THE COMMONWEALTH FUND, HOW BENEFICIARIES FARE UNDER THE NEW MEDICARE DRUG BILL 7 (2004), available at http://www.cmf.org/usr_doc/Moon_MedicareRxdrug_ib_730.pdf. The Act provides that each geographic region must have two or more PDPs. *Id.* In regions where the economics are not attractive to private plans, Medicare must provide a fallback. *Id.* The MMA will create a federally run drug plan in areas where less than two private plans participate. *Id.*

137. *Id.*

138. *Id.* Such Medicare beneficiaries may have to purchase two Medigap supplemental policies, one for prescription drug coverage and a second for all other benefits not covered by traditional Medicare. *Id.*

139. *Id.*

140. *Id.*

141. It is not difficult to imagine that employers, given the opportunity, will exclude retirees from their group health insurance programs or that Medigap sup-

This privatization continues the congressional experiment with managed competition for Medicare, which began in 1998, after the passage of the 1997 Balanced Budget Act.¹⁴² The BBA created a Medicare Part C that authorized Medicare to contract with risk-bearing private plans that offered beneficiaries not only Parts A and B benefits but additional benefits such as outpatient prescription drug and catastrophic coverage that were unavailable from traditional Medicare.¹⁴³ If a robust marketplace for such plans could be sustained, private plans would compete for the business of Medicare beneficiaries who would choose their plans as their health care preferences dictated. Many hoped that the privatization of Medicare through Medicare + Choice would bring down the cost of care for Medicare beneficiaries as well and shift the risk of that cost to the private market through risk-bearing contracts with Medicare.¹⁴⁴

In the years since the implementation of Medicare + Choice, it has become clear that the program has failed, in part because the capitated payments made by Medicare to the participating private plans became unprofitable, causing private plans to withdraw from the Medicare marketplace.¹⁴⁵ This contraction of the private market left Medicare beneficiaries with fewer choices of health plans, and in some rural areas, traditional Medicare is the only viable choice. As perhaps a response to the failure of the BBA's experiment with a private marketplace in Medicare, Congress has provided a remedy in the form of a subsidy. To induce private health care providers to enter the Medi-

plemental policies with prescription drug benefits may become unavailable in a shrinking marketplace. *MEDICARE & YOU*, *supra* note 40, at 40.

142. Managed competition was the brainchild of the Jackson Hole group and particularly Stanford Business School economist Alain Enthoven in the 1980s and formed the basis for the failed Clinton administration health reform legislation, the Health Security Act. Under managed competition, health plans would compete with each other for beneficiary enrollment. The health plans are required to sell a uniform product or a number of standardized products in order to give prospective enrollees some grounds to compare the plans for price, benefit, and quality. The MMA requires that the country be divided into Prescription Drug Plan (PDP) regions, and the various private health plans that wish to participate in the Medicare program will bid to cover the regions. HAYNES JOHNSON & DAVID BRODER, *THE SYSTEM* 72 (1996); *see also* Robert Pear, *Insurers Object to New Provisions in Medicare Law*, N.Y. TIMES, Aug. 22, 2004, at A1 (detailing the PCPs early reluctance to bid for such large geographic coverage).

143. *See* Patricia Neuman & Kathryn M. Langwell, *Medicare's Choice Explosion? Implications for Beneficiaries*, 18 HEALTH AFF. 150 (1999).

144. *See id.*

145. At the beginning of the Medicare + Choice program in 1998, there were 346 contractors; in 2002, only 156 contractors remained. Gold, *supra* note 128.

care insurance marketplace, Congress has allocated approximately \$14 billion over ten years to subsidize the creation and sustainability of a private health plan marketplace, although some speculate that even before the marketplace has begun, the cost of the subsidy will be closer to \$50 billion.¹⁴⁶ Given the lessons of Medicare + Choice and the apparent preference of Congress to continue the private market experiment with Medicare,¹⁴⁷ the subsidy should have been no surprise. However, it is not a well-known fact that because of subsidization, Congress' experiment with managed competition will end up costing the taxpayers substantially more than fee-for-service Medicare would have cost.¹⁴⁸

Whether Congress' imprimatur and subsidization of the private Medicare marketplace will constrain the projected costs of the MMA is a key question not only for Medicare health policy but also for more general health policy. Cost is, after all, at the core of all public programs, and the cost of Medicare is projected to rise for a number of reasons, not the least of which is demographics. Approximately forty-three million Americans are entitled to receive Medicare benefits, but that number is projected to double when the baby boomers begin to reach Medicare eligibility age in 2010.¹⁴⁹ While the MMA disproportionately benefits lower income enrollees in Part D and provides catastrophic drug coverage for all beneficiaries, a significant number of people sixty-five and older had prescription drug coverage prior to

146. See THE HENRY J. KAISER FAMILY FOUND., *PRESCRIPTION DRUG BENEFIT UNDER MEDICARE: BACKGROUND BRIEF* (2004), available at http://www.kaiseredu.org/topics_im.asp?id=131&imID=1&parentID=66; John Wasik, *Marketing Abuses Emerging in Medicare Drug Plan*, BLOOMBERG.COM, Dec. 12, 2005, http://www.bloomberg.com/apps/news?pid=10000039&sid=aqzBUv0MUpFw&refer=columnist_wasik.

147. Although it is all too easy to credit the Republican administration with a private market preference, I believe that it is the projections of huge Medicare expenditures, particularly in the face of the upcoming baby-boomer generation, coupled with no other viable solution that pushes Congress to pursue the private market solution. It may be that an expenditure of \$14 billion to induce private plans into risk-bearing contracts is small compared to what the potential liability of the federal government would be if Part D of Medicare were administered under traditional Medicare.

