# The Most Important Health Care Legislation of the Millennium (So Far): The Medicare Modernization Act

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Whether or not one believes that the Medicare Prescription Drug, Improvement, and Modernization Act (MMA)[1] in fact improves or modernizes Medicare, the legislation obviously changes the program radically. The extent and nature of these changes make the MMA the most important piece of health care legislation to be adopted by Congress to date in this young millennium.[2] The MMA also contains what are arguably the most important amendments to the Medicare program since its creation.[3] This Essay first describes the identifying characteristics of the current Medicare program, then examines the significant changes that the MMA makes in the program, and finally discusses the importance—and danger—of these changes.

## I. TRADITIONAL MEDICARE

The Medicare program, as it was created in 1965 and has evolved over the past four decades, exhibits a number of distinguishing characteristics. First, Medicare is an entitlement program.[4] According to the statutes

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

2. Indeed, the only legislation that could compete with the MMA for the title of most important health care legislation of the past decade would be the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

3. The Medicare statute has been amended almost annually since the early 1970s, but most of the amendments have brought about only marginal changes in the program. *See* Timothy S. Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 66 (1999). The MMA's most significant competitors would probably be the Medicare Catastrophic Care legislation of 1988, which also added a drug benefit as well as catastrophic care coverage, but was repealed a year later, and the Balanced Budget Act of 1997, which added the Medicare+Choice Program.

4. The word "entitled" appears over one hundred times in Title XVIII of the Social

creating both the Part A Hospital Insurance Program and the Part B Supplemental Insurance Program, any person who has qualified for benefits[5] is legally entitled to go to any health care professional, institutional provider, or health care supplier in the United States that participates in the Medicare program (that is, most health care professionals and virtually all health care institutions in the United States) and receive any medically necessary product or service covered by Medicare.[6] Medicare will then pay for the service after any cost-sharing obligations of the beneficiary have been met.[7] A person denied eligibility or denied coverage for a particular service may appeal through a multi-layered appeals process and, ultimately, may seek judicial review.[8]

A second characteristic of the traditional Medicare program is that it does not discriminate among its beneficiaries with respect to premiums, cost-sharing, or coverage. All beneficiaries of the traditional Medicare program—from the poorest to the wealthiest—face the same cost-sharing obligations for Parts A and B and are expected to pay the same premiums.[9] In fact, the premiums and cost-sharing obligations of very low income beneficiaries are covered by the federal/state Medicaid program, and wealthier beneficiaries often purchase individual Medicare supplement policies or have retiree benefits which cover their cost-sharing obligations,

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Security Act (the Medicare title) in, for example, phrases referring to individuals' entitlement to benefits. *See, e.g.*, 42 U.S.C. §§ 426, 1395c, 1395d, 1395f(e), 1395k (2000); *see also* TIMOTHY S. JOST, DISENTITLEMENT 30-32 (2003).

5. Any legal U.S. resident who is sixty-five or older or permanently disabled, who has paid sufficient quarters of Medicare payroll taxes or who, alternatively, enrolls in Medicare Part A and B and pays a Part A premium is eligible for Part A. 42 U.S.C. §§ 426, 1395c, 1395i-2. Persons who are over 65 or disabled are also eligible for Part B, 42 U.S.C. § 1395o; however, Part B is a voluntary program, and persons who opt to enroll in it must also pay Part B premiums. These premiums are currently equal to about one-quarter of the cost of the program, while the rest is subsidized by general revenue funds. *See* Press Release, U.S. Dep't of Health & Human Servs., HHS Announces Medicare Premium, Deductibles for 2005 (Sept. 3, 2004), http://www.hhs.gov/news/press/2004pres/20040903a.html.

6. *See* JOST, *supra* note 4, at 38-45.

7. *See* BARRY R. FURROW ET AL., HEALTH LAW HORNBOOK §§ 11-10 to 11-22 (2d ed. 2000) (describing Medicare payment provisions).

8. 42 U.S.C. § 1395ff(b) (2000).

