Grandma and Grandpa, Watch Out! The Medicare Drug-Coverage Fight

by Linda Everett

Congress may be on August recess, but there is, nonetheless, a major national battle on, over whether and how Congress will provide Medicare prescription drug benefits, which would be the most critical improvement in the Medicare program since its inception 38 years ago.

Medicare is the Federal insurance plan for 41 million older and disabled Americans. It covers hospital care, and with monthly premiums, Part B Medicare covers physician care; but, it does not cover prescription drugs utilized out-of-hospital. As former Medicare Administrator Nancy-Ann DeParle wrote, "Medicare beneficiaries face a double whammy. They have greater need for prescription drugs than their younger counterparts, and they disproportionately lack coverage." While some Medicare beneficiaries have limited benefits from former employers or other plans, at least 25%—about 10 million people—have no prescription coverage at all.

It is this population who pay the full price of critically needed prescription drugs, the prices of which have skyrocketted year after year. Prices for the 50 drugs most prescribed for the elderly rose last year at more than three times the rate of inflation (Families USA 2003 study). Stories of the elderly choosing between eating or taking medication abound, and are accurate.

The issue of the Federal government creating Medicare prescription drug coverage is set against a backdrop of free-market fanatics' privatization "solutions" versus the nation's needs to address the general welfare. During the House debate, quotes from Ways and Means Chairman Bill Thomas (R-Calif.) were repeated often by the opposition: "To those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.' " Rick Santorum (R-Pa.), the third-ranking Republican in the Senate, said, "I believe the standard benefit, the traditional Medicare program has to be phased out." Sen. Robert Bennett (R-Utah) claimed, "Medicare is a disaster. Medicare will have to be overhauled. Let's create a whole new system." Thomas A. Scully, the Bush Administration's head of the Center for Medicare and Medicaid Services, which oversees administration of the programs, says there can't be a free market without more privatization of Medicare. Scully, 45, who formerly led the for-profit hospital lobby, calls Medicare "an unbelievable disaster" and a "dumb system." He likens overseeing Federal health insurance for the elderly and disabled to the carnival game of whack-a-mole. "When spending shoots up," he says, "you whack it down."

Those, such as Sen. Don Nickles (R-Okla.), who called the Senate bill the "biggest, most expensive expansion" of a government entitlement program in U.S. history," claim they are focusing on "saving" Medicare for baby-boomers. The free-market small government people in Congress call for cutting Medicare costs by setting for-profit insurance privateers and managed care companies loose on the elderly. This allegedly will ensure more "choices" because of competition between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)—whose history demonstrates do *not* work for Medicare. The bills hope to bribe insurers with enough that they will participate in plans that will be overwhelmingly confusing to Medicare beneficiaries. Both chambers' bills push beneficiaries out of traditional Medicare into private plans offering drug coverage. The House version features what conservative Republicans call "reforms," that aim to abolish traditional Medicare altogether.

Traditional Medicare Lengthens Life

The only real way to save Medicare, and any other tax-funded Federal program, is to save the nation's economy—launch "Super-TVA" infrastructure projects funded by low-interest-rate loans as developed by FDR-Democratic Presidential candidate Lyndon LaRouche.

More than 88% of Medicare beneficiaries want traditional Medicare—fewer than 11% now participate in for-profit Medicare HMOs, which have dumped hundreds of millions of Medicare patients, hiked premiums by up to 100%, cut promised services, and ended some benefits altogether. Traditional Medicare is proven to save lives. Take one study: Americans under 65, because of poverty or lack of affordable health insurance, have a higher mortality rate than the citizens of many European countries or Japan (*New England Journal of Medicine*, Nov. 2, 1995). But, after these folks reach 65 and are eligible for Medicare, their mortality rate *drops*, because Medicare assures them medical help when they need it. Life expectancy for Americans 80 years old or older is *greater* than it is in Sweden, France, England, or Japan. Traditional Medicare forestalls costly medical calamities and disabilities later in life. But instead of expanding that life-saving capability, parts of either the House or Senate "reform" bills would limit or explicitly destroy it.

The Case Against PBMs

Pharmacy Benefit Managers (PBMs) are creatures of the infamous managed-care revolution. They claim to negotiate with drug companies to secure lower costs for drugs for their clients, shift patients to using mail-order pharmacies, and switch to lower-cost generic drugs. But they have a history of taking bribes from drug companies to promote the more costly drugs on their formularies—the lists of drugs doctors must choose from under their plan. In March, the American Federation of State, County, and Municipal Employees filed suit against the nation's four largest PBMs, saying their "secret dealings" with drug companies drive up drug costs for consumers. The New York Attorney General is also investigating top PBMs.