148. Reginald D. Williams, II, *Payment and Participation: A Renaissance for Medicare's Private Health Plans?*, in *MEDICARE BRIEF*, at 5-6 (Nat'l Acad. of Soc. Ins., Medicare Brief Series No. 12, 2005), available at http://www.nasi.org/usr_doc/medicare_brief_12.pdf.

149. Paul Hodge, Chairperson, Global Generations Policy Inst., Expert Testimony at the 2005 White House Conference on Aging, D.C., *Living Younger Longer: Baby Boomer Challenges* (Dec. 11-14, 2005), available at http://www.genpolicy.com/articles/2005_WHCoA_Policy_Committee.html.

the passage of the MMA that was better than that provided under Part D.¹⁵⁰ Although there certainly are means-testing provisions in the MMA, such as subsidies for premiums, deductibles, and co-payments for lower-income beneficiaries, Congress elected to make Part D available to all Medicare beneficiaries with little regard to the sufficiency of prior prescription drug coverage.¹⁵¹

V. Is the Problem the Cost of Prescription Drugs No Matter Who Pays?

Acknowledging the power of PhRMA in the Medicare reform debate, the MMA prohibits the federal government from negotiating directly with pharmaceutical companies the cost of drugs on behalf of Medicare beneficiaries. Instead, the MMA authorizes the PDPs and MAs to negotiate with the pharmaceutical companies. The clause, known as the noninterference provision,¹⁵² prohibits the Secretary of HHS from interfering with these price negotiations. The same language constrains the Secretary with regard to private coordinated health plans under the new MA program administered under Part C of Medicare. The purpose of the clause is to advance private market competition as the means of setting the price of prescription drugs. The clause underscores Congress' shift in policy away from the system of administered pricing that has been the hallmark of Medicare reimbursement since the 1980s.¹⁵³

A number of Democratic legislators, joined by some Republicans, continue to question this constraint on the Secretary's authority to negotiate on behalf of Medicare beneficiaries.¹⁵⁴ Comparing Medi-

150. The CBO estimates that 17% of beneficiaries with retiree benefits would lose them because of employer pull-backs in response to the MMA, and more recent HHS estimates suggest that the actual number may be twice that. Stuart et al., *supra* note 37.

151. *But see* Marilyn Moon, *Perspective: Medicare Means-Testing: A Skeptical View*, HEALTH AFF., Dec. 8, 2004, at w4-558, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.558v1>. *See generally* Mark V. Pauly, *Means-Testing in Medicare*, HEALTH AFF., Dec. 8, 2004, at W4-546, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.546v1>.

152. 42 U.S.C.S. § 1395W-111(i) (LexisNexis 2006).

153. *See* Barbara S. Cooper & Bruce C. Vladeck, *Bringing Competitive Pricing to Medicare*, HEALTH AFF., Sept./Oct. 2000, at 49, 49. *See generally* Susan A. Channick, *The Ongoing Debate over Medicare: Understanding the Philosophical and Policy Divides*, 36 J. HEALTH L. 59 (2003) (examining the evolution of Medicare).

154. California Healthline reports that Senator Ron Wyden (D-Or.) said that he has gathered enough votes in the Senate to pass legislation, which he cosponsored with Senator Olympia Snowe (R-Me.), authorizing the HHS secretary to negotiate

care to the VA pharmacy program that negotiates drug prices on behalf of its 3.5 million beneficiaries,¹⁵⁵ supporters of a policy permitting HHS to negotiate drug prices argue that the purchasing power of the federal government would inevitably lead to lower prescription drug prices for the forty-one million Medicare beneficiaries, who represent 14% of the population but 40% of total U.S. drug consumption.¹⁵⁶ In anticipation of this issue, the GAO issued a report in October 2000, which examined the ramifications of expanding the VA pharmacy benefit to Medicare and predicted that permitting the Secretary to negotiate drug prices on behalf of all Medicare beneficiaries would adversely affect the whole health care system.¹⁵⁷ Because of the size of the Medicare population, pharmaceutical companies would suffer large revenue losses and would make these up by raising drug prices to the under-sixty-five pharmaceutical market, thus causing health insurance premiums in that marketplace to rise.¹⁵⁸

In response to bipartisan attacks on the noninterference clause,¹⁵⁹ Senate Majority Leader Bill Frist (R-Tenn.) learned from CBO Director

drug prices on behalf of Medicare directly with the pharmaceutical companies. *Senate Bill to Authorize Medicare Prescription Drug Price Negotiation Has Votes Required to Pass*, CAL. HEALTHLINE, Sept. 28, 2005, <http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=114940&ClassCD=CL635>.

155. Studies have shown that drug prices negotiated by U.S. purchasers such as the VA have generated drug prices that are similar to or lower than those negotiated by the national health systems of Canada and European countries. LEIF W. HAASE & KRISTEN WIKELIUS, THE CENTURY FOUND., THE MEDICARE DRUG BENEFIT: STRAIGHT ANSWERS TO THE TOUGHEST QUESTIONS 10 (2005), available at <http://www.tcf.org/Publications/HealthCare/drugbenefit100305.pdf>.

156. REPUBLICAN POLICY COMM., U.S. SENATE, COMPETITION VS. PRICE CONTROLS: THE ROAD TO LOWER PRESCRIPTION DRUG PRICES 6 (2004), available at http://kyl.senate.gov/legis_center/rpc/030904.pdf.

157. *Id.*

158. U.S. GEN. ACCOUNTING OFFICE, PUBL'N NO. GAO/HEHS-00-118, PRESCRIPTION DRUGS: EXPANDING ACCESS TO FEDERAL PRICES COULD CAUSE OTHER PRICE CHANGES 6 (2000), available at <http://www.gao.gov/archive/2000/he00118.pdf>.

