

**Improving Prescription Drug Coverage:  
Opportunities and Challenges for Reform**

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### **Statement of Patricia Neuman, Sc.D.**

Thank you, Mr. Chairman and Members of the Committee, for the opportunity to testify on efforts to improve prescription drug coverage for Medicare beneficiaries. I am Patricia Neuman, a vice president of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project. I am also an associate faculty member in the Department of Health Policy and Management at The Johns Hopkins University School of Hygiene and Public Health.

By many measures, Medicare has been and continues to be one of the nation's most successful federal programs. Medicare has provided a vital source of health coverage for elderly and disabled Americans, a population that faced significant difficulties obtaining health insurance before Medicare was created. Since its enactment in 1965, Medicare has been reformed incrementally over time to address many critical problems as they have emerged. Due to changes in Medicare payment systems, for example, Medicare has been at least as effective as the private sector in controlling the rise in health care spending over time. Perhaps most importantly, Medicare's successes can be measured by the broad popular support it enjoys among both the general public and the high level of satisfaction reported by its beneficiaries.

Of course, Medicare continues to face challenges that will need to be addressed through ongoing reforms. Over the long term, the greatest challenge will be to finance care for an aging population that will double in size over the next 30 years. This will require an infusion of revenues in addition to the new funds that would be needed to pay for the addition of a new drug benefit. Improvements are also needed to stabilize the Medicare+Choice program, to help Medicare become a more fair and reliable business partner for health providers and plans, and to ensure the program evolves with advances in medical practice.

From the beneficiary perspective, however, no problem is more pressing than filling one of the primary gaps in Medicare's benefit package with affordable prescription drug coverage. Today, in the presence of a federal budget surplus, a bipartisan commitment to addressing this problem, and public support for a Medicare prescription drug benefit, this appears to be an historic window of opportunity to take on this policy

challenge. My testimony today begins with a brief review of existing sources of prescription drug coverage and a discussion of why coverage matters. It then reviews efforts to improve coverage, identifying both significant areas of common ground and key policy issues and challenges, and their budgetary implications.

### **Who Lacks Prescription Drug Coverage?**

According to data released just last week, more than 10 million beneficiaries—accounting for more than a quarter of the Medicare population—lacked prescription drug coverage throughout 1998, the most recent year for which data are available. This number masks the much larger share of beneficiaries—about one-half—who were without continuous coverage at some point over the course of that year. Lack of coverage disproportionately impacts those who are low-income, living in a rural area, and among the oldest-old (ages 85 and older).

The absence of drug coverage affects beneficiaries of all income levels. Half of all beneficiaries without drug coverage have an income above 175 percent of the federal poverty level (above \$14,600 for an individual in 2000) (Exhibit 1). Still, it is the near-poor (those between 100-175 percent of the poverty level) who are the most likely to be without drug coverage because their incomes and assets tend to exceed the levels necessary to qualify for Medicaid, but still leave them unable to purchase a Medigap policy with drug coverage easily on their own (Exhibit 2). More than 30 percent of beneficiaries with incomes between 100 and 175 percent of poverty lacked drug coverage in 1998, compared with 23 percent of those with incomes above 300 percent of poverty, and 27 percent of those with incomes below poverty.

Beneficiaries living in rural areas are more likely than those living in other areas to lack drug coverage. Nearly four in ten beneficiaries living in rural areas (37 percent) lack drug coverage, compared to 23 percent of those in metropolitan areas (Exhibit 3). These beneficiaries are both less likely to have been in jobs that offer retiree health benefits and to have access to a Medicare managed-care plan. Only 14 percent of rural beneficiaries have a Medicare+Choice plan in their region, explained in part by the difficulties of establishing plans in these areas.

Medicare's oldest-old are significantly more likely than younger beneficiaries to go without drug coverage—despite the need for multiple medications that often comes with advancing age and multiple chronic conditions. More than a third of those ages 85 and older (34 percent) were without coverage in 1998 compared to 25 percent of those between ages 65 and 74. This lack of drug coverage comes at a time when seniors' retirement savings are often insufficient to help them afford expensive medications.

