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The Medicare Gold Rush

by Dee Mahan

Come mid-November, along with the familiar autumn sounds of crackling fires and crunching leaves, there will be confusion in the air, too. That's because open enrollment for Medicare Part D, Medicare's drug benefit, will be starting. More than 40 million seniors and people with disabilities who rely on Medicare will have the difficult job of sorting through what promises to be an abundance of choices for drug coverage. For some—those who have no drug coverage now and who qualify for low-income subsidies—Medicare Part D may be a real improvement. But many, if not most, of those enrolled in Medicare are likely to find the coverage disappointing, the process of picking a plan unduly daunting, and their remaining drug costs surprisingly high.

And it's not just seniors who may be facing sticker shock. Controversy around the program's budget assumptions continues in Washington as the projected pricetag for the benefit rises. Recalling the refrain of Harry and Louise, the seniors who were insurance company props lamenting Clinton's health plan in 1990s television commercials, "There's got to be a better way." There was. It just didn't happen.

There's no doubt that it is well past time for Medicare to add an outpatient prescription drug benefit. But the Byzantine structure of the program known as Medicare Part D is a gift to insurance companies and the drug industry, less so for patients.

The new drug benefit will only be available through private companies that contract with Medicare. These will include HMOs that cover prescription drugs; other medical services and plans that only offer drug coverage; and the so-called Medicare Prescription Drug Plans (PDPs) that only offer drug coverage. While the law has some requirements for what these plans have to cover and how, these companies will all have a great deal of latitude in deciding which drugs to cover, how to structure their benefit and how to market their services. Plans submit bids to Medicare with a monthly cost estimate. For accepted bids, Medicare pays the bulk of the monthly costs, and Medicare beneficiaries pay a share through monthly premiums. To make the proposition less risky for insurers, the law provides for reinsurance for high-cost cases and payment adjustments if a plan's costs are higher than expected.

The Bush administration pushed this program structure, arguing that such privatization would give beneficiaries more choices and that competition among private plans would keep program costs down. Well, beneficiaries certainly will have choices—probably too many. Massive confusion among beneficiaries trying to make plan selections is nearly guaranteed. As for competing private plans keeping costs low, that premise has been tested and failed before. HMOs were touted as a private sector approach to lower Medicare costs, but the per capita costs of care in Medicare HMOs exceeds costs in traditional Medicare.

What does seem clear is that insurers that will be offering the drug benefit anticipate big profits. The title of a June 2005 forum sponsored by health insurance trade publications and featuring insurance company executives captures the industry spirit: "The Medicare Drug Gold Rush." As the seminar promotional material states,

“One after another, health care companies are lining up to win big.” And lining up they are. Although the number of plans has not been made public yet, the number will undoubtedly be considerable, with most major insurers and pharmacy benefit managers already having announced their plans to participate. And industry analysts predict most will come out handsomely ahead financially. In fact, one industry expert commented that in the first two years of the program, 2006 and 2007, “It’s almost impossible for a [Prescription Drug Plan] to lose money.”

But it isn’t just the insurance industry that comes out a winner with Medicare’s drug benefit. The drug industry also stands to do well. Many provisions in the law protect the high drug prices in the United States. The law made legalization of importation of less expensive drugs from Canada and other countries dependent on the findings of a study on importation safety by the Department of Health and Human Services. It was no surprise when that study—which focused on individual rather than regulated, controlled importation—found that importation was unsafe.

But the biggest victory for the industry is that the law bars the government from negotiating with manufacturers for lower drug prices. The rationale for this prohibition is that multiple private insurance companies in competition for enrollees will be able to negotiate lower prices than Medicare. Hmm. Does it seem likely that any of the multitudes of private Medicare drug plans will be able to exert as much bargaining clout with drug companies as could Medicare, representing over 40 million covered lives? It seems more likely that the more than \$116 million that the industry spent lobbying the government in 2003 paid off—that was the year the drug benefit passed and was signed into law.

So here's what's coming this fall: a complicated benefit that gives people in Medicare too little and costs taxpayers more than it should. The alternative? A benefit run through Medicare, rather than private plans, that lets the government negotiate for lower drug prices. That kind of benefit would have been better for people, not companies. With any luck, maybe we can have something like that, someday.