AN ABSTRACT OF THE NEW MEDICARE ACT-- "THE MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003"

By Ronald J. Iverson, December, 2003

Medicare is a huge issue in America—not just for those who currently utilize Medicare, or intend to in the near or distant future, but for every worker and taxpayer. The program, developed as an entitlement program nearly four decades ago, has worked—for both the recipient and the taxpayer. In a phrase, Medicare insures our older citizens that they can receive necessary health care at a time in their lives when medical costs are increasing at unprecedented rates, and when most elderly people do not have the resources to cope with those costs.

However, over the years, Medicare has become the second largest social insurance contract between the federal government and the American people—the first being Social Security. As a result of "turn of the century" runaway medical costs, which are becoming increasingly significant, both taxpayers and recipients are in a precarious position. Higher Part B premiums are eating away at any "COLA" increases Social Security recipients receive. In addition, the general rise in the cost of hospital care, and the increasing number of recipients receiving Medicare has also strained the Part A (hospital benefits) portion of the program.

The Part A trust fund, established at the outset of Medicare—a "pay ahead" proposition—has been under continuous assault for the last ten years, and is in peril of running out of money. This will result in a "pay as you go" circumstance, which then falls entirely on the backs of the American taxpayer—since the Part A benefit of the entitlement program of Medicare is ***totally*** supported by payroll taxes. Hopefully, these and other similar fiscal issues would have been addressed in the Act, but I see no evidence that they were. Unfortunately, we shall have to wait and see. But, for the moment, let's take a brief look at the "accomplishments" of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

What started out as a "Medicare Prescription Drug" bill became everything but that, as the bill passed by the Senate in July of 2003, grew to an eleven-hundred-page document by the time it was passed in the House of Representatives in November, approved with much rancor by the Senate in November, and signed by the President in December. There is a great deal of reservation by many in the American public about the legislation, and the law will likely see some modification during the ensuing decade. The problem, as many see it, is that the law had

little to do with the basic problems of Medicare, and a lot to do with outside influences, to the extent that Medicare reform was not really achieved.

We were told at the outset, that the original version of the prescription drug legislation would cost somewhere around $400 billion over the next ten years. Forget that. With the final version, It will be more. Much more. There are so many additional financial "incentives," and an embarrassing absence of any cost containment efforts, that a $400 billion cost will not even be close to reality. In short, the gigantic piece of legislation led proponents and opponents to view the legislation as being divided into two camps—winners and losers. However, there is another camp—those who gained very little. Let's identify some of each.

The apparent current "winners" of the law would include:

Medicare HMO's (now referred to as Medicare Advantage)—As the Medicare prescription bill proceeded from July to November, it became a full blown Medicare ***revision*** bill, with HMO's, (the "private sector") gaining in several ways, including $12 billion in subsidies to compete with traditional Medicare, as well as incentives to develop "regional" operations.

Drug Companies and the drug lobby achieved nearly everything they requested in the bill. The new law prohibits the government (Medicare and Medicaid) from forcing price controls or price reductions in prescription drug prices. In other words, Medicare, Medicaid, etc, cannot collectively approach drug companies for price reductions in their products, no matter what inflationary factors are involved. This would be acceptable if recent drug costs were not increasing at a 13% inflationary rate, or half a dozen times more than Social Security COLA increases. In addition, the bill continues the prohibition of "importation," or "reimportation" of drugs from other countries, such as Canada and Mexico—a practice which has enabled millions of Americans to save as much as 50% on prescription drug items. Some in the Administration immediately began to reassess that stance, and future revision in prescription drug availability and pricing, as envisioned in the new law, will be challenged.

Rural hospitals and doctors gained equitable Medicare payments after being underpaid by Medicare forever. The point is that a piece of medical equipment or the services of physicians are no cheaper in rural areas than they are in urban areas. The new law will allow for an increase in Medicare payments to health care providers in rural areas.

Medicare beneficiaries whose prescription drug costs are over $5,000 per year. The mathematics for the drug benefits, which will be made available in 2006, are definitely in the favor of those who have large prescription needs. This is a positive factor, given the fact that many elderly currently spend more than $400 per month on prescription drugs. According to

the current formula, Medicare beneficiaries will be paid 95% of drug costs after reaching a plateau of $5,100 in a year.