### **What Is the Current State of Prescription Drug Coverage?**

While an estimated 73 percent of beneficiaries had some form of drug coverage for at least part of the year in 1998, such coverage is often inadequate and, for many, likely to decline in the near future. Beneficiaries today rely upon a range of sources for help with the cost of their medications, including employer-sponsored retiree coverage, individually purchased Medigap policies, Medicare managed-care plans, the Medicaid program, and—in some states—state-operated pharmacy assistance programs. Although these sources have helped to fill Medicare's gaps and shield seniors from high out-of-pocket costs, access to such coverage is increasingly limited and expensive.

Employer-sponsored plans, the leading source of drug coverage for seniors, provided relatively comprehensive drug benefits to nearly 33 percent of the Medicare population in 1998. There is some concern, however, that reductions in drug benefits for retirees are on the horizon. Forty percent of large employers say they are seriously considering cutting back on drug benefits for their retirees in the next three to five years, according to a recent survey of large employers conducted for the Kaiser Family Foundation by Hewitt Associates (Exhibit 4). Further, with the share of large employers offering health benefits to retirees over age 65 declining from 80 percent in 1991 to 66 percent in 1999, today's workers are less likely than current retirees to receive drug benefits from their employers when they retire.

Individually purchased Medigap policies have been another source of prescription drug coverage for the Medicare population. The premiums for these policies, however, are rising rapidly -- by as much as 20 to 30 percent in many markets - - and now range from about \$1,400 to \$4,700 per year, depending on where beneficiaries live, the type of coverage they obtain, and their age. As a result, only 9

percent of all beneficiaries with a standard Medigap policy—accounting for less than 2 percent of the entire Medicare population—have a standard Medigap plan that includes drug coverage (Exhibit 5). Access to Medigap drug coverage is further restricted by rules permitting insurers to deny Medigap drug coverage to many under-65 disabled Medicare beneficiaries and to others who lose coverage upon disenrolling from an HMO.

Medicare HMOs were, until recently, a promising source of prescription drug coverage, assisting 15 percent of all beneficiaries with their drug costs in 1998. There is much uncertainty, however, about the future role of Medicare+Choice plans as a source of prescription drug coverage. In recent years, the number of plans participating in the Medicare+Choice program has declined, as have both the number of plans offering drug benefits and the level of drug coverage offered. (Exhibit 6). As a result, 22 percent of Medicare HMO enrollees had no drug coverage in 2000 and another 25 percent had a drug benefit of \$750 per year or less (Exhibit 7).

For those with low incomes, Medicaid is a critical source of drug coverage, most notably those receiving cash assistance through the Supplemental Security Income (SSI) program and those living in nursing homes. Although states are not required to provide drug coverage under Medicaid, all include it as part of their Medicaid benefits package. More than 5 million (12 percent) community-based Medicare beneficiaries were enrolled in Medicaid in 1998, most of whom (89 percent) received prescription drug coverage from this source. It is important to note, however, that only about half of all beneficiaries living below the poverty level received any assistance from Medicaid (Exhibit 8).

Many states are now struggling with the budgetary impact of prescription drug costs. Medicaid payments for outpatient pharmaceuticals rose from an estimated \$5 billion in 1990 to \$17 billion in 1999, at an average annual increase of almost 15 percent. This growth stemmed largely from rising costs for the disabled and elderly, who accounted for 80 percent of all Medicaid prescription drug spending in 1998 (Exhibit 9). States already have some ability to limit the costs of their Medicaid drug benefits through the drug rebate program, which uses the government's volume purchasing authority to obtain discounted prices. States are also adopting additional strategies to control the rapid growth in pharmacy spending, by limiting the number of prescriptions covered per

month, seeking larger discounts from manufacturers, restricting access to expensive brand-name drugs, and proposing that local pharmacies lower their prices. In sum, states are looking to restrain—rather than expand—their Medicaid coverage of prescription drugs.

Finally, some states (26 as of January 2001) have enacted state-based pharmacy assistance programs to assist seniors on fixed incomes. Combined, these programs assist an estimated one million individuals, the majority of whom are concentrated in three states. As with Medicaid, these programs vary widely in terms of structure, eligibility, and benefits. While most provide a direct subsidy to low-income seniors, other approaches include discount programs, tax credits, and private-insurance models. Most are relatively new and not widely utilized.