Rep. Pete Stark (D-Calif.), on the floor of the House in late July, lamented the fact that the House prescription drug bill would turn Medicare over to private companies. "It's very interesting that one of the largest and best known private companies, Medco, a subsidiary of Merck, was just indicted by the U.S. Attorney in Philadelphia for a series of crimes committed on our Federal Employees Health Insurance Benefits," Stark said. "This company, that the Republicans would turn the management of [their] drug benefit over to, was indicted for canceling, deleting, and destroying patients' mail-order prescriptions to avoid penalties for late filling; shortchanging patients for the number of pills paid for; making false statements to the insurance plans they were contracted with about compliance with mailing timelines; calling and inducing physicians to authorize switching to higher costing medications while representing that this would save money for the insurance company, which was untrue; fabricating records of calls by pharmacists to physicians; and the list goes on."

The Justice Department will join a lawsuit that alleges Merck's Medco pharmacy-benefits subsidiary adopted an "aggressive, profits-before-patients policy." Medco's approach resulted in potentially dangerous lack of oversight in filling prescriptions and increased pharmaceutical costs for the Federal government, the suit says. The government also intends to file its own suit against Medco shortly.

The 1,043-page Senate proposal (S1) passed in a bipartisan 76-21 vote on June 27. On the same day, the 700-plus-page House plan (HB1) squeaked by on a vote of 216-215 along straight party lines, and only after heavy arm-twisting of several Republican members by House Speaker J. Dennis Hastert (R-Ill.). Now, both Medicare drug benefit bills are in a conference committee made up of 10 Republicans and 7 Democrats, to seek common ground. Both bills have Americans outraged, for different, good reasons.

Under the Senate plan, traditional fee-for-service Medicare beneficiaries can buy separate drug coverage from private, at-risk, for-profit, government-subsidized drug-only insurers. Well, no such animal exists. Insurance experts say stand-alone drug plans are not likely to exist, because people who sign up for them do so because they have plenty of medication needs—they're not profitable. Both bills want to utilize for-profit intermediary companies known as Prescription Benefit Managers (PBMs) or Pharmacy Delivery Plans (PDPs), which major businesses use to manage employee prescription drug benefits. Such plans are not now at-risk companies—if they become so, they might discourage patients with heavy medication needs. PBMs have historically focused on the bottom line, endangering patients.

The Senate plan would let Medicare patients join a Medicare HMO or PPO that offers prescription drug coverage; or, join a high-priced "Medicare Advantage" private plan with drug and catastrophic care coverage. It says patients must have the choice of at least two competing drug plans in their region. If only one or none exists, Medicare would offer a back-up drug insurance plan. The problem is that private companies bounce in and out of markets, according their profitability. When the drug-plan company leaves a market, the 85-year-old grandmother would have to shift to the government fall-back option. If a company returns, the same chronically ill woman must bounce back to enroll with it—each time giving personal medical and financial information to the new insurer. Do we really want the elderly to go through this?

The House bill is worse. If no for-profit drug-coverage plan is offered in a region, its elderly inhabitants would go without Medicare drug coverage. The "free-market" must provide, or nothing is provided.

The Killer Doughnut Hole

Under the Senate bill, Medicare beneficiaries would pay about $35 a month in premiums (which increase according to different plans and geographic regions), and an annual $275 deductible, after which the government would pay 50% of drug costs to a maximum of $4,500 a year. (Thus, a senior citizen with $4,500 annual drug expenses would have about $1,500 net paid by Medicare.) There, all coverage stops, until the patient's drug expenses exceed $5,800 a year, at which point the government pays 90% of remaining drug costs. The infamous "doughnut hole" in each plan is supposed to hold its costs to $400 billion.

Compare what happens in the House bill: When Medicare beneficiaries pay a $35 a month premium and a $250 deduct-

ible, the government will cover 80% of a person's drug costs up to $2,000 a year (of which about $900 would be paid, net, by Medicare), at which point the infamous doughnut hole kicks in. No further drug costs are covered until the patient's expenses reach $4,900 for the year, at which point, catastrophic coverage starts. Between $2,000 and $4,900, about 48% of Medicare beneficiaries get no help when they need it the most, but would still pay the monthly $35 premium. And nothing in the bill assures a premium limit of $35. According the House debate, the only place this model has been tried is in Nevada, where premiums are $85 a month.