9. *Id.* §§ 1395e, 1395*l*, 1395r. Those few beneficiaries who enroll voluntarily in Part A because they lack coverage based on their payroll contributions also pay the same premiums. *Id.* § 1395o. There are a few exceptions to this general principle, one of the most important of which is that enrollees who do not enroll in Part B at the date they become eligible for enrollment face a penalty for late enrollment. *Id.* § 1395r(b).

but Medicare itself treats all the same. Moreover, the same products and services are generally available to all beneficiaries regardless of where they live, although Medicare coverage varies to a limited extent across the country because Medicare contractors are authorized to make their own local coverage determinations.[10] In this respect, Medicare resembles the national health services and social insurance programs of most other developed countries, under which all, or virtually all, citizens are covered, and all receive the same benefits.[11]

Third, Medicare pays for virtually all covered products and services on an administered price basis. Initially, Medicare paid for services based on reasonable charges or reported costs, following the model relied on by the Blue Cross and Blue Shield plans of the time, but this proved wildly inflationary.[12] Beginning with diagnosis-related hospital prospective payment in 1983, Medicare has moved steadily toward administered price systems, with the movement virtually completed by the passage of the Balanced Budget Act of 1997.[13] In practice, administered prices for health care products and services are set through a rather messy mixture of technical analysis and interest group politics. The Medicare payment under the resource-based relative value scale for a particular physician's service, for example, is based on a formula that includes a component for the physician's work,[14] as well as components for the practice and malpractice costs associated with a given procedure (adjusted for geographic variation). These components are summed and multiplied by a conversion factor based on a "sustainable growth rate" to reach a final payment amount.[15] The process is not purely technical, however. In response to physician arguments that they are underpaid and will not participate in the program unless they are paid more, Congress has consistently stepped in to upwardly adjust the payments that would have

10. Local medical review policies often address new technologies and utilization management issues. *See* Susan Bartlett Foote et al., *Resolving the Tug-of-War Between Medicare's National and Local Coverage*, 23 HEALTH AFF. 108 (2004).

11. *See* Timothy Stoltzfus Jost, *Why Can't We Do What They Do?*, 32 J.L. MED. & ETHICS 433 (2004).

12. FURROW ET AL., *supra* note 7, § 11-10.

13. *Id.* § 11-16.

14. The component of the formula that accounts for the physician's work is based on a technical evaluation of the time, mental effort, psychological stress, technical skill, and physical effort expended in producing a particular service.

15. *See* 42 U.S.C. § 1395W-4; FURROW ET AL., *supra* note 7, § 11-20 (describing 42 U.S.C. § 1395W-4).

resulted from this formula.[16] In the end, however, this technical and political process has proved very successful as a cost-control strategy, holding increases in the cost of the Medicare program below increases in the private sector throughout the late 1990s and early 2000s, and indeed leading to an absolute decrease in the cost of the program during one of those years.[17]

Fourth and finally, traditional Medicare covered a limited bundle of products and services. Medicare was patterned after the Blue Cross and Blue Shield programs that dominated the health insurance industry at the middle of the twentieth century, and, like them, was focused on hospital and physician services.[18] From the outset it covered a few other services as well (such as home health care and a limited amount of nursing home care), and with each decade its coverage expanded at the margins (most recently to cover more preventive care). In general, however, Medicare's coverage has in recent years been more limited than that found in commercial employee benefit plans.

As Medicare has evolved over the decades, it has strayed to some extent from these basic patterns. In particular, Medicare beneficiaries have long been able to receive both Part A and Part B benefits through Medicare managed care plans. Under the 1997 Balanced Budget Act the Medicare managed care program was renamed "Medicare+Choice" and designated as a new Part C. Medicare+Choice members were not entitled to obtain services from any Medicare-participating provider, but were instead limited in most instances to providers participating in their managed care plans.[19] Service coverage varied among Medicare+Choice plans, with many covering drug benefits or preventive services similar to those covered by commercial managed care plans and not otherwise covered by Medicare.[20] Moreover, providers who participated in Medicare+Choice plans were paid on the basis of prices they negotiated with the plans, rather than based on prices set by the Medicare program.[21]

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16. It did so, in particular, in the MMA, Pub. L. No. 108-173, sec. 601.

17. *See* Cristina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades*, 22 HEALTH AFF. 230 (2003).

18. *See* Nancy-Ann DeParle, *Medicare at 40: A Mid-Life Crisis?*, 7 J. HEALTH CARE L. & POL'Y 70, 76-77 (2004).

19. *See* GERALDINE DALLEK ET AL., LESSONS FROM MEDICARE+CHOICE FOR MEDICARE REFORM 4 (Commonwealth Fund Policy Brief No. 658, June 2003), http://www.cmwf.org/usr_doc/Dallek_lessonsM+C_658.pdf.

