
Weighing in on the Medicare Prescription Drug Benefit Plan

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Citation

K Keene, R Byington. *Weighing in on the Medicare Prescription Drug Benefit Plan*. The Internet Journal of Healthcare Administration. 2006 Volume 4 Number 2.

Abstract

The purpose of this analysis is to look at the Medicare Prescription Plan and determine how well it is performing, obstacles that it will face, and the potential longevity of the plan. The Medicare prescription plan will not be an easy fix as there are complex problems with few easy answers. The plan provides much needed drug coverage for millions of Americans and most agree it is the socially responsible thing for the government to do; however, the plan will face sustainability challenges in the future from controlling costs, an aging population, and technological advances in medicine. Medicare was in deep financial trouble before the addition of the new prescription plan. The addition has put a further cost burden on an already weakened system. The plan was not well thought out from a financial stand point and will not be able to endure into the future in its current state.

INTRODUCTION

Medicare helps to assure the elderly and people with disabilities that neither they nor their families will have to bear the full burden of their health costs. Medicare was necessary because health insurance companies were not meeting the needs of the elderly. Most seniors simply could not afford health insurance once they retired and were no longer covered by their employer provided policies. Today, on the brink of Medicare prescription drug coverage insurance companies still aren't interested in covering seniors. Health Maintenance Organizations (HMOs) have exited some markets, cut benefits in others, and increased insurance premiums in all markets when research shows they are being paid adequately in most markets.

The elderly finally have access to prescription drug coverage if they are Medicare recipients. Congress tried unsuccessfully for years to overcome partisanship and pass prescription drug coverage for seniors covered under Medicare; however, in 2003 the new legislation entitled the Medicare Modernization Act (MMA) was signed into law by President George Bush. This was the most sweeping health reform legislation to pass since the introduction of Medicare and Medicaid in 1965. Since its inception there has been a burning question on the minds of most Americans, how well is the Medicare prescription drug benefit working and at what cost?

REVIEW OF LITERATURE

After a long running debate spanning decades President

Bush finally signed the MMA into law in 2003 although the policy did not take affect until 2006. The MMA provides a comprehensive prescription drug plan to Medicare recipients and is labeled Medicare Part D. This was the most notably missing component separating Medicare from other private insurances. There have been numerous unsuccessful attempts by congress and several presidents to pass the prescription drug plan prior to the legislation passing under President Bush in 2003. The Medicare Catastrophic Coverage Act (MCCA) had a prescription drug plan packaged with it and successfully passed, but was then later repealed in 1989. President Clinton tried to add a drug benefit in 1993 under the Health Security Act and followed up with the proposal of Medicare Part D both of which were struck down decisively. The House of Representatives passed a prescription drug plan in both 2001 and 2002; however the house failed to get approval through the senate in either year. The biggest reason (according to political scientists and economists) for such turmoil in passing a prescription drug benefit was disagreement on the fiscal cost of the plan between Democrats and Republicans and who would bear that cost. The deciding factors that helped finally push the legislation through congress were the sky rocketing costs of health care, a sharp increase in drug expenditures, a lack of affordable access for supplemental drug coverage, and increased lobbying efforts from senior organizations such as the American Association for Retired Persons (AARP). All of these factors were not going away and were only going to get worse, forcing the political machine on Capitol Hill to take some form of action to appease the

masses if nothing else (Kaiser, 2004).

COST OF THE PRESCRIPTION DRUG PLAN

The new legislation created a federally subsidized benefit that varies from state to state. Medicare recipients must voluntarily sign up for the Part D coverage, it is not required. In other words Medicare recipients can elect not to receive Part D coverage and it will not interfere with their Part A (inpatient) or Part B (outpatient) coverage. However, if recipients do elect to participate in Part D they will pay an estimated 35 dollar monthly premium and they will have a 250 dollar out of pocket deductible as well. Patients can then expect to receive 75 percent coverage resulting in a 25 percent coinsurance for most prescription drugs that they require. The benefit limit for year 2006 will be 2,250 dollars. "Once they reach the benefit limit, they will face a gap in coverage in which they will pay 100 percent of their drug costs up to 5,100 dollars in total drug spending (equal to 3,600 in out-of-pocket spending). Medicare will then pay 95 percent of drug costs above that amount. These benefit levels are indexed to? rise annually with the growth in per capita drug expenditures for the Medicare population" (Kaiser, 2004).

Health care providers continuing development of better diagnostic tests and expansive use of technology have in part forced the per patient cost of Medicare to increase. This cost is added to the high priced growing cost of marginally funded Medicare program. An example of this phenomenal growth in expense follows: "Medicare expenditures were 0.7 percent of Gross Domestic Product (GDP) in 1970 and grew to 2.6 percent of GDP in 2003. This reflects the rapid increases in the factors that affect health care costs" (CATO Institute, 2005).

The new drug coverage plan was enacted due to pressures resulting from the high medical costs for seniors. However, the Part D program adds to the already financially burdened Medicare program. "By enacting the drug benefit, congress has increased the financial burden of Medicare by more than a third. In 2006, when the full phase-in of prescription drug coverage is completed Medicare's projected expenditures will immediately jump to 3.4 percent of GDP" (CATO Institute, 2005).