How many people are harmed by the "doughnut hole"? The average Medicare beneficiary spends about $2,300 on medications each year; nearly a fifth will spend $4,000 or more; 4.7 million Medicare recipients have drug costs greater than $4,500 a year; 17% spend over $5,000; 2.9 million, or 12%, have expenses of more than $5,800 a year.

Incredibly, the Senate bill denies drug coverage for Medicare beneficiaries who are so poor they must depend on Medicaid, the joint state-Federal plan for the poor and disabled, to pay for their medications. The Senate leaves it up to bankrupt states—which are slashing billions of dollars of Medicaid benefits left and right—to decide whether to pay for medications for these 17% of all Medicare beneficiaries, who are known as the dual-eligibles. And, because the poorest 6 million Medicare beneficiaries account for nearly half of all state Medicaid drug spending (about $16 billion a year), they are likely to face more cutbacks in their medications as the fiscal crisis deepens. Governors want Medicare to pick up the state share of these Medicaid costs, which have been growing by more than 15% a year.

Senator Santorum says the Senate bill provides "too much subsidy to too many people," although it does so with a means-test for the indigent. The House bill has no help for the indigent, so that even those living on $18 a day would have to scramble to pay for medications in the "doughnut hole," or go without. The House enforces a sliding scale for those with incomes over $60,000. The higher the income, the higher your out-of-pocket costs before catastrophic benefits kick in. Pharmacies have to have personal financial data on file to enforce this. The plans would increase the premiums enrollees pay for Medicare Part B (which covers doctor's care)—and could put it out of reach for millions. Millions of people who now have drug coverage through their employer retirement plans, would lose it as a direct result of the Senate plan.

Insurance Death Spiral

The plans would go into effect in 2006. In the House plan, by 2010, traditional fee-for-service Medicare has to *compete* with private plans. Healthier patients typically join cheaper PPOs or HMOs, but sicker patients with more medical needs need traditional Medicare. Concentrating the sickest patients in traditional Medicare means higher Medicare costs and higher and higher premiums too costly for the sickest to pay (this is the opposite of spreading the risk pool over the total patient population). Medical actuaries estimate that in the first five years of such competition alone, premiums for traditional Medicare would go up 25%, and more after that. Such an insurance death spiral, says Bill Vaughn of Families USA, could make traditional Medicare prohibitively expensive, killing it.

In 2010, the House plan enforces convoluted premium supports or vouchers. It would give beneficiaries a defined contribution or a fixed, per-patient amount of money, and tell them to go find their own plan, either a private for-profit or traditional Medicare. Ultimately, though having a voucher, the patient is responsible for the total premium costs. Under the House bill, there is no guarantee of what benefits a private insurer will provide and at what costs. As Sen. Olympia Snowe (R-Me.) says of the House bill: "It unravels the whole essence of the Medicare program."

Lobbyists of the insurance and drug companies are spending tens of millions to sway legislators on the bills. The Congressional Budget Office estimates that Medicare beneficiaries will spend $1.8 trillion on prescription drugs over the next decade; the "reforms" would set aside only $400 billion for the same period.

There Is an Alternative

After a Medicare prescription drug plan is passed, President Bush wants Medicare beneficiaries to have drug discount cards that will allegedly save 10-25% of their costs. But the Administration, in deference to the "free market," objects to provisions in the Senate bill that guarantee a discount of 20% off the wholesale price of drugs. And it opposes any restriction that says drug prices cannot be increased more than once every 60 days for card holders. Nothing in either bill would be done to slow or stop the rise in the actual costs of prescription drugs. In fact, the House bill forbids the Health and Human Services Secretary from negotiating for lower drug costs. U.S.-based drug companies made $38 billion in profits last year.

There is another option—which pharmaceutical companies vehemently oppose. The government could use its buying power to purchase drugs for seniors at discount rates—just as it does for hospitals, facilities, and individuals participating in programs of the Department of Defense, the Department of Veterans Affairs (VA), Public Health Services, Bureau of Prisons, and Indian Health Services. The Federal supply schedule, administered by the VA for 25 years, is a multiple-award, multi-year contract for medical, dental, and surgical supplies, pharmaceuticals, medications, equipment, and more. The program is based on how companies do business with their best commercial customers—none of which are as large as the Federal government. Prices in these programs have been reduced by up to 25%; they have worked for 25 years. It could work for our vulnerable elderly now.