20. *Id.* at 3.

21. *Id.* at 4.

Yet, in most respects, the Medicare+Choice program still fits the basic Medicare model. For example, Medicare+Choice plans were required to cover all of the services covered by traditional Medicare.[22] The Medicare+Choice plans themselves were paid on the basis of administered prices set by Medicare through the use of a statutory formula, which allowed the Medicare program to control its costs.[23] Most importantly, the vast majority of beneficiaries remained enrolled in traditional Medicare, and in the last few years the Medicare+Choice program shrank dramatically in size.[24]

## II. THE MEDICARE MODERNIZATION ACT

### *A. The Medicare Drug Benefit*

The MMA promises to produce far greater changes in the traditional Medicare program and to change Medicare managed care as well. First, the MMA modernizes the Medicare benefits package—particularly by adding coverage for outpatient prescription drugs and additional preventive services, such as an initial screening physical and cardiovascular and diabetes screening tests.[25] The Medicare benefits package has been expanding for a number of years, and the package of benefits offered under the MMA bears a heightened resemblance to the packages of current commercial plans.

As the MMA expands Medicare benefits, however, it also makes them less uniform. Indeed, the changes that the MMA works in the Medicare benefit package go to the fundamental nature of the Medicare entitlement. The new prescription drug program will be provided through private prescription drug plans (PDPs) or Medicare Advantage (MA) managed care plans, which have replaced Medicare+Choice plans under an expanded new program. The statute states that a Medicare beneficiary is entitled to enroll in a qualified prescription drug plan or to obtain prescription drugs through a Medicare Advantage program. The Medicare program is supposed to ensure that each beneficiary has a choice between

22. *See* COLLEEN L. BARRY & JANET KLINE, MEDICARE MANAGED CARE: MEDICARE+CHOICE AT FIVE YEARS 3 (2002), http://www.cmwf.org/programs/medfutur/barry_fiveyears_ib_537.pdf.

23. *Id.* at 3-4.

24. DALLEK ET AL., *supra* note 19, at 2-4.

25. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, secs. 101, 611-613, 117 Stat. 2066-2152, 2303-06 (2003).

at least two plans (either two PDPs or MAs).[26] But beneficiaries will only have this choice if private plans choose to participate in Medicare. Beneficiaries are only entitled to a drug benefit if PDPs or MA plans offer the benefit, and only on the terms that those plans choose to offer.[27] Each beneficiary will have to decide individually whether the prescription drug benefits offered by the available PDP or MA plans are worth what he or she will have to pay for those benefits.

The PDPs are not, in fact, wholly free to define the benefit packages that they will offer. The MMA sets those terms generally by describing a "standard benefit package." The standard benefit package under the program will include a $250 deductible and a twenty-five percent co-payment for the first $2000 in benefits beyond that. Beneficiaries whose drug costs exceed $2250, but do not reach $5100, fall in a "doughnut hole" and will have to pay all of their costs in excess of $2250 out-of-pocket.[28] Once a beneficiary's out-of-pocket costs exceed $3600 (i.e., when total costs exceed $5100), catastrophic coverage kicks in, and thereafter the beneficiary must pay only five percent in co-insurance.[29] Both thresholds for co-payment will grow over the years if only because of inflation: In seven years, the program's deductible is projected to grow to $445, and the catastrophic protection threshold to $9066 in total drug spending.[30] Each PDP must offer coverage for at least two drugs from each therapeutic drug category or class.[31] The average beneficiary will have to pay about $35 per month for this package of benefits, initially,[32] with the federal government picking up roughly three-quarters of the cost for the basic package plus

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26. *Id.* sec. 101(a)(2), § 1860D-3, 117 Stat. at 2081-82 (providing that participants have a choice of plans).

27. If not enough plans offer to provide coverage on a risk-bearing basis, the Centers for Medicare and Medicaid Services can enter into contracts with "fallback" plans to provide coverage with Medicare bearing the full risk. *Id.* § 1860D-3(3)(b)(2), -11(g), 117 Stat. at 2081-82, 2092-99. Even this approach, however, will only work if a plan agrees to contract with Medicare on a fallback basis. Medicare is not authorized anywhere in the statute to provide prescription drug coverage itself.

