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When More Means Less

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In its headlong rush to provide a prescription drug benefit for the elderly and disabled, Congress risks abandoning a fundamental principle that has been a hallmark of Medicare since the program's inception in 1966. That principle — universality — ensures that all Medicare beneficiaries, no matter where they live or what their financial circumstances, are eligible for the same basic benefits.

If either the Senate or House bill is enacted, the ideal of universality will be history — though each proposal undermines this principle in a different way. In their conference to reconcile the two bills, which first met yesterday, members of both the House and Senate should work to ensure that Medicare's universal nature is preserved.

To save money, the Senate proposal would deny the new drug benefit to the 6.4 million Medicare beneficiaries — about one in six — who, because of their limited incomes, are also fully eligible for Medicaid, the program that covers the health care costs of some of nation's poorest residents. These so-called dual eligibles would be required to obtain drug coverage through their state's Medicaid program. Under current practice, Medicare pays first for services provided to dual eligibles, while Medicaid picks up any costs or charges Medicare doesn't cover.

The difference for these beneficiaries is more than a matter of which program pays for their prescriptions. Because each state determines its own Medicaid drug benefit, the drug plan available to dual eligibles will vary depending on where they live. Although many state Medicaid programs have provided generous prescription drug coverage in the past, spiraling Medicaid costs and severe budget difficulties have forced many of them to cut back. Some have imposed limits on the number of prescriptions that a beneficiary can fill each month; others have restricted access to some drugs. Thus, Medicare's poorest participants — those who qualify for Medicaid — could find themselves with skimpier drug coverage than other beneficiaries.

In addition to being unjust, denying Medicare's poorest participants access to a benefit available to other Medicare beneficiaries imposes an unfair burden on hard-pressed states, which already pick up the 43 percent of the Medicaid bill that the federal government does not cover. Once Medicare starts providing drug coverage, states will be tempted to shift some of their burden for dual eligibles, which constitutes more than one-third of total Medicaid costs, to federally financed Medicare. (They can do this by simply lowering their maximum income limits for full Medicaid eligibility.)

If states yield to such pressures, millions of low-income elderly and disabled Medicare beneficiaries could find themselves without a Medicaid safety net. They will no longer be dual eligibles, and thus will qualify for a Medicare drug benefit, but they will be denied Medicaid's coverage for other services.

The House proposal undermines universality as well — at the other end of the income spectrum. Its plan would use a beneficiary's income to determine the threshold at which catastrophic protection kicks in. Elderly people with incomes below \$60,000 would have all their drug costs picked up once they spend \$3,500 out of pocket; those with incomes of \$200,000 or more would have to spend nearly \$12,000 on drugs before they received such protection.

While a good case can be made for asking the upper-income elderly to pay higher premiums, varying the benefit according to beneficiaries' incomes is simply impractical. Income-related benefits are confusing and intrusive for participants and difficult to administer, since Medicare does not collect information about participants' incomes. Income-related premiums, on the other hand, could be collected quite simply from more wealthy beneficiaries when they filed their annual tax returns.

Both the Senate and House proposals further undermine universality by allowing considerable variation from plan to plan, and place to place, in the drug benefit that private insurers will offer beneficiaries.

All plans will be required to offer overall benefit packages worth the same dollar amount to an average beneficiary. But beyond this constraint, insurers would have considerable discretion. They could set different deductibles and require different cost-sharing rates for all or certain classes of drugs. Beneficiaries filling the same prescriptions could pay quite different amounts out of pocket depending on the plan they chose and the state in which they live.

There is nothing wrong with a system that offers options that differ by region or are more affordable to some beneficiaries than others. That's how Medicare and the supplemental insurance purchased by most elderly people work today. Such choice could spur competition that improves the quality and efficiency of both the drug benefit and Medicare itself.

But choice should not come by sacrificing Medicare's commitment to universality. A modern Medicare program should ensure that, in addition to other options, all beneficiaries — rich and poor alike — are guaranteed access to an identical basic drug benefit whether they live in Portland, Me., Portland, Ore., or Portland, Tex.

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