159. On February 6, 2004, Senators Snowe (R-Me.), Wyden (D-Or.), and Feinstein (D-Cal.) introduced a bill entitled the Medicare Enhances for Needed Drugs Act of 2004, allowing the federal government to directly negotiate drug prices with private drug companies. The bill also takes steps to legalize the importation of drugs from Canada and penalize drug companies that limit their exports to Canada. A second Senate bill with bipartisan support from former Senator Tom Daschle (D-S.D.) and Senators Byron Dorgan (D-N.D.), Edward Kennedy (D-Mass.), John McCain (R-Ariz.), Olympia Snowe (R-Me.), Debbie Stabenow (D-Mich.), and Trent Lott (R-Miss.), which calls for the importation of drugs from Canada and contains a prescription drug benefit, received endorsement by the AARP. Geoff Earle, *AARP Backed the Drug Bill to Appease Dems, Says GOP*, THE HILL.COM, June 17, 2004, <http://www.thehill.com/news/061704/aarp.aspx/aspx>.

Douglas Holtz-Eakin that striking the provision would have a “negligible effect” on federal spending because the “substantial savings” would, in fact, be achieved by the participating private plans, and that the Secretary would not be able to negotiate prices that would “further reduce federal spending to a significant degree.”¹⁶⁰

Notwithstanding the effects of the Secretary’s negotiations, the argument is actually one of philosophy. For a public insurance program administered by the government, as Medicare has been, the federal agency in charge of its administration essentially sets the prices and reimbursement schedules for Medicare providers.¹⁶¹ For a public insurance program administered by a private market, such as private insurers contracting with Medicare, prices are set by the marketplace. Assuming that private insurers enter the Medicare marketplace to profit, they have incentives to negotiate the best prices for services, including prescription drugs for their customers. But if the unregulated market does not result in satisfactory pricing, one could expect the federal government to use its power to regulate the price of pharmaceuticals for the Medicare marketplace.¹⁶² As Professor Uwe Reinhardt has noted, the pharmaceutical industry is correct to fear the Medicare 800-pound gorilla, which has proved it can be brutal when it comes to pricing.¹⁶³

Whether the privatization agenda springs from a true belief that private markets can do it better and cheaper than the government or is considered by conservative legislators as a shield protecting against the inevitable momentum toward universal health insurance, the MMA is replete with provisions designed to move the entire health insurance market in the direction of multiple payers, competition, and, inevitably, insurance market segmentation. The legislation con-

160. Letter from Douglas Holtz-Eakin, Director, Cong. Budget Office, to William H. Frist, Majority Leader, U.S. Senate (Jan. 23, 2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4986/FristLetter.pdf>.

161. The history of Medicare provider reimbursement could be instructive to the pharmaceutical industry. When Medicare was first enacted in 1965, the legislation was very deferential to providers setting reimbursement retrospectively at the providers’ fee-for-service amount. It was not until the mid-1980s that Medicare began to pay its providers on an administratively priced reimbursement schedule, which represented a profound defeat for providers. Jonathan Oberlander, *Medicare and the Politics of Prescription Drug Pricing*, 64 N.C. MED. J. 303, 304 (2003).

162. *Id.*

163. See generally Interview by Frontline with Uwe Reinhardt, Professor, Princeton Univ. (Nov. 4, 2003), available at <http://www.pbs.org/wgbh/pages/frontline/shows/other/interviews/reinhardt.htm> [hereinafter Reinhardt Nov. Interview].

tains tens of billions of dollars in subsidies to private plans as inducement to enter the Medicare marketplace. These subsidies are intended to ensure that private plans, which are able to offer richer benefits than public Medicare, will induce beneficiaries to choose them over Medicare.¹⁶⁴ In addition, private plans may be attractive because of their simplicity.¹⁶⁵ A beneficiary enrolled in public fee-for-service Medicare may also be enrolled in a PDP—her only option to receive the Medicare prescription drug benefit—as well as a Medigap supplemental insurance policy to cover the deficits in public Medicare's benefit structure, while a beneficiary enrolled in a private Medicare Advantage plan could be getting the same benefits.¹⁶⁶

Is there any realistic possibility that the continuously rising cost of prescription drugs will spur some sort of price regulation of pharmaceuticals as in other countries?¹⁶⁷ Or will the legislation be revised to give HHS the authority to negotiate drug prices for the MMA? As many skeptics have noted, it is highly unlikely that Congress would have passed a Medicare prescription drug benefit with the government rather than PBMs as the price negotiators because PhRMA, the chief lobby for pharmaceutical manufacturers, would not have allowed it. There has been plenty of experience over the years in Medicare with the government as the price setter, and the drug companies knew that their success selling pharmaceuticals to Medicare beneficiaries depended on a regime in which they would negotiate prices with smaller, weaker entities such as PBMs rather than a big gorilla like Medicare. “And I understand why,” Professor Reinhardt said. “[B]ecause Medicare can be brutal.”¹⁶⁸

164. Bruce Vladeck, *The Struggle for the Soul of Medicare*, 32 J.L. MED. & ETHICS 410, 413 (2004).

165. See Karen Davis et al., *Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries*, HEALTH AFF., Oct. 4, 2004, at W5-45, 53.

166. REGINALD WILLIAMS II, NAT'L ACAD. OF SOC. INS., MEDICARE BRIEF NO. 12, PAYMENT AND PARTICIPATION: A RENAISSANCE FOR MEDICARE'S PRIVATE HEALTH PLANS? (2005), available at http://www.nasi.org/usr_doc/medicare_brief_12.pdf.

