Medicare Part D Gets an "F"

BY JAMES WOOLMAN AND JAMES MCBRIDE

Medicare Part D, the new drug benefit package that went into effect on January 1, is projected to cost $724 billion over 10 years. Not only is it expensive, it's confusing, and it provides more benefits to insurance companies than to enrollees. Here are five key reasons Medicare Part D deserves an "F":

1. Meager Benefits

Despite the program's huge cost, the actual benefits are minimal. A standard plan requires members to pay a $32 monthly premium, a $250 deductible, and 25% of drug costs up to $2,250. After that, they must pay 100% of the costs until their total drug spending reaches $5,100, then 5% of costs exceeding $5,100. Subsidies are available for low-income enrollees (those whose incomes are under 150% of the federal poverty line), but most participants will still have to pay the majority of their drug costs out of pocket (see Figure 1).

In addition, analysts predict one in four enrollees will actually end up spending *more* under the new plan than they would have without it. This is because many seniors who already have prescription drug coverage—through an employer, a supplemental Medicare policy, or Medicaid —will lose this coverage and be forced to accept the less generous benefits provided by Part D.

To make matters worse, the new drug plan may undermine one important source of prescription drugs for hundreds of thousands of people without health insurance: the pharmaceutical companies' patient assistance programs for the indigent. Some companies have said that anyone who signs up for Medicare D will become ineligible for such programs; others have indicated they will drop anyone who is even eligible for the new benefit.

2. Less Negotiating Power

Because conservatives have decreed that markets will always provide the lowest prices and the greatest efficiency, the new Medicare drug law explicitly bans the government from negotiating with drug companies. Of course, the federal government already negotiates directly with drug makers and receives deep discounts for drugs purchased by the Department of Defense and the Veterans Administration.

FIGURE 1

2006 OUT-OF-POCKET SPENDING WITH STANDARD PART D BENEFIT PACKAGE

Annual Drug Costs	*Out of Pocket Spending (Including Premiums)*	*Percent of Drug Costs Paid By Enrollee*
$500	$699	140%
$1,000	$824	82%
$2,250	$1,136	51%
$3,000	$1,886	63%
$4,000	$2,886	72%
$5,100	$3,986	78%
$6,000	$4,031	67%
$8,000	$4,131	52%
$10,000	$4,231	42%

Spending calculations were based on the standard Part D benefit package.

Source for percent of enrollees: Actuarial Research Corp. and the Kaiser Family Foundation, Estimates of Medicare Beneficiaries Out-of-Pocket Drug Spending in 2006, November 2004.

According to a study done by the staff of Rep. Henry Waxman (D-Calif.), the price of a month's supply of the top ten drugs under Medicare D is 80% higher than the negotiated price the VA pays for those same drugs (see Figure 2). Rather than using the government's purchasing power to provide seniors with a better benefit, Congress, citing fears of "price controls," has essentially cut a blank check to the drug industry.

3. Less Consumer Protection

Enrollees who sign up after the May 15, 2006, deadline will incur a 1% per month penalty for every month they delay enrollment, with no limitation. For example, someone who signs up three years after the deadline will be charged an additional 36% on their premium, *forever*. This is designed to prevent people from signing up only when they know they will need expensive medications.