28. *See id.* § 1860D-2(b)(4), 117 Stat. at 2076-77.

29. *Id.*

30. GERALDINE DALLEK, THE HENRY J. KAISER FOUND., CONSUMER PROTECTION ISSUES RAISED BY THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, at 3 (July 2004), http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=43996.

31. *See* Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-4(b)(3)(C), 117 Stat. 2066, 2085; 69 Fed. Reg. 46632 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. § 423.120(b)(2)).

32. DALLEK, *supra* note 30, at 3.

reinsurance for high-cost insureds.[33]

The much-discussed parameters of the standard plan, however, almost certainly do not describe the prescription drug plan that most Medicare beneficiaries will be offered. PDPs may in fact offer any package they choose, as long as it is "actuarially equivalent" to the standard benefit package described in the MMA and meets other legal requirements.[34] Most plans will probably offer tiered benefit coverage, with different "copays" for generics, formulary brand name drugs, and nonformulary brand name drugs.[35] Each plan will also come up with its own formulary, and each may change its formulary or the preferred or tier status of drugs at will as long it gives appropriate notice (usually thirty days).[36] Thus, although beneficiaries will only be able to change plans once a year, the plans can change their benefits at any time more than thirty days after the beginning of the contract year, making for an odd and one-sided market.[37] A beneficiary who is denied coverage or preferred-tier status for an off-formulary drug can request coverage and appeal a denial of coverage if the beneficiary's physician determines that the preferred or formulary drugs would not be as effective or would have adverse effects on the beneficiary.[38] But beneficiaries will otherwise have to live with the formulary and cost-sharing structure of the plan they have chosen, no matter how much this structure changes. Finally, premiums will also vary from plan to plan, based on the bids submitted by the plans.[39] Some plans will likely cost less than $35, others more.

As noted above, enrollment in the new Medicare prescription drug

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33. Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-4(b)3(c), -11(g)(6), -13(a)(3), -15, 117 Stat. at 2085, 2098, 2103, 2113-20.

34. *Id.* § 1860D-2(c), 117 Stat. at 2079-80.

35. *See* DALLEK, *supra* note 30, at 9, 21-22; HAIDEN A. HUSKAMP & NANCY L. KEATING, THE NEW MEDICARE DRUG BENEFIT: POTENTIAL EFFECTS OF PHARMACY MANAGEMENT TOOLS ON ACCESS TO MEDICATIONS (July 2004), http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=40660. A formulary is a list of drugs covered by the plan and usually includes drugs with respect to which the PDP has negotiated a favorable price with a drug manufacturer.

36. Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-4(b)(3)(E), 117 Stat. at 2085; *see* 69 Fed. Reg. 46632 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. § 423.120(b)(5)).

37. *See* 69 Fed. Reg. 46632 (proposed Aug. 3, 2004) (to be codified at 42 C.F.R. §§ 423.120(b)(6), 423.36).

38. Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-10(h), 117 Stat. at 2091.

39. *Id.* § 1860D-13(a), 117 Stat. at 2102-07; Ctrs. for Medicare & Medicaid Servs., Choices for Drug Coverage (Aug. 4, 2004), *at* http://www.cms.hhs.gov/medicarereform/issueoftheday/08042004iotd.pdf.

benefit will be voluntary. Enrollment in Medicare Part B has always been voluntary as well, but because the terms of Medicare Part B are so favorable, because private insurance is effectively unavailable to people over sixty-five, and, perhaps most importantly, because a person who is eligible must affirmatively opt out of the program to be excluded from it,[40] enrollment has been almost universal.[41] Enrollment in the drug benefit is likely to be more selective, with many young and healthy beneficiaries concluding that the program is not worth its cost. If premiums in fact cost about $35 per month, only beneficiaries whose drug costs exceed that figure ($810 a year) will benefit from the program; currently, seventeen percent of beneficiaries face annual drug costs below $250 per year.[42] Beneficiaries who choose not to enroll when first eligible face significant penalties if they choose to enroll later, but they may not realize this fact until it is too late.[43] Many Medicare beneficiaries, therefore, likely will not participate in the program.