167. The United States is the only developed nation that does not regulate drug prices. The methods vary from country to country—for example, Britain caps profits while France puts a ceiling on total drug spending. Only in the United States are the drug prices established, in the best of circumstances, in a competitive marketplace. In the worst-case scenario, the manufacturer is free to set a profit-maximizing price unless the purchaser refuses to pay. Patricia M. Danzon & Michael F. Furukawa, *Prices and Availability of Pharmaceuticals: Evidence from Nine Countries*, HEALTH AFF., Oct. 29, 2003, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.521v1>; Newhouse, *supra* note 98.

168. Reinhardt Nov. Interview, *supra* note 163.

In her recent book on the role of the pharmaceutical industry in U.S. health care, Dr. Marcia Angell, the former editor-in-chief of the *New England Journal of Medicine*, discusses at length how successful the pharmaceutical industry and its trade association, PhRMA, have been in buying influence from Congress.¹⁶⁹ From 1998 to 2004, the industry spent an estimated \$675 million on lobbying alone.¹⁷⁰ In December 2003, Congress passed the MMA with its many provisions favoring the private market as the primary player in negotiating and selling drugs to seniors. In addition to expressly forbidding the federal government from being the price negotiator of prescription drugs, the legislation authorizes significant spending to ensure that private companies will enter the Medicare marketplace and be indemnified in the event that their actual costs exceed expectations:

[The Medicare prescription drug benefit] should be administered through the Medicare program itself, which should be able to negotiate prices like any other large purchaser. All senior citizens should be fully covered for all cost-effective drugs. Medicare should have a formulary of the most cost-effective drugs, just as large private insurers do. Done this way, a Medicare prescription drug benefit would probably cost less than the present one will but provide much better and more efficient coverage. Nearly all of the money would go toward purchasing drugs, not toward windfall profits for the pharmaceutical and insurance industries and the pharmacy benefit management companies.¹⁷¹

Perhaps other unanticipated budgetary demands will overwhelm the power of PhRMA to dictate the terms of the MMA. The recent destruction in the Gulf Coast, particularly in New Orleans, as a result of Hurricane Katrina has left Louisiana and Mississippi badly in need of funding to restore and rebuild public infrastructure, private housing, social services, the local job market, and other necessities. Some projections estimate the cost of rebuilding to be as high as \$200 billion, a huge amount by anyone's reckoning.¹⁷² The federal govern-

169. See generally ANGELL, *supra* note 94.

170. M. Asif Ismail, *Drug Lobby Second to None: How the Pharmaceutical Industry Gets Its Way in Washington*, CTR. FOR PUBLIC INTEGRITY, July 7, 2005, <http://www.publicintegrity.org/rx/report.aspx?aid=723>.

171. ANGELL, *supra* note 94, at 196. The windfall profits are the \$46 billion in subsidies promised by the federal government to insurers and PBMs who participate in the MMA. In addition to federal subsidies, insurers are protected by risk-adjusted Medicare payments to insurers for seriously ill beneficiaries as well as by catastrophic guarantees. Robert Pear, *Defying Experts, Insurers Join Medicare Drug Plan*, N.Y. TIMES, Mar. 6, 2005, § 1.

172. *Katrina May Cost as Much as Four Years of War*, ASSOCIATED PRESS, Sept. 10, 2005, <http://www.msnbc.msn.com/id/9281409>.

ment's open-wallet approach to rebuilding without a plan for the source of such funds is drawing negative reactions from both sides of the political aisle.¹⁷³

As reported in the *Washington Post*, while conservatives are calling for spending cuts to existing programs, some GOP moderates are talking about the possibility of a tax increase, and many moderates would like to freeze the tax cuts that are yet to take place.¹⁷⁴ In fact, conservative House Republicans proposed a one-year delay in the Medicare prescription drug program as a way to help offset costs associated with Hurricane Katrina relief efforts.¹⁷⁵ The proposal also suggested increasing the Medicare Part B premium from 25% to 30% for a ten-year savings of \$84.77 billion, restructuring Medicare's cost-sharing requirement for a ten-year savings of \$87.46 billion, and imposing a home health co-payment of 10% for a ten-year savings of \$31.48 billion.¹⁷⁶

It should not be long before Democrats, joined by moderate Republicans, roll out additional legislation to allow HHS to act as the chief negotiator with the pharmaceutical companies on drug prices or to adopt administered pricing as the reimbursement standard for pharmaceuticals, just as administered pricing is the standard for other Medicare benefits.¹⁷⁷ Otherwise, Medicare Part D may well suffer the same fate as the 1988 Medicare Catastrophic Coverage Act, legislation including prescription drug and catastrophic health insurance for the elderly that was repealed one short year after it was enacted. In the case of the MMA, the imminent explosion in drug costs will sound the death knell for the legislation unless Congress finds an effective means of controlling the costs. "The Medicare trustees report that the drug entitlement alone will add a stunning \$8.1 trillion to Medicare's unfunded liabilities over the next 75 years, sharply increasing the financial burden on current and future taxpayers."¹⁷⁸

173. Dana Milbank, *Message Chaos Afflicts Both Parties as Katrina Aftermath Washes Discipline Away*, WASH. POST, Sept. 21, 2005, at A4; Shailagh Murray & Jim VandeHei, *Katrina's Cost May Test GOP Harmony: Some Want Bush to Give Details on How U.S. Will Pay*, WASH. POST, Sept. 21, 2005, at A01.

174. Murray & VandeHei, *supra* note 173.

175. *Conservatives Propose Delay of Medicare Rx Drug Benefit in Plan to Reduce Spending*, Health Care Daily Rep. (BNA) (Sept. 22, 2005).

176. *Id.*

177. Administered pricing is the price CMS sets for reimbursing providers under Medicare. See *supra* note 153 and accompanying text.

