



policy points

Prescription Drug Coverage at Last...With Much More The new Medicare prescription drug act affects not only prescription drugs for seniors, but payments to physicians, hospital reimbursements and electronic prescriptions.

BY JEFF ATKINSON



After years of partisan disputes about coverage of prescription drugs under

Medicare, Congress finally passed a law to provide partial coverage of prescription drugs for seniors. President Bush signed the law in December (Public Law No. 108-173). The tradeoff for passage of the [Medicare Prescription Drug, Improvement, and Modernization Act of 2003](#) seemed to be inclusion of many other changes to the Medicare system favored by different constituencies.

Coverage of prescription drugs begins with “prescription drug discount card.” By June of 2004, the federal government will issue discount cards for seniors, which the White House says will let seniors save between 10 and 25 percent of the cost of medicines. For the typical senior who spends \$1,285 per year on medicines, the savings could be as much as \$300 according to the White House. The level of savings will depend on the willingness of drug

companies and pharmacies to provide the discounts. Low-income seniors will receive a \$600 credit on the card in 2004.

Limits on coverage

The discount card program is regarded as transitional. It will conclude at the end of 2005, and will be replaced in 2006 by a Medicare-approved drug plan. Under this plan, seniors will pay a monthly premium of approximately \$35 (\$420 per year). The seniors will have

a \$250 annual deductible. The drug plans will then pay 75 percent of medicines up to an “initial coverage limit” of \$2,250.

After the coverage amount of \$2,250 is met, there is what some call a “doughnut”—a lapse or hole in coverage—that leaves seniors on their own to pay for the next \$2,850 in medicines. When seniors’ annual out-of-pocket expenses reach \$3,600 (not including the premiums), drug plan coverage kicks in again, with the plan paying 95 percent of the costs of drugs on the plan’s formula. The threshold coverage amounts are subject to in-

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crease each year based on a “the annual percentage increase in average per capita aggregate expenditures” for drugs under this program.

The benefit structure has the gap in coverage because Congress wanted to keep the total cost of the prescription drug program to \$400 billion over a ten-year period, and this way of controlling the costs was deemed preferable to providing continuous coverage at lower percentage amounts.

Seniors with incomes below 150 percent of the poverty level and limited savings will be eligible for subsidies that would reduce the payments of premiums and copayments. (In 2003, 150 percent of the poverty threshold was a yearly income of \$13,470 for an individual and \$18,180 for a couple, according to the White House.)

Developing formularies

The formularies for each drug plan must be developed by a “pharmacy and therapeutic committee,” the majority of members of which must be practicing physicians or practicing pharmacists. Decisions on what is included in the formulary must, according to the law, be based “on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature.” The law also provides, “the formulary must include drugs within each therapeutic category and class of...drugs, although not necessarily all drugs within such categories and classes.”

If a patient has an expensive drug that may not be covered by all drug plans, the physician may suggest to the patient that the patient check (or have the physician’s office staff check) if the patient’s drug plan covers the medication in question and, if not, if another plan does. Under

the act, the Secretary of Health and Human Services is supposed to make sure that there are at least two qualified drug plans in all areas of the U.S.

Managed Competition analogy

The Medicare Prescription Drug Act is reminiscent of the Clinton Administration’s plan for

“Managed Competition” that failed to be enacted by Congress in the mid-1990’s. Under Clinton’s plan of Managed Competition, multiple health plans, supervised by a government bureaucracy, were to compete with each other in each part of the country. In theory, the plans would promote competition for quality and price, but Congress concluded the Clinton plan was too cumbersome and might not deliver as promised.

The Medicare Prescription Drug Act follows a similar theory, but is smaller in scope. The act focuses primarily on competition between drug plans rather than full health plans. As with Managed Competition, the drug plans are required to generate a variety of data that consumers can use to compare plans. The data includes: the level of benefits, the monthly premium, cost-sharing provisions, and consumer satisfaction surveys.

The drug companies are pleased with the new law since they avoided having to deal with one very large purchaser (the

Studies and pilot projects under the new law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directs that dozens of studies and pilot projects be undertaken to identify problems and come up with solutions. Some are listed below:

- ▶ Evaluation of health-care performance measures in the public and private sectors and exploration of ways to implement policies that align performance with payment.
- ▶ Pricing of drugs and biologicals in general, along with specific investigation of the difference in payment amounts between prescription drugs dispensed by mail-order pharmacies owned by pharmaceutical benefit managers versus mail-order pharmacies not owned by pharmaceutical benefit managers.
- ▶ Establishment of standards for the quality of durable medical equipment (DME) and the clinical conditions that justify insurance coverage for equipment.
- ▶ Level of usage of “concierge care” (for which patients pay an extra fee) and the degree to which concierge services have affected access to care by Medicare beneficiaries (report due by the end of 2004).
- ▶ A general assessment of the U.S. health-care system, including the cost and effectiveness of different services, the costs to communities when persons are uninsured, and methods of financing health-care coverage.

Medicare system) that potentially could drive a hard bargain. Instead, the drug companies will be dealing with a variety of drug plans, which will presumably negotiate discounts, but smaller discounts than might be negotiated by one dominant purchaser.