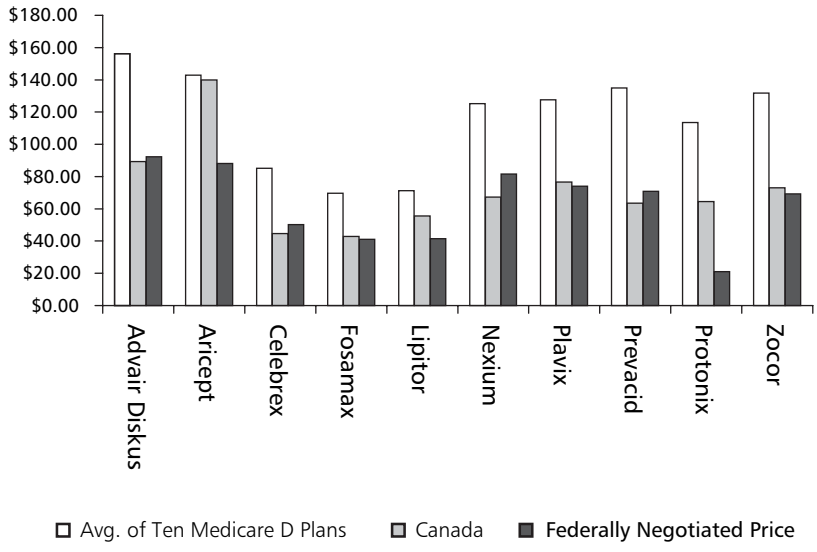
Once enrolled, consumers cannot change plans for a year. Insurance companies, however, are free to drop drugs from their coverage lists at any time, as long as they cover two drugs within each class of drugs used to treat similar conditions—for example, two statin drugs for high cholesterol. Consumers are stuck, even if their medical needs or the drugs offered by their plan change. There is an appeal process, but the law gives plans the power to decide whether or not to grant exceptions—and even allows them to overrule a patient's doctor.

4. Intoxication with Markets

Conservatives have been dying to privatize Medicare for years, and they got their way with Part D. Instead of being handled directly through Medicare, the prescription drug benefit will be delivered by private insurance companies through competing Prescription Drug Plans. The justification is that competitive markets will cut out government inefficiency and lower prices for consumers. (This justification is questionable from the start, of course, given that traditional Medicare, a government-run, single-payer system, has a super-low overhead of less than 4% *and*

FIGURE 2

COST OF MONTHLY SUPPLIES



Source: http://www.pharmawebcanada.com/web/new_medicare_drug_plans.htm

a high level of beneficiary satisfaction.)

However, unless insurance companies can screen patients or set higher prices for sicker people, they are reluctant to enter the market for providing drug insurance. So Congress packed the law with sweeteners to reduce the risk borne by companies. During the first two years, the government will pay 50% of the losses for plans whose costs are more than 2.5% higher than expected, and will also pay 80% of the costs of very expensive patients through a "reinsurance" provision. Insurers quickly realized that these terms make it nearly impossible to lose money, so many more than expected have chosen to participate.

The huge number of plans worsens another problem with the insurance market: consumer confusion. With so many competing offers, it's hard for seniors to tell which plan is right for them. In many regions more than 40 plans are available, each with its own benefit and pricing structure. With limited time to choose, and with the financial and medical stakes high, seniors understandably feel overwhelmed. Republicans refer to this as "empowering the consumer." The rest of us call it stress.

5. Undermining Social Insurance

Part D is part of a larger effort to transform the health care system through market-based "reforms." These strategies, which include health savings accounts, high-deductible health plans, and tax credits for the purchase of individual insurance, are designed to reduce health spending by placing more financial burden on patients.

A public plan, like the enormously popular traditional Medicare program, would have provided more benefit to more people at lower cost, and would not have required any of the backwards market fixes that make the Part D program so complex. In reality, private markets for individual health insurance do not work well—except for enriching corporations—and relying more heavily upon them will only further impoverish and destabilize our health care system. ■

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SOURCES Geraldine Dalleck, "Consumer Protection Issues Raised by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," July 2004; Kaiser Family Foundation, "The Medicare Prescription Drug Benefit," September 2005; Actuarial Research Corp. and Kaiser Family Foundation, "Estimates of Medicare Beneficiaries Out-of-Pocket Drug Spending in 2006, Modeling the Impact of the MMA," November 2004, all available at www.kff.org/medicare/upload/; "Falling Short: Medicare Prescription Drug Plans Offer Meager Savings," Families USA Special Report, December 2005; "Health Plans Undaunted By Medicare Part D," *Managed Care,* May 2005; "New Medicare Plan to Cut Off Free Drugs," *Philadelphia Inquirer*, 11/17/05.