178. Moffit, *supra* note 14 (citing CTRS. FOR MEDICARE & MEDICAID SERVS., 2004 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL

VI. Who Is Really Paying the Bill?: The MMA “Clawback” Provision

As the MMA moved toward full implementation on January 1, 2006, a federalism issue emerged involving the always contentious issue of fiscal responsibility. Prior to January 1, 2006, all of the state Medicaid programs, although not required by federal law, had provided some level of pharmaceutical coverage to their Medicaid beneficiaries, including those dually eligible for both Medicaid and Medicare. Medicaid prescription drug funding had reached \$29.16 billion by 2002, contributing heavily to the growth in overall Medicaid spending.¹⁷⁹ One of the purposes of federalizing prescription drug coverage under the MMA was to relieve the states of the growing fiscal burden of prescription drug coverage for their indigent elderly.¹⁸⁰ Indeed, neither the House or Senate version of the MMA contained language requiring the states to partially subsidize federal legislation.¹⁸¹

Enacted in 1965, at the same time as Medicare, Medicaid is the health care program for low-income families, the elderly, and persons with disabilities.¹⁸² It is jointly financed by the federal and state governments, with federal funding ranging from a low of 50% of total cost to a high of 77% of total cost.¹⁸³ The condition for receipt of federal matching funds is state funding of health care costs for covered persons.¹⁸⁴ Federal matching funds create a strong incentive for states to cover their Medicaid populations because the federal government

INSURANCE AND FEDERAL SUPPLEMENTAL INSURANCE TRUST FUNDS 109 (2004), available at www.cms.hhs.gov/ReportsTrustFund/downloads/tr2004.pdf.

179. VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., THE CONTINUING MEDICAID BUDGET CHALLENGE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2004 AND 2005, at 7 fig.4 (2004), available at <http://www.kff.org/medicaid/upload/The-Continuing-Medicaid-Budget-Challenge-State-Medicaid-Spending-Growth-and-Cost-Containment-in-Fiscal-Years-2004-and-2005-Results-from-a-50-State-Survey.pdf>.

180. Robert Pear, *States Rejecting Demand to Pay for Medicare Cost*, N.Y. TIMES, July 4, 2005, at A9.

181. James N. Gardner, ‘Clawback’ May Fuel Federalism Debate, STATE NEWS 8 (2005).

182. VICTORIA WACHINO ET AL., THE HENRY J. KAISER FAMILY FOUND., FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS 8 tbl.1 (2004), available at <http://www.kff.org/Medicaid/upload/Financing-the-Medicaid-Program-the-Many-Roles-of-Federal-and-State-Matching-Funds-Policy-Brief.pdf>.

183. *Id.*

184. *Id.* at 2.

bears between 50% and 77% of the cost of coverage.¹⁸⁵ Moreover, because the states administer their own Medicaid programs, they have had a strong incentive to be efficient in the use of Medicaid funds to maximize the benefit for their citizens.¹⁸⁶ To that end, the states have been extremely innovative in the design of their state pharmacy assistance programs, using such cost-containment methods as prior authorization and mandatory use of generic drugs, cost-sharing requirements, intrastate and interstate compacts to leverage larger bulk purchasing discounts, international imports of cheaper drugs from Canada, and contracting for voluntary discounts with pharmacies and manufacturers.¹⁸⁷

In 2002, the states spent a total of \$5.6 billion on prescription drug coverage for dual eligibles alone, representing about half the total cost of the benefit, the other half of which came from the federal government.¹⁸⁸ The MMA covers all Medicare beneficiaries including dual eligibles and ostensibly shifts the cost of providing prescription drug coverage to the federal government even for dual eligibles. However, to meet federal budgetary constraints, Congress added the clawback provision during joint conference committee deliberations.¹⁸⁹ This provision requires the states to make a “phased-down State contribution” to the federal government in roughly the amount the state would have spent of its own funds if it continued to pay for outpatient prescription drugs through Medicaid on behalf of its dual eligibles.¹⁹⁰ The clawback provision is projected to cost the states from \$6 billion in 2006 to \$15 billion in 2013.¹⁹¹

185. On July 1, 2004, the Federal Medical Assistance Percentage, which had been temporarily raised by Congress during the fiscal downturn of 2002 and 2003, and had provided an additional \$20 billion in federal assistance to the states, was reduced to its pre-2003 percentages. Matthew Quigley, Fed. Reserve Bank of Boston, *States May Face Higher Spending in Give-and-Take of Medicare/Medicaid Changes*, NEW ENGLAND FISCAL FACTS 1 (2004/2005).

186. Whatever the benefits of Medicaid may be to the states, there is also a significant financial burden. Since 1965, Medicaid programs and populations have grown so much that Medicaid represents 16% of state general-fund spending nationwide, second only to education. Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416 (2004).

187. William G. Weissert & Edward E. Miller, *Punishing the Pioneers: The Medicare Modernization Act and State Pharmacy Assistance Programs*, PUBLIUS, Jan. 1, 2005, at 121.

188. *Id.*

189. *Id.*

190. 42 U.S.C.S. § 1396u-113(c)(1) (LexisNexis 2006).