In sum, while a patchwork of alternative sources of prescription drug coverage may compensate, in part, for the absence of a Medicare prescription drug benefit, both the generosity and the reliability of each of these sources are increasingly questionable in today's environment. Given these trends, there is concern that the number of those without drug coverage will rise, along with the number of those who are underinsured for the costs of their prescription medications.

### **Why Is Drug Coverage Important?**

Prescription drug coverage matters to people of all ages, but it is especially important to the sick and chronically ill who are disproportionately represented among the elderly and disabled on Medicare. Seniors are more likely than younger adults to have multiple acute and chronic conditions typically treated with medications, which explains why drug use increases dramatically with age. Those ages 65 to 74, for example, fill on average 20 prescriptions per year, compared with an average of 5 prescriptions filled by those between the ages of 19 and 44 (Exhibit 10).

The need for prescription drugs often comes at a substantial cost to the Medicare population – a population that generally lives on fixed incomes. Forty percent of all Medicare beneficiaries – 14 million people – have incomes below 200 percent of poverty, or below \$16,500 for an individual (Exhibit 11).

Given the key role of pharmaceuticals in medical care today, those without drug coverage are basically uninsured for what may arguably be the most critical component of their medical treatment. In addition, there is a growing body of research documenting the widening gap between the haves and the have-nots. Beneficiaries without drug coverage filled 8 fewer prescriptions per year on average than those with coverage in 1998. Even more striking, beneficiaries in poor health without drug coverage averaged 15 fewer medications than their insured counterparts (Exhibit 12).

There is also anecdotal evidence of beneficiaries misusing drugs because they cannot afford to take their medications as prescribed by their doctor, by skipping doses, splitting pills, and sharing medicines with friends or family members. Systematic underutilization of prescribed medications poses a threat to quality of care and potentially increases costs to the system in terms of avoidable emergency room and hospital admissions, physician visits, and nursing home stays.

Beneficiaries without drug coverage also incurred higher out-of-pocket costs in 1998, spending on average \$221 more than beneficiaries with drug coverage (\$546 vs. \$325). Among those in poor health, the disparities in out-of-pocket spending widened between those who lacked coverage and those with coverage (\$820 vs. \$490) (Exhibit 13).

Beneficiaries without drug coverage incur relatively high costs both because they do not have an insurer to share the cost of each prescription and because they often pay the full retail price when they go to the pharmacy. By contrast, those with prescription drug coverage are often shielded from the full effect of high and rising drug costs as they may benefit from pharmacy discounts negotiated by their employer-sponsored plan or HMO.

The predicted rise in drug expenditures will likely compound these concerns. Since 1990, national drug spending has almost tripled from \$40 billion to an estimated \$117 billion in 2000 and will, according to both the Congressional Budget Office and the Health Care Financing Administration, rise at an even more rapid rate in the next decade. In addition, spending on prescription drugs has grown more rapidly other

services, including physician, hospital, and nursing home care (Exhibit 14). If, as expected, employers, Medicare+Choice plans, and states look to limit their financial liability for drug spending, the financial burden will likely be shifted directly to Medicare's elderly and disabled, who could face dramatic increases in drug costs.

## **Efforts and Opportunities for Expanding Prescription Drug Coverage**

There are now three general approaches at the forefront of the national policy debate on improving prescription drug coverage for all Medicare beneficiaries. Drawing on models introduced during the last Congress, these include: an integrated Medicare drug benefit that would be administered by private entities, such as pharmacy benefit managers; a Medicare drug benefit that would be offered along with other benefits through high-option plans, as part of a broader framework for reform; and a stand-alone Medicare drug benefit that would be offered by private plans.

In addition to these efforts to provide a universal Medicare prescription drug benefit, the President has proposed the Immediate Helping Hand program that would assist beneficiaries with low incomes (below 175 percent of poverty) and those of all income levels with high out-of-pocket prescription drug expenses (above \$6,000) through a new block grant to the states. This is proposed as an interim measure -- in anticipation of enacting universal access to drug coverage as part of more comprehensive Medicare reforms.

Viewed together, these plans reflect a range of philosophical perspectives and policy priorities and illustrate difficult tradeoffs that policymakers face in designing a Medicare prescription drug benefit. A review of these proposals also reveals significant areas of apparent agreement among them.