Many Medicare beneficiaries will also opt out of the drug program because they are otherwise covered by employment-related retiree drug benefit programs. It has always been the case that some Medicare beneficiaries have enjoyed richer health care coverage than others because they receive supplemental benefits under retiree programs. The MMA goes further, however, explicitly subsidizing employee benefit programs that offer benefits at least as generous as the Part D benefit.[44] The regulations proposed to implement the program suggest several approaches that retiree drug benefit programs may take to fulfill this role, but the bottom line is that many retiree plan members will be receiving federally subsidized drug coverage through private programs that will replace, rather than supplement, Medicare.[45] Members of Medicare Advantage plans are also likely to face different premiums and cost-sharing structures for their drug benefits than those who receive drugs through the

40. *See* 42 U.S.C. § 1395p (automatic enrollment provisions); *id.* § 1395r (premium setting provisions).

41. The participation rate for Part B is 95.5 %. Dahlia K. Remler & Sherry A. Glied, *What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs*, 93 AM. J. PUB. HEALTH 67, 68 tbl.1 (2003).

42. DALLEK, *supra* note 30, at 16.

43. *Id.* at 15-16; Pub. L. No. 108-173, sec. 101(a)(2), §1860D-13(b)], 117 Stat. at 2104-06.

44. Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-22(a), 117 Stat. at 2125-27.

45. *See* Ctrs. for Medicare & Medicaid Servs., The Retiree Drug Subsidy: More Secure Coverage for Retirees (Aug. 11, 2004), *at* http://www.cms.hhs.gov/medicarereform/issueoftheday/08112004iotd.pdf.

traditional program, leading to further variation in the program.[46]

### *B. Means-Testing Medicare*

Some Medicare beneficiaries, moreover, will not have to pay any premium and will face much lower cost-sharing obligations for the drug benefit. The MMA for the first time means-tests part of the Medicare program. Dual-eligibles—i.e., persons who are eligible for both Medicare and Medicaid—will not need to pay any premiums for the Medicare drug program, while low-income beneficiaries with incomes slightly above the Medicaid eligibility level will receive assistance with premiums and cost-sharing.[47] High-income beneficiaries, on the other hand, will have to pay higher premiums than other beneficiaries under the MMA for the Part B program, albeit not for the drug benefit. Beginning in 2007, higher premiums will be charged to those with incomes above $80,000 for an individual, $160,000 for a couple.[48]

Beginning in 2010, moreover, MA plans in some regions will be placed in direct competition with the traditional Medicare program, with the possibility that premiums for traditional Medicare beneficiaries will increase so that Medicare beneficiaries in some parts of the country will pay higher Part B premiums than beneficiaries in other parts of the country.[49]

In sum, the simplicity of the traditional Medicare program—in which every one paid the same premiums and got the same services—is radically broken down under the MMA. This change will undoubtedly benefit some—Medicaid recipients in some states, for example, will receive more generous drug benefits—but the virtues of equality and solidarity that attended the old program will be lost, probably forever. These changes, however, may ultimately also sacrifice the widespread political support the program has always enjoyed, as some healthier and wealthier beneficiaries may realize that they receive fewer benefits or pay higher premiums than their neighbors and may begin to question whether they would be better

46. Medicare Advantage plans may, for example, offer enhanced drug coverage for no additional premium if they are required under Medicare Advantage payment formulas to offer additional benefits. *See* Ctrs. for Medicare & Medicaid Servs., New Medigap Options and Supplemental Options (Aug. 30, 2004), *at* http://www.cms.hhs.gov/medicarereform/issueoftheday/08302004iotd.pdf.

47. Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-14, 117 Stat. at 2107-13.

48. *Id.* sec. 811, 117 Stat. at 2364-65.

49. *Id.* sec. 241, 117 Stat. at 2214-21.

off without a public program.[50] Experience with the United States's Medicaid program and the experiences of other countries have shown that where health care benefits and costs are shared universally or nearly universally, programs enjoy strong political support, but where wealthier persons opt out, public programs are weakened.[51]

### *C. Payment for Services*

The most radical change wrought by the MMA, however, may not be in the way it provides benefits, but rather in the way it pays for services. As noted above,[52] Medicare has in recent years paid for most products and services using an administered price system. The Medicare program will not pay for outpatient prescription drugs through this approach, however—indeed, the MMA expressly forbids the program from doing so.[53] Rather, PDPs will negotiate drug prices directly with pharmaceutical companies. The PDPs will in turn submit bids to Medicare, as noted above, and will be paid based on these bids, with Medicare paying approximately three quarters of a weighted average bid and the beneficiary paying the amount by which the PDP's premium exceeds this amount.[54] MA plans, after a transition period, will be paid based on a bidding process, but they will also receive heavy subsidies from the federal government, which will be even more substantial in some markets.[55]