191. See generally ANDY SCHNEIDER, THE HENRY J. KAISER FAMILY FOUND., THE “CLAWBACK:” STATE FINANCING OF MEDICARE DRUG COVERAGE (2004), available at

Starting in 2006, not only will the federal government no longer pay the states its share of prescription drug Medicaid money, but states will also be required to pay the federal government a percentage of the savings realized as a result of the MMA prescription drug coverage. The payments will start at 90% and will eventually reach and remain at 75%.¹⁹² The Congressional Budget Office has estimated that in the first five years of implementation, the states' contribution toward financing the MMA will total approximately \$50 billion, or 13% of the total cost of the program.¹⁹³ As noted earlier, the only option the states have to reduce the amount of their clawback payments is to reduce the number of optional dual eligible Medicaid beneficiaries, that is, Medicaid beneficiaries whom the states are not required to count among their dual eligibles,¹⁹⁴ to discontinue prescription drug coverage for all Medicaid beneficiaries, or to withdraw completely from participation in Medicaid.¹⁹⁵

As noted by Weissert and Miller, the MMA represents a watershed in the state-federal fiscal relationship with respect to health policy: the state role has shifted from one of innovative and activist administration to that of passive payer in a federal program.¹⁹⁶ Although this shift in position may not cause the state to be worse off financially,¹⁹⁷ for the first time in the forty-year history of Medicare and Medicaid, states no longer control how their dollars are spent. If, for example, the MMA privatization experiment results in higher drug prices for dual eligibles than the states had been able to negotiate in the past, a significant percentage of the financial burden of that failed experiment will fall on state budgets. The effect of the clawback is particularly burdensome at a time when the federal government is ac-

<http://www.kff.org/medicaid/upload/The-Clawback-State-Financing-of-Medicare-Drug-Coverage.pdf>.

192. *Id.* at 2.

193. *Id.* at 1.

194. See *supra* notes 65–70 and accompanying text.

195. This option is highly unlikely because states depend on the federal government to finance a number of other programs extremely important to the states. WACHINO ET AL., *supra* note 182.

196. See generally Weissert & Miller, *supra* note 187.

197. For example, the clawback formula may lead to inaccurate calculations of state savings. The clawback formula relies on a per capita expenditure (PCE) amount that is determined by each state's Medicaid spending for prescription drugs for dual eligibles in 2003. A state that had innovated between 2003 and 2006 and reduced its PCE would, under the MMA's formula, not receive any benefit for this innovation because PCE is determined by 2003 prescription drug spending. SCHNEIDER, *supra* note 191, at 6.

tively committed to trimming the states' Medicaid budgets by \$10 billion over the next decade.

States are becoming vocal about the effect this new era of reverse federalism in health policy will have on their state budgets. California estimates that it "will have more than \$215 million in prescription drug costs as a result of the [MMA]."¹⁹⁸ Governor Rick Perry (R-Tex.) has vetoed a \$444 million appropriation covering the Texas clawback contribution for two years, stating, "For the first time, state governments would be expected to directly finance federal Medicare benefits with state tax dollars."¹⁹⁹ Ohio Medicaid director Barbara Coulter Edwards praised Governor Perry's statement and said it "captures my views on the conversation we need to have with the federal government."²⁰⁰ In New Hampshire, the Republican majority leader of the state Senate, Robert E. Clegg Jr., said, "We are not going to pay. We are not sending the feds any money. We don't think it's constitutional for the federal government to commandeer our revenue. The federal government can print its own money. We can't."²⁰¹ "In Connecticut, Lieutenant Governor Kevin Sullivan [is asking] the state attorney general to review the constitutionality of the clawback requirement, which he describes as 'a hidden tax.'"²⁰² The Bush administration claims that the states will save 10% on drug costs.²⁰³

Speculation is growing that the clawback provision will spark constitutional challenges to the MMA by the various states. On October 19, 2005, Kentucky Attorney General Greg Stumbo announced he was suing the federal government over the clawback provision, saying that "[n]ever before has the federal government made such a bold, and I believe, unconstitutional, attack on Kentucky's right to control the spending of its own tax money."²⁰⁴ Prompting the initiation of the

198. *State Officials Express Concern About Drug Coverage for Beneficiaries Eligible for Medicare, Medicaid*, MED. NEWS TODAY, Mar. 8, 2005, available at <http://www.medicalnewstoday.com/medicalnews.php?newsid=20870>.

199. Pear, *supra* note 180.

200. *Id.*

201. *Id.*

202. *Id.*

203. *Medicare Drug Benefit Likely to Cause States to Lose Money*, MED. NEWS TODAY, Mar. 27, 2005, available at <http://www.medicalnewstoday.com/medicalnews.php?newsid=21844>.

204. Press Release, Office of the Attorney Gen., Attorney General Stumbo to Challenge State "Clawback" Provision of the Medicare Drug Prescription Act (Oct. 19, 2005), <http://ag.ky.gov/NR/rdonlyres/5FD0FA9B-B743-40E2-BBE7-A5E5BCF0E3E5/0/AGToChallengeStateClawbackProvisionoftheMedicareDrugPrescriptionAct.htm>.

lawsuit was the “bill” the Bush administration handed to the states on October 17, 2005, enumerating the state contributions to the MMA’s cost for fiscal year 2006. While federal legislation frequently seeks to encourage the states to legislate or regulate in a particular way by imposing conditions on the receipt of federal funds, legislation that oversteps the “encourages” boundary and becomes “coercive” is an unconstitutional use of federal power.²⁰⁵ Recent federal court federalism jurisprudence places significant new state sovereignty-based constitutional restrictions on Congress’ ability to exercise federal powers such as the spending power to “encourage” state legislative action.²⁰⁶

In response to the governors’ cries for help with growing Medicaid budgets and the need to trim the federal budget in light of unexpected and expensive budget items such as Hurricane Katrina recovery programs and the MMA, Congress is weighing programmatic changes to Medicaid by taking a second look at the propriety, fairness, and constitutionality of the MMA’s clawback provision. These changes would, in part, give the states authority to charge premiums, increase co-payments, and trim benefits for Medicaid recipients, making this public health insurance program for the poor look more like private insurance.²⁰⁷ As a result, Medicaid recipients of the age of majority who could not or would not pay their share may be refused coverage. In effect, Medicaid beneficiaries are being targeted to bear the financial burden of the MMA, the Iraq war, and Hurricane Katrina, to name just a few of the current demands on the federal budget. As Senate Minority Leader Harry Reid (D-Nev.) has said, this approach is immoral: “It hurts the poor and the middle class and makes all the rewards to those people who are already fat as a result of our system.”²⁰⁸ In addition, reforming Medicaid in the image of private insurance will certainly swell the ranks of the uninsured and underinsured from the current sixty-one million.