The apparent current "losers" of the law would include:

Medicaid recipients and state governments, for a variety of reasons. First the states cannot collectively bargain (through Medicaid or themselves) for lower prescription drug prices. That, then, filters down to Medicaid recipients, since they are subject to the limitations of what states can afford when it comes to Medicaid. Recent state budgets in nearly every state in America have had to wrestle with demand and inflation problems in the Medicaid area. "Bare bones" Medicaid support has become the norm, since states are strapped for tax money needed to provide all the services, which the public has come to expect. In addition, more than six million elderly persons on Medicaid will lose that drug coverage because they will now be shifted to the new program. Low income seniors will, however, get some help with premiums, deductibles and coinsurance portions of the program, and in 2004 and 2005, they are able to purchase a drug discount card with a built-in $600 free drug provision.

Millions of retirees who currently have stayed on their previous employer's group health insurance program, are now vulnerable to the employer eliminating them from the plan due to the heavy "adverse selection" components of elderly health care costs. The law provided, however, a $28 billion incentive for employers to keep their elderly retirees on their plans. This factor will have to wait and play itself out, because some companies may not see the value of using this incentive in light of the fact that about 33% of them had said that they would begin to drop retirees if the Medicare Prescription bill became law.

Older, Poorer and More frail beneficiaries of Medicare will see their traditional Part B costs rise, as the new Medicare Advantage plans try to attract the newer, younger Medicare enrollees into their plans. That leaves traditional Medicare with a more expensive demographic group. An example of this has already occurred in 2004, when the COLA adjustments of 2.1% balanced against the 13.5% raise in Medicare Part B premiums, caused the increase in a $745 Social Security check to net out only $11.00 more than in 2003. This situation will worsen, even without the new law, but the "private sector" Medicare Advantage of 2006 will create even further imbalances.

Those who gained very little in the new law:

The bill does not provide a great deal of relief for most Medicare beneficiaries. The real prescription drug portion of the bill (as currently written) does not take effect until 2006. In the meantime, Medicare recipients are able to purchase a Medicare drug discount card with a

built in 15-25% discount. Many Medicare Supplement purchasers already have such cards through their Med Supp companies, with discounts often times larger than the Medicare card allows. The biggest problem for most Medicare recipients occurs when the actual plan activates in 2006, and that's where they gained very little***. Most Medicare recipients do not have an annual drug bill of more than $5,100.*** (At least they won't until an uncontrolled inflationary trend aided by the "protectionism" measures of this law, causes costs to reach that point.) Let's discuss how the plan works.

The reason that the act does little to help ***most*** people, is found in the ***expense*** of the "benefit." First of all, there will be an "approximate" $35 per month charge for the feature. That adds up to ***$420 annually***. Then there is a ***$250 deductible***. That adds up to ***$670***. Then, the benefit will pay 75% of the next (after the deductible) $2,000 of allowable covered prescription drugs, In other words, $1,500. So now the drug benefit purchaser has added another ***$500*** which, when added to the premium and deductible adds up to ***$1,170.*** At this point, the benefit has paid ***$1,500 and the expense has been $1,170***. Not too bad. About a ***55-45 ratio—benefit over expense.*** But—and this is the big lament—next, there is a ***$2,850 vacuum, or "black hole," or coverage gap***, where ***nothing*** is paid under the plan. So at this point, the enrollee has now used ***$4,020*** of his, or her, own money for the "features" of the new Medicare Drug bill. Into this "less than $5,100 per year" category, is where most recipients fall—discounting the fact that any amount of inflation has been protected. ***$4,020 in expense against a $5,100 "benefit,"*** —now the ratio becomes a ***20-80 proposition—with the enrollee paying the 80%.*** Double this experience for married couples, and it is clear, that many people look with disfavor on this portion of a bill, which should have been designed to help ***most*** Medicare beneficiaries. In addition, it would appear that the recipient who has over $400 in monthly drug charges would be satisfied with this formula, but in reality, they must remind themselves that they paid nearly $350 per month of the drug bill themselves. After the $5,100 plateau, purchasers gain a 95% benefit to a 5% expense ratio, this is good and thankful news for people with needs at this level—but as stated before—that is not an accurate scenario for ***most*** Medicare recipients.

Time will tell, and so, undoubtedly, will Congress. A bill that contains 1,100 pages obviously deals with much more than we have discussed, and alterations to some of the law will come about. Which ones are addressed first, and which ones are modified the most, will definitely play out over the next decade. In the meantime, the Medicare prescription drug bill had become a political football, and a "catch all" for American politics, by the time of its enactment in December of 2003. The problem is that a program, which is so valuable to so many in the American public, and to those which it serves, has seen little in this legislation, to correct and overcome the real needs, or genuine reform, of the existing Medicare program.