There seem to be two reasons why Congress has abandoned administered prices in the MMA. First, many in Congress genuinely believe that managed competition—that is, requiring PDPs or MAs to compete with each other through a managed bidding process that results in beneficiaries having to choose among plans based on marginal premiums—is the best way to control the cost of health care. There are several ironies in this reasoning. First, the generous payment formulas initially being used initially to pay MA plans, the subsidies built into the MA program, and the budget projections from the U.S. Congressional

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50. *See* Jacob S. Hacker & Theodore R. Marmor, *Medicare Reform: Fact, Fiction and Foolishness*, PUB. POL'Y & AGING REP., Fall 2003, at 1, 20-23 (discussing the perils of means-testing Medicare).

51. *See* JOST, *supra* note 4, at 50-51, 270-73.

52. *See supra* text accompanying notes 13-15.

53. Pub. L. No. 108-173, sec. 101(a)(2), § 1860D-11(i)], 117 Stat. at 2098.

54. *See id.* sec. 101(a)(2), § 1860D-4(b)3(c), -11(g)(6), -13(a)(3), -15, 117 Stat. at 2085, 2098, 2103, 2113-20. Medicare will also provide PDPs with reinsurance for high cost beneficiaries. *Id.* § 1860D-15(b), -15(e), 117 Stat. at 2114-15, 2116-20.

55. *Id.* sec. 222, 117 Stat. at 2193.

Budget Office clearly indicate that the MA program will not save money in the foreseeable future; on the contrary, it is expected to cost a great deal more than traditional Medicare.[56] Second, it is unlikely that the drug and insurance lobbies that supported the MMA would have fought so hard for it if they had believed that it would result in them earning *less* than they would have under an administered price system. Third, years of experience with Medicare managed care have proven that managed care plans cannot, and will not, provide care at a lower cost than traditional Medicare.[57] Fourth, every other developed country has controlled health care costs better than the United States, and most of them use some form of administered prices—none use managed competition.[58] Nevertheless, such is the power of ideology that many members of Congress view managed care and managed competition as potent tools for controlling Medicare costs, despite all evidence to the contrary.

With respect to paying for drugs, however, more is at stake. Congress is very reluctant to allow Medicare to set prices for drugs in the same way that Medicare sets prices for hospital or physician care. This reticence undoubtedly has something to do with the clout of the pharmaceutical industry, which spends far more on lobbying Congress than does any other health care interest group.[59] But even independent of any lobbying efforts, members of Congress might genuinely fear that if administered prices for drugs are set too low, drug companies may cut back on their investment in research and development, in turn retarding efforts to find new miracle cures.

The question of how to pay for drugs is a complex topic and cannot be addressed fully here.[60] The arguments for Medicare cutting payments for

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56. *See* BRIAN BILES ET AL., THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS (May 2004), http://www.cmwf.org/usr_doc/biles_extrapayments_ib_750.pdf. Medicare Advantage cost 8.4% more than traditional Medicare—$552 for each beneficiary. *Id.* at 1.

57. DALLEK ET AL., *supra* note 19, at 6-7.

58. *See* Timothy S. Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS (forthcoming 2004) (describing how other countries manage health care costs).

59. *See* Steven H. Landers & Ashwini R. Sehgal, *Health Care Lobbying in the United States*, 116 AM. J. MED. 474, 474 (2004) (noting that pharmaceutical companies spent $96 million on lobbying in 2000, compared to $46 million for physicians and other health professionals).