205. *New York v. United States*, 505 U.S. 144, 174, 176 (1992).

206. See Gardner, *supra* note 181, at 9.

207. Robert Pear, *Congress Weighs Big Cuts to Medicaid and Medicare*, N.Y. TIMES, Oct. 30, 2005, at A17.

208. Carl Hulse, *Congress Mounts Drive for Big Budget Cuts*, N.Y. TIMES, Oct. 31, 2005, at A15.

VII. Conclusion: The MMA May Prove to Be Bad Medicine for U.S. Health Policy

The projected price tag of a universal Medicare prescription drug benefit makes it more difficult to spend additional tax dollars on health care for other U.S. populations. It requires increasing the absolute percentage of GDP spent on health care, and dollars spent on health care are dollars not available for other products and services. The MMA raises the question of the equitable allocation of health care dollars among competing populations: are the elderly more worthy than children, the poor, the disabled, or the growing uninsured middle class? This question certainly does not speak to the worthiness of the elderly as a population. Few would dispute that Medicare sorely needed some provision for prescription drug coverage. But in the larger context of affordable health insurance for all Americans, it is misguided to provide first-dollar insurance for the portion of the Medicare population that already had prescription drug coverage, rather than simply providing them with only catastrophic coverage.

There seems to be little doubt that the ever-escalating cost of health care is driving both public and private health insurance toward a shifting of costs from employers and governments to employees and public health insurance beneficiaries. It is impossible to pick up a newspaper or magazine that does not contain evidence of this late twentieth-century and early twenty-first-century social phenomenon in the United States. The MMA is exceptional in that it expands public health insurance for the over-sixty-five cohort even for Medicare beneficiaries who already had prescription drug coverage prior to the program. The financing for this benefit is shared by taxpayers, Medicare beneficiaries' contributions to Part D, and state coffers through the clawback provision. In addition, to defray the enormous cost of the MMA, Congress is proposing changes to the Medicaid program that may give states the authority to make Medicaid beneficiary cost sharing a condition for receiving health insurance.²⁰⁹

209. Recent proposals to cut entitlement programs involve making changes to both Medicare and Medicaid. Cuts to Medicare Part D, such as the \$10 billion stabilization fund included in the 2003 legislation, intended to help attract managed-care plans to Medicare and keep them in the program. Alternatively, proposals are on the table for trimming costs of Medicaid by, for example, shifting more of the cost of health care onto beneficiaries. *Bush Threatens Veto over Senate Plan to Eliminate Managed Care Fund*, Health Care Daily Rep. (BNA) (Nov. 3, 2005).

Why did Congress and the Bush administration look only at Medicare's shortcomings in designing the prescription drug benefit rather than looking more broadly at health care reform? There are several reasons. One is the political preference for incrementalism over wholesale change. Adding a prescription drug benefit to a health insurance program for the elderly makes medical sense, is palatable to the public, and benefits a popular and deserving population. It will inure to the benefit of all of us if only we live to age sixty-five. It will inure to the benefit of our parents and grandparents. It was an easy and popular fix. A second reason is that the elderly are a significantly large group of more than forty million constituents who are enfranchised and regularly exercise their franchise. Many other worthy populations such as children and the poor are either not enfranchised or may not exercise their right to vote. Thus, benefiting the elderly was politically expedient and savvy.

Third, the significant price tag of adding a prescription drug benefit to Medicare may simply preclude adding benefits for other populations. A fourth reason may have been the opportunity to subsidize one of Congress' and the administration's favorite special interest groups—the pharmaceutical industry. Finally, the opportunity for the MMA to be the laboratory in which to experiment with the private market for a solution to the uncontrolled growth of Medicare as a public entitlement was undoubtedly irresistible. Although adding Part D to Medicare might appear to be a continuing commitment to a social insurance model, the private market's central role in the design, marketing, and implementation of heretofore public insurance belies that assumption.²¹⁰

The MMA makes clear this administration's commitment to private markets as a solution to social problems. While the privatization of Social Security, once the centerpiece of President Bush's reform legislation, has been eclipsed by other and more pressing problems, it too relied heavily on private ownership and private markets to "solve" Americans' retirement income issues. The MMA leaves no doubt that privatization is alive and well in the health care arena. The use of private insurers as the only way to obtain prescription drug coverage under Medicare is only the beginning of the privatization of heretofore public insurance in the United States. The next likely step is the

210. See *supra* notes 27–32 and accompanying text.

more dramatic shift from a defined-benefit Medicare to a defined-contribution Medicare. As a result, beneficiaries will be allocated a premium support amount with which they can purchase health insurance from a variety of options including high-deductible health savings accounts.

Regardless of whether this sea change in philosophy reduces the absolute dollars spent on health care for the elderly, it is certain to reduce the public-sector dollars spent on health care for the elderly. What makes up the shortfall is another story. In the past, a supplemental insurance market arose to pay for benefits not included in the Medicare program. Will a supplemental insurance marketplace that covers cost sharing arise? Will only affluent Medicare beneficiaries be able to afford comprehensive coverage while less affluent beneficiaries choose between preventive care and prescription drug coverage? Will privatized defined-contribution Medicare serve as the benchmark for all health insurance in the United States?