## **Key Similarities**

Recognizing the Need to Help Beneficiaries Who Lack Meaningful Drug Coverage. For the first time in many years, there now appears to be a growing consensus on the need to help all beneficiaries with prescription drug expenses, rather than targeting benefits to those with low incomes or catastrophic expenses. There are,

of course, important differences among proposals that would have a significant impact on both the number of people who would get drug coverage and the level of that coverage, but the rhetoric of the debate appears to be converging on the need for a universal approach.

Protecting Low-Income Beneficiaries. Virtually every major proposal recognizes the need to provide additional protections for low-income beneficiaries. Many would provide full premium assistance to the lowest-income beneficiaries (with incomes below 135 percent of poverty) and partial premium assistance to those with incomes up to 150 percent of poverty, with some offering assistance to those with incomes up to 175 percent of poverty. In addition to premium assistance, many of the leading proposals would assist low-income beneficiaries with cost-sharing requirements.

Most plans would rely upon states to administer additional benefits to the low-income population, and many would require states to use asset tests to determine eligibility for benefits (at less than twice the limit permitted for SSI). Based on the experience of the Qualified Medicare Beneficiary Program, this approach could pose significant barriers for individuals applying for the program, potentially resulting in lower participation rates.

Providing Protection Against Catastrophic Drug Expenses. Several leading proposals would aim to assist beneficiaries with catastrophic prescription drug expenses. Catastrophic protection, sometimes referred to as “stop-loss,” helps protect the relatively small share of beneficiaries with high-end drug expenditures. While proposals differ in terms of the threshold amount above which expenses would be covered (i.e., \$4,000 vs. \$6,000) and how that amount would grow over time, there appears to be recognition of the special needs of those with extraordinarily high drug expenses.

Establishing a Voluntary Benefit. Virtually all of the current proposals would allow beneficiaries to take advantage of the new prescription drug benefit on a voluntary basis. Those satisfied with their existing coverage (from a former employer, for example) would not be required to enroll in the new program, nor would they be forced to pay for a benefit, unless they elected to receive it. The decision to make the benefit

voluntary reflects one of the chief lessons learned from the ill-fated Medicare Catastrophic Coverage Act (MCCA) of 1988.

Distancing Government from Direct Drug Pricing. Marking another major departure from the MCCA, none of the current proposals for improving coverage advocates the use of a government-administered pricing system. Instead, they tend to delegate cost-management decisions to risk-bearing private plans or to other private entities such as pharmacy benefit managers (PBMs).

Maintaining a Role for Employers. Acknowledging the key role that employers play in financing prescription drug coverage for retirees and the trend toward eroding employer-sponsored drug coverage, many proposals would offer financial incentives to encourage some level of continued employer-based drug coverage.

## **Policy Challenges**

Despite the many important areas of agreement, there remain a number of difficult decisions and policy challenges that have implications for both beneficiaries and program costs.

What strategies should be used to reach beneficiaries without drug coverage? One of the major challenges is designing a program that will reach the largest number of beneficiaries who lack drug coverage, including those who live in rural areas, those who have modest and low incomes, and those who are frail or among the oldest-old. This means developing an approach that can adapt to highly variable local markets and health delivery systems, that is available everywhere, that is affordable, and that is relatively user-friendly given the vulnerabilities in this population.

*Making coverage available.* One of the key issues is ensuring that Medicare drug benefits are available to those who live in all parts of the country. Despite differences pertaining to the desirable size of traditional Medicare and the role of competitive private plans, one of the major policy challenges is finding a way to deliver drug benefits to those in the traditional fee-for-service program, recognizing both the sheer number of beneficiaries covered under the traditional program today (86% of all beneficiaries) and the challenge of delivering benefits through private plans in difficult-to-serve areas. The

recent withdrawal of many Medicare HMOs, which disproportionately affected non-urban areas, underscores the need to provide a reliable, stable source of drug coverage – that can withstand the swings of private plans’ participation decisions and that will work for beneficiaries no matter where they live, or what plans are offered in their area.

Some proposals would make the prescription drug benefit available through both traditional Medicare (administered by private plans) and Medicare+Choice plans. As with other benefits covered by Medicare today, this approach guarantees benefits, whether the beneficiary lives in Miami or Manchester. Others would rely on subsidized private plans to offer drug benefits, and give the Secretary authority to assure that there is a fall back for beneficiaries in areas where private plans are not available. The latter strategy provides less clarity about how drug benefits will be provided to beneficiaries living in areas where private plans are less likely to be present, or where plan turnover is a problem.