60. *See* Ernst R. Berndt, *Unique Issues Raised by Drug Benefit Design*, 23 HEALTH AFF. 103 (2004) (discussing Newhouse's article); Joseph P. Newhouse, *How Much Should Medicare Pay for Drugs?*, 23 HEALTH AFF. 89 (2004) (discussing the role Medicare should play in "setting

drugs are well known: Drug companies make very high profits and spend a great deal on marketing practices that have questionable value to society, such as direct-to-consumer advertising and wining and dining doctors.[61] Drug manufacturers are protected to a considerable degree from the normal pressures of competitive markets by the generous patent and market exclusivity protection that their products are afforded by federal law.[62] Much of the cost of drug research is already borne by the federal government, which pays tens of millions of dollars for research each year, and which should get some return on its investment.[63] And much of the research being carried on by drug companies presently is not directed at "miracle cures," but rather at lifestyle and "me-too" drugs.[64] Finally, citizens of other countries pay far less for drugs than we do and seem to have quite adequate access to drugs.[65]

On the other hand, the United States likely subsidizes pharmaceutical research for the rest of the world, and if a major payer like Medicare were to cut drug prices sharply, the cuts would not all come out of marketing or profits.[66] The task of setting administered prices for drugs, moreover, is terribly difficult, and it is not clear that other countries are doing it right.[67] In the end, Congress found it easier to punt the problem of establishing payments for drugs over to the PDPs, which the pharmaceutical companies apparently believe will not interfere significantly with their profits.

In the long run, however, the prescription drug program and the Medicare Advantage program are going to prove very costly, a fact that became increasingly clear after the MMA was adopted and information on

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manufacturers' prices").

61. *See* Timothy Stoltzfus Jost, Pharmaceutical Research and Manufacturers of America v. Walsh: *The Supreme Court Allows the States To Proceed with Expanding Access to Drugs*, 4 YALE J. HEALTH POL'Y L. & ETHICS 69, 74-75 (2004).

62. DAVID G. ADAMS ET AL., 2 FUNDAMENTALS OF LAW AND REGULATION 180-84 (1997).

63. MICHAEL E. GLUCK, THE KAISER FAMILY FOUND., FEDERAL POLICIES AFFECTING THE COST AND AVAILABILITY OF NEW PHARMACEUTICALS 17 (July 2002), http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14078.

64. *See* Thomas W. Croghan & Patricia M. Pittman, *The Medicine Cabinet: What's in It, Why, and Can We Change the Contents?*, 23 HEALTH AFF. 23 (2004).

65. Gerard F. Anderson et al., *Doughnut Holes and Price Controls*, HEALTH AFF. W4-396, W4-396 (Web Exclusive July 21, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.396v1.

66. *Cf.* Patricia M. Danzon, *Closing the Doughnut Hole: No Easy Answers*, HEALTH AFF. W4-405, W4-406 (Web Exclusive July 21, 2004), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.405v1.

67. *Id.*

the legislation's cost embargoed during the congressional debate finally leaked out.[68] This brings us to the final provision of the MMA–its doomsday clause.[69] This provision requires the trustees of the Medicare trust funds to project each year whether during that year or any of the six succeeding years the proportion of Medicare expenditures funded by general revenue funds (i.e., that component not covered by beneficiary premiums, Part A payroll taxes, or other dedicated sources) is likely to exceed forty-five percent.[70] If, for two years in a row, the trustees project that this will happen during the current fiscal year or the succeeding six years, the President must take action.[71] Specifically, the President must within fifteen days present to Congress proposed legislation to eliminate the "excess general revenue funding" problem. Legislation addressing the problem will then be handled under special rules in the Senate and House and be subject to very limited debate.[72] Depending on who is the President at the time, this provision could very well open the door for eliminating the Medicare program as we have traditionally known it with very little opportunity for Congress to debate the change.

## CONCLUSION

In sum, the MMA makes radical changes in the Medicare program, undermining in particular the commitment to solidarity and equality that has kept the program politically strong and loosening the cost controls that have kept it fiscally sustainable. The statute expands benefits for many beneficiaries in the short run, but adopts an approach to financing and distributing those benefits that may not be viable in the long run. In decades to come we may well look back at the MMA, the most important Medicare legislation of its decade, as a statute whose primary lasting effect was not to modernize the Medicare program, but rather to doom it.

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68. *See* BILES ET AL., *supra* note 56 (discussing the high costs of privatization); U.S. Gov't Accountability Office, Dep't of Health & Human Servs., Chief Actuary's Communication with Congress, B-302911 (Sept. 7, 2004), http://www.gao.gov/decisions/appro/302911.htm.

69. Pub. L. No. 108-173, secs. 801-04, 117 Stat. at 2357.

70. *Id.* sec. 801, 117 Stat. at 2357-60.

71. *Id.* sec. 802, 117 Stat. at 2360.

72. *Id.* secs. 803-04, 117 Stat. at 2360-64.