Although the cost of the new program is uncertain, estimates predict that the cost of Medicare could reach 720 billion in 2015. This does not include of course the cost of any future legislation that may expand coverage or reduce out of pocket expenses for participants. The cost of the program to the

consumer will inevitably be higher since some of the costs will have to be passed on to the consumer. House Republicans have already proposed to cut spending by placing a cap on prescription drugs each year. This would mean that if there is an excess in spending one year then the expenditures could be recouped the next year. This would result in higher premiums for the consumer or a reduction in benefits or both (CATO Institute, 2005).

In the end patients will suffer. As scarce resources are allocated during the budgeting process, the high cost of the new program could potentially result in funding for other public programs being cut or done away with altogether. Future generations will also suffer due to the higher tax burdens that will be passed on down the line. The end result will be a spending crisis that will spiral out of control (CATO Institute, 2005).

The burden of paying for the 400 billion dollar plan will fall on those 30 years of age and under. In addition to the huge costs of the plan without new sources of revenue Part D will also lead to increased drug costs and further add to the insurmountable 7 trillion dollar debt. If one-half of the 41 million seniors enrolled in Medicare participate in the new program they would pay an average of 14.4 billion a year premiums and associated costs to receive only 14.3 billion in health care benefits. This shows that the numbers do not add up the program is paying out more than it is taking in from the get go (Code Blue Now, 2004).

As a result the program has no financial longevity, which is very discouraging news for the future of the plan. Recent studies by the National Center for Policy Analysis show that out of 400 billion of the cost needed to fund the new drug program only 25 billion will actually be allocated to cover the cost of new drug benefits. Private employers, pharmacy subsidizes, and insurance companies will use the remaining 35 billion. In essence only \$1.00 per taxpayer out of \$16.00 will go toward new drug benefits. "The bill also prohibits Medicare from negotiating discounts on drug prices. If Medicare negotiated an average discount of just 20% it would save seniors an estimated \$20 billion in 2004 and \$250 billion over the ten year period covered by the bill" (Code Blue Now, 2004).

ARGUMENT FOR GOVERNMENT DRUG NEGOTIATION

Drug companies in many situations have monopoly power; because they possess patents on certain drugs they can essentially charge whatever price they chose and the market

will either pay it or do without. Drug companies often give volume discounts for providers with large memberships, health maintenance organizations, mail order recipients, or point of sale cash customers, rather than run the risk of losing their business. The distributions of drugs from manufacturers to retail pharmacies (depending on the distribution channel) quite often lead to a large amount of administrative costs. This is why there are often differences in the prices of the medications on the same day but at different retailers. Each retailer must pass the administrative cost of the drug on to the customer. Medicare may help make this process more efficient for its beneficiaries, thus eliminating some of the administrative costs involved (Congressional Research Service, 2005).

ARGUMENT AGAINST GOVERNMENT DRUG NEGOTIATION

Some critics feel that government involvement may result in limited availability of drugs at a discount. The non-Medicare populations along with pharmaceutical manufacturer's research and development will suffer long-term effects due to the government power to drive the prices down. In order to offer drugs at a discount the government must be able to negotiate prices. Currently the government does not have the market power or the track record that the private sector has. Because the government lacks market power it may be beneficial to have a variety of organizations negotiating different prices. This scenario could possibly offer more choices than the government could provide to the consumer. Among some there is also a fear that with government involvement the result will be price setting instead of price negotiations (Congressional Research Service, 2005)

MEANS TESTING

Means testing is a possible alternative to helping pay for the sky rocketing costs of Medicare and is being considered a viable solution given the strain that the prescription drug plan has put on the already over burdened Medicare system. Medicare is under significant financial strain and is paying out more in benefits than it is taking in from budget allocations from the tax base. Under the current system Medicare will most assuredly go broke within a 50 year time span. It is feasible to ascertain that if Medicare is to survive it will require multiple elements working in unison to make that goal of survivability to come to fruition.

MMA will for the first time allow both Medicare premiums and insurance benefits to vary by beneficiaries' income. This would essentially mean that premiums are based upon a

patient's ability to pay and benefits would be based on each patient's individual needs. The short run cost savings is estimated to only be around \$2 billion per year. The plan essentially works by having the wealthiest recipients pay more and get fewer services. Although means testing would seem to have a great deal of appeal, it still falls short as a cure all for what ails Medicare.

The financial challenge for Medicare would actually require more than \$60 trillion in present value money to sustain the plan into the future for the next generation. The \$2 billion dollar savings that means testing would create will not even scratch the service of what is required to solidify the plan. Some critics argue that this plan is not a fair allocation of public insurance and does not promote equal and fair access. "For example, some people may save less in order to have lower incomes and qualify for better benefits, but those with higher incomes who do not expect to be subsidized will need to work harder and save more to replace lost Medicare benefits" (Pauly, 2004). Another criticism of means testing is that it is not politically correct, the wealthiest individuals are paying for the biggest part of the benefits and are receiving the least amount of service in return. This means that the wealthy are most likely never to receive a fair return on their investment (Pauly, 2004).