Although it is impossible to answer these questions, one can predict an increase in the numbers of uninsured and underinsured in the United States as a fall-out to the MMA. Because of Part D's unexpectedly high price tag, Congress is looking for ways to cut the costs of other programs. Medicaid is a perennial favorite and is likely to be the target of cuts or cost shifts by both the federal government and the states. For example, the recently proposed deficit-reduction legislation by the House of Representatives is expected to save more than \$30 billion over the next ten years, "not because cost-shifting measures would bring in revenue, but because new costs would keep the poor out of the health care system."²¹¹ In California, the implementation of Medicare Part D has prompted the state to discontinue funding managed-care plan premiums for its dual eligibles, something it had been doing since 2000 to help this vulnerable population defray the cost of prescription drugs.²¹²

In addition, Medicare beneficiaries who were receiving health insurance coverage through employer retiree health plans risk losing this coverage if they choose to enroll in Medicare Part D. For exam-

211. Jonathan Weisman, *Senate Passes Plan to Cut \$35 Billion from Deficit*, WASH. POST, Nov. 4, 2005, at A1.

212. NORMAN FINEMAN ET AL., UNIV. OF CAL. S.F., IMPLEMENTING MEDICARE PART D IN CALIFORNIA: A SCAN OF THE LANDSCAPE 5-6, 14-15 (2005), available at <http://calendow.org/reference/publications/pdf/npolicy/Medicare%20D%20Scan%20Report.pdf>.

ple, a letter Boeing recently sent to 100,000 retirees and their dependents said, “Your Boeing prescription drug coverage is part of your Boeing retiree medical plan. If you cancel your Boeing prescription drug coverage” to enroll in the new Medicare drug benefit, “your Boeing medical coverage also will be cancelled.”²¹³ This is a consequence of the penalty the MMA imposes on seniors who do not enroll in Part D during its initial offering, which may cause seniors who fear losing their current prescription drug coverage to enroll in Part D immediately to ensure penalty-free prescription drug coverage.²¹⁴ In addition, private employers seeking to reduce their liability for their employees’ health insurance, most particularly retired employees, will be looking for ways to reduce their employee population or shift the cost of health insurance to employees.

The newly created Presidential Advisory Panel on Federal Tax Reform has recommended limiting the currently unlimited employee income exclusion for employer-provided health insurance to \$5000 per individual and \$11,500 per family.²¹⁵ The stated purpose of this recommendation is to make taxable any amount of employer-provided health insurance in excess of the capped amount, thus increasing revenue to be used, ostensibly, to provide basic health insurance to people who are unemployed or who are employed but do not receive health insurance as an employment benefit. This plan has drawn a favorable response from the House Ways and Means Committee, whose chair, William Thomas (R-Cal.), has said that “the favored treatment afforded to employer-provided health insurance creates market distortions that result in many employees of large

213. *Some Firms Say Employees Who Enroll in Medicare Drug Benefit Will Lose Employer-Sponsored Benefits*, CAL. HEALTHLINE, Nov. 4, 2005, <http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=115758&ClassCD=C L635> (quoting Milt Freudenheim & Robert Pear, *Retirees Must Weigh Company Coverage Against Medicare Plan*, N.Y. TIMES, Nov. 4, 2005, at C1).

214. An eligible Part D beneficiary who fails to enroll in Part D upon first becoming eligible but elects to enroll at a later date will be subject to a late enrollment fee. 42 U.S.C.S. § 1395w-113(b)(1)–(2) (LexisNexis 2006). The late enrollment fee is a permanent penalty of 1% of the monthly premium. *Id.* § 1395w-113(b)(3)(A). This fee may be waived if the beneficiary had creditable prescription drug coverage during the time he or she was not enrolled in Part D. *Id.* § 1395w-113(b)(3)(B)–(4)(H).

215. The unlimited exclusion has been in effect since 1943, when the IRS ruled that employees were not required to pay taxes on the dollar value of group health insurance premiums paid on their behalf by their employers. PRESIDENT’S ADVISORY PANEL ON FED. TAX REFORM, FINAL REPORT: SIMPLE, FAIR, AND PRO-GROWTH: PROPOSALS TO FIX AMERICA’S TAX SYSTEM (2005), available at <http://www.taxreformpanel.gov/final-report/>.

companies receiving overly generous, first-dollar health coverage, while workers without access to an employer plan end up shopping for far more pricey coverage with the same tax advantage.”²¹⁶ While cross-subsidization is one means to expand the pool of people who are insured, this recommendation has potential short-falls. For instance, a reduced corporate tax deduction might encourage employers to stop paying for their employees’ group health insurance, and employees with limited income might not be able to afford to pay for health insurance themselves.

However imperfect the MMA may be, it does bring a much-needed benefit to the elderly, allowing them to live out the last part of their lives in better health and dignity. As with so much legislation, perhaps it was important to get a rough version on the table that can, in the future, be refined. But a health insurance model that segments populations necessarily prefers certain populations and ideologies over others. These preferences reflect our values as a society, and the MMA demonstrates where these values lie: in beneficiaries who are sympathetic and familiar such as the elderly; in a political system whose fourth branch of government consists of powerful interest groups such as the pharmaceutical and insurance industries; in a political philosophy that rewards incrementalism over broad sweeping changes; and in a clear preference for using the private market rather than the government to solve big societal problems such as access to health care. Perhaps this legislation is meant to bring the nation one step closer to the perfect storm that will finally unravel its frayed health care system and bring it closer to broad, comprehensive, inclusive reform.

216. *Tax Panel Proposal for Health Care Changes Draws Favorable Ways and Means Response*, Health Care Daily Rep. (BNA) (Nov. 4, 2005).