*Making coverage affordable.* A second key decision that will affect participation is the level of premium subsidies. Decisions about premium subsidy levels will have a direct impact on both the number of beneficiaries expected to gain drug coverage and program spending. The willingness of beneficiaries to pay a premium (and participate in the new drug program) will be directly related to their perception of the value of the benefit. Previous CBO estimates indicate that, all things being equal, higher subsidy levels are likely to result in more beneficiaries getting drug coverage. There appears to be agreement across proposals to provide general premium subsidies, although the level of the subsidy ranges from 25 to 55 percent of the drug costs covered under the plans.

Premium subsidies are also necessary in a voluntary program to avoid selection problems, given concerns that beneficiaries with low drug costs will not sign up if premiums are too high, while those with predictably high drug costs will be more likely to do so, ultimately resulting in higher costs for all. Subsidies are viewed as a means of encouraging those with relatively low drug costs to enroll, guarding against such problems.

*Making coverage user-friendly.* A third critical factor in helping the largest number of people is making the program “user-friendly” and easy to navigate to accommodate the growing share of beneficiaries who will be among the oldest-old, those with diseases such as Alzheimer’s, and others with frailties and disabilities. Medicare is popular among beneficiaries today, in part because obtaining coverage requires relatively few transactions. Seniors are automatically covered when they turn 65 if they are on Social Security. Payments are automatically deducted from Social Security checks, so seniors don’t have to remember to write a check each month. The easier it is for beneficiaries to sign up for prescription drug coverage, pay their monthly premiums, and stay covered, the more likely they are to do so.

How should benefits be structured? The design of the Medicare benefit will also influence the extent to which the plan shields beneficiaries from rising drug costs, the level of program spending that will be required, and the rate at which spending will grow over time.

One of the key decisions is whether prescription drugs should be offered as a defined, uniform benefit or as a benefit valued at a specific dollar amount. The rationale for using an actuarially defined value is that it gives plans maximum flexibility to adapt benefit packages to changing drug technologies and changes in health-care delivery more broadly. It can also be a strategy for explicitly limiting the government’s financial liability for drug expenses. The chief downside, however, is the potential for selection problems resulting from plans modifying benefit packages to attract healthier and lower-cost enrollees. There is also concern that a specified dollar approach, if not indexed to grow with the rise in drug spending, would diminish the value of the benefit and shift costs to beneficiaries over time. A further issue, and one that would make the new drug benefit different from all others that are covered by Medicare, is that drug benefits could vary across plans, and across markets, potentially creating fairness concerns and confusion for beneficiaries.

Among proposals that specify a uniform benefit, there are many important decisions regarding deductibles, cost-sharing and benefit levels, and catastrophic protections.

- Deductibles: Most would impose an annual deductible for drug benefits (@\$250).
- Benefit levels and cost-sharing: Many would impose 50% co-insurance on drug expenditures up to a specified amount (@\$2,100). A modification of this approach would reduce the level of co-insurance from 50% to 25% as the beneficiary's level of drug expenditures increases.
- The "Hole in the Donut": Many proposals would cover expenses up to a specified amount, but leave a gap in coverage between the benefit limit and the level of drug expenditures required to qualify for catastrophic protection.
- Catastrophic protection: Virtually all plans would assist beneficiaries with extraordinary drug costs, but they differ in both the level above which such coverage would begin (i.e., \$4,000 vs. \$6,000) and the means by which this amount would be indexed over time.

Each of these decisions could have significant implications for the number of people who are helped by the new program, the extent to which the new program shields beneficiaries from high out-of-pocket spending for prescription drugs, and for program spending.

What are the key strategies for controlling costs? Given the projected rise in drug expenditures, all of the major proposals face difficult decisions about how to control Medicare spending for this new coverage without compromising the capacity for research and development. In the past five years alone, average per capita prescription drug expenditures for Medicare beneficiaries have basically doubled. According to the latest CBO numbers, drug spending will rise at an even more rapid rate over the next decade, due to increases in drug prices, increases in utilization, and the introduction of new, higher priced drugs.