DISCUSSION

The AARP is the largest and most powerful lobbying organization for seniors in the United States. AARP began about 40 years ago as an insurance company that provided coverage to the elderly. Although the company lost over 45,000 members in its health insurance plan within 2 months of the start of the Medicare prescription plan, the company remains one of the drug plans biggest advocates. The company has spent over \$7 million to educate seniors about the new prescription drug benefit and how it can save seniors money. "The AARP claims that the 400 billion Medicare bill will help millions of seniors and their families to have better lives. The company publicly assures seniors that it would never support legislation that would threaten the well being or longevity of Medicare" (Code Blue Now, 2004).

There is however one thing that the AARP is not publicly announcing to seniors. Despite the fact that the company lost 45,000 health care policies it stands to gain millions of secondary insurance policies with the implementation of the Medicare drug benefit. Many Americans will now be able to afford a coinsurance policy since they will have more available funds to invest in their health care. AARP is the

largest supplier of Medicare coinsurance and as a result has a vested interest in having seniors participate in Medicare including the prescription coverage portion.

The government should not try to negotiate pharmaceutical prices for the Part D plan. Government interference most likely will lead to the exclusion of certain drugs and inevitably increase costs in the long run. Anytime that governments control industries and they become regulated, it leads to inefficiency and a decrease in innovation. When the private sector suppliers are not in direct competition with each other costs tend to rise. This has been proven in other industries and there is no reason to believe the pharmaceutical insurance industry would be the exception to the rule. Currently the Medicare prescription plan has fostered a competitive spirit within the program as competing private sector insurance plans are bidding on Medicare contracts. "Competitive elements have been introduced into Medicare in the hope of lowering cost, raising efficiency, and maintaining or improving quality and consumer satisfaction" (American Enterprise Institute, 2006).

The plan to finance Medicare is short-term in nature with no long-term plan to assure the longevity of the program. The increased costs resulting from the prescription drug coverage addition to Medicare will only drain the program that much quicker. The current program takes in less funding in the form of taxes and premiums than it pays out in benefits. This type of financing is fiscally irresponsible and was most likely a quick fix to implement drug coverage for Medicare in the face of intense political pressure. The plan would require around 60 trillion dollars to insure it remains solvent for generations to come. The funding of course is nowhere near that amount (roughly only 400 billion allocated currently). The plan will soon become even more burdened as the number of workers reaching benefit eligibility will continue to rise because of America's aging population.

Although, means testing does show promise as a cost saving measure, it will not lead to any real significant cost containment on its own. The ideal of letting individuals who are more financially sound pay for a greater portion of their health care while simultaneously receiving less benefits sounds like a good ideal unless you are financially secure. One of the ideals behind public health care is that it should be fair and just. This is really no different than if you just raised taxes proportionately according to income to fund Medicare. The bigger issue is of course is the fact that means testing will only create a small ripple in a very large pond

that is Medicare spending. It would only save an estimated 2 billion dollars if implemented. This is an insignificant amount when compared with how much the plan costs currently and the plan's future projected costs.

CONCLUSION

The Medicare prescription plan is a wonderful concept in theory. Seniors do deserve prescription drug coverage and it is an invaluable addition to the existing Medicare coverage available. However, the fiscal spending that is required to solidly the program well into the future was severely underestimated and financing the program was only looked at for the short-term. The program with its current enrollment is already operating under a deficit spending arrangement and all of the Part D eligible participants have not signed up yet. Furthermore, the plan is expected to be hit with an influx of new participants in the near future as the number of new participants in the program will rise as the population ages. The financing of the whole Medicare plan (especially with the addition of the Part D coverage) must be revamped if it has any chance of affording coverage to senior citizens in generations to come.

RECOMMENDATIONS

The Medicare system obviously is not perfect and there is not a magic cure for all that ails it. It will take a multitude of changes to have any real impact on the cost of Medicare. One of the best ways to reduce cost is to promote competition within the Medicare system. The prescription drug benefit has already shown that competition is healthy and leads to efficiency and cost savings. If Medicare policymakers would increase the level of reimbursement under Part B coverage it could promote the same competition that exists under the Part D plan. HMOs would bid for and aggressively court Medicare contracts, which would lead to considerable savings. Congress should fund Medicare fully, allotting more budget dollars to the program to bring it up into equal standing with other private health care insurers. It should be a program that is accepted nationwide without stipulations. Any future budget surpluses like those seen under the second Clinton administration should be dedicated to the Medicare fund. There should be a spending cap on prescription drugs.

The whole Medicare plan should be phased into national health coverage and turned over to the private sector. The public health insurance system is already primarily funded by the tax base from employment payrolls. The government should issue a federal mandate that all employers must

provide health insurance to their employees. The job of maintaining public insurance is too cumbersome for the government and tax payers to carry alone. The private sector could ease the financial strain and insure the continuity of health insurance for all individuals.

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