Most Medicare prescription drug proposals would rely on the private sector to help control spending. Some would give risk-bearing private plans (such as HMOs) responsibility for managing the new drug benefit. Others would have Medicare contract

with private entities, such as pharmacy benefit managers (PBMs), to manage the drug benefit, following the practice of employers and many health plans in the private sector today. PBMs use a variety of strategies to influence drug use and spending. Typically, they negotiate discounts with pharmaceutical manufacturers, pharmacies, and mail-order firms; establish formularies; develop utilization review procedures; and work with their clients to develop cost-sharing structures that encourage generic substitution and the use of lower-cost brand name drugs.

The capacity of PBMs and other private entities to influence Medicare drug spending, however, will be directly related to how much authority they are given to use the tools that appear to be working in the private sector. For example, some proposals would give beneficiaries access to non-formulary drugs, provided their physician certifies the drug is medically necessary. Others would make it more difficult for beneficiaries to access non-formulary drugs without going through an appeals process. The Medicare drug proposals now under consideration differ in the extent to which they would permit PBMs and other plans to use these types of tools, and these decisions could have a significant impact on access and savings.

Who should be at risk for the cost of a new drug benefit? Related to the issue of cost-containment is the extent to which proposals rely on risk-bearing plans, rather than non-risk bearing entities such as PBMs, to manage drug benefits and control costs. The strategy of having private plans assume full risk for a drug benefit would limit the federal government's liability for drug expenditures and distance the government from decisions involving price. However, as noted by the insurance industry in testimony last year, insurers may be reluctant to assume the full risk of a new drug benefit, posing uncertainties in terms of access for beneficiaries in the absence of a clearly defined fall-back plan. To address this concern, some would have the federal government assume partial risk, through reinsurance, in the form of subsidies to private plans with high cost enrollees.

An alternative approach would have the government assume full risk, paying private entities, such as PBMs, a fee for managing benefits and costs. This approach follows the lead of the private sector in controlling drug costs, by relying on entities that already have an infrastructure in place for managing a drug benefit. A modification of

this approach would have PBMs assume partial risk, providing a stronger incentive for such entities to achieve savings.

How should the new benefit be administered? As prescription drug benefits are often discussed within the context of broader Medicare reforms, proposals for improving coverage offer a range of strategies for administering this particular benefit. Some plans advocate preserving HCFA's existing administrative authority, while others propose the creation of an independent entity responsible for the administration and oversight of M+C plans and private plans offering the drug benefit or—more broadly—of all plans, including the traditional Medicare program. Under the latter approach, an independent agency could govern everything from competition among both traditional and private plans to beneficiary enrollment, education, and outreach.

There are a number of questions to consider regarding the administration of a new drug program, some of which depend on the extent of other reforms under consideration. For example, what operational changes are needed to make the program as user-friendly as possible for beneficiaries? Would a new agency eliminate concerns about HCFA's ability to be a fair and impartial manager of both fee-for-service and managed Medicare, or add inefficiency, bureaucracy, and confusion for beneficiaries? Are there functions that should be out-sourced or delegated? For example, would it make sense to have an independent outside entity advise the Secretary on the classes of drugs that should be covered by all plans, as is suggested under one of the leading proposals?

## **Conclusion**

Today's 40 million Medicare beneficiaries are disproportionately likely to suffer an array of chronic health conditions now treatable with prescription medications. The range of proposals currently under consideration for improving prescription drug coverage is a promising sign that the needs of this population could soon be addressed. While there are differences among these proposals, they also reflect a significant amount of common ground.

These policy issues are set within the broader context of the debate over whether a prescription drug benefit should be enacted before consensus is achieved on more comprehensive reforms, and the debate over how much money should be dedicated to a new drug benefit versus other national priorities. Decisions regarding spending for a new drug benefit will clearly impact both the number of people who receive help and the level of assistance they receive.

This appears to be an historic window of opportunity for addressing the prescription drug needs of people on Medicare. There is widespread agreement on this problem, apparent bipartisan interest in arriving at a solution, and strong public support for action. There is also a large federal budget surplus that would greatly facilitate the financing of what promises to be an expensive addition to the Medicare program. The decisions made by this Congress could significantly improve prescription drug coverage for Medicare beneficiaries.