Most pharmacists are pleased with the law too. They got a provision in the law that allows “any willing pharmacy” to participate, as long as the pharmacy is willing to meet the conditions (including related to price) of the drug plan. The drug plans will not be in a position to pick and choose which pharmacies they will deal with and potentially exclude some pharmacies from the Medicare market.

Electronic prescriptions

The act favors transmitting prescriptions electronically. This is viewed as a potential way to save costs and reduce errors in filling prescriptions. Future regulations set by the Department of Health and Human Services will provide the details

for use of electronic prescriptions, but the law provides “to the extent practicable, the standards [should] not impose an undue administrative burden on prescribing health-care professionals and dispensing pharmacies and pharmacists.” The department is required to test proposed regulations in pilot programs before imposing the new rules nationwide.

The act allocated \$50 million or more beginning in 2007 to give grants to physicians for the purpose of setting up electronic drug prescription programs. Only one grant is allowed per physician or physician group. The funds can be used for hardware, software, and training. The physician or physician group is supposed to provide at least 50 percent of the funds related to the electronic prescription program through its own money or through non-federal sources of funds. When awarding grants, the government will give preference to physicians who serve a disproportionate number of Medicare patients or serve rural or underserved areas.

Competition with health plans

In addition to encouraging competition between drug plans, some members of Congress want to see more competition between private health-care plans and Medicare. To that end, the act authorizes pilot programs in several cities in which private health-care plans will compete with traditional fee-for-service Medicare to enroll patients. How well this will work is uncertain.

In 1997, Congress established a program called “[Medicare + Choice](#)” to enroll seniors in private health plans. In recent years, however, enrollment in such plans has dropped by about one third as private health plans did not find the program sufficiently profitable and some seniors were dissatisfied with the service. In addition, a [Government Accounting](#)

[Office study of payments made in 1998](#) reported that Medicare paid 13.2 percent more to health plans than would have been paid had the beneficiaries remained in the traditional fee-for-service Medicare program. For a chart showing the amount of money spent on capitated health plans and other Medicare expenditures. [See chart.](#)

The new Medicare plan for use of private health plans is called “[Medicare Advantage](#).” It will provide financial incentives for plans to expand, particularly in areas that are considered underserved by private health plans willing to serve Medicare patients.

Additional beneficiaries under the law

The Medicare Prescription Drug, Improvement, and Modernization Act weighs in at more than 1,100 pages. Part of the reason for its length is that it contains dozens of provisions not related to prescription drugs that (depending on one’s perspective) were placed there to further improve Medicare or to gather support from different interest groups for passage of the act. Here is a list of some of the additional provisions:

More pay for physicians. Under the law and regulations in effect for most of 2003, Medicare payments to physicians were scheduled to drop another 4.5 percent in 2004. Under the new law, the 4.5 percent cut was replaced by a 1.5 percent increase.

Help for rural areas. Traditionally under Medicare, rural hospitals received less reimbursement than urban hospitals on the theory that the cost of doing business was less in rural areas. Under the new law, the reimbursement rates for rural and urban hospitals within a given region will be equalized. The Medicare system also will begin a demonstration project to encourage establishment of more community hospitals in rural areas. In addition, rural ambu-

lance services, home care services, and hospital residency programs will receive increased funding.

Payments for AIDS patients. Payments for AIDS patients at skilled nursing facilities will be increased by 128 percent.

Reimbursement for nurses. Under the new law, nurse practitioners are specifically allowed to be reimbursed for care of patients in hospices. In addition, the [Medicare Payment Advisory Commission](#) is directed to conduct a study about the feasibility and advisability of making payments for surgical first assistant services furnished by certified registered nurses.

Adult day-care. A demonstration project will be conducted to determine if adult day-care should be used (and reimbursed) in lieu of a portion of home health services.

Pancreatic islet cell transplantation.

A clinical investigation that includes Medicare beneficiaries will be funded to determine the benefits of pancreatic islet cell transplantation.

Medicare Fund Warning

The drafters of the Medicare Prescription Drug Act anticipate bumps in the road as the new law is implemented and as Medicare deals with existing problems. The law directs that dozens of studies be undertaken to identify problems and come up with solutions, such as assessing private health plans serving Medicare beneficiaries. (See “[Studies and Pilot Projects Under the New Law](#)”.)

Funding of Medicare is likely to be a significant problem in the years ahead. The new law directs the Board of Trustees of the Medicare Trust Fund to issue a “[Medicare Fund Warning](#)” in the event that financial difficulties are found to exist according to a formula in the law that takes into account the report’s current year and the six succeeding years. In the event of a “[Medicare Fund Warning](#),” the President is obliged to submit legislation

to deal with the warning, and Congress is obliged to act upon the President's proposal in an expedited manner.

The new law seeks to raise additional funds by reducing the subsidies of Part B Premiums paid by Medicare beneficiaries earning more than \$80,000 per year. The increased premiums paid by higher-income seniors will be phased in over a period of five years, beginning in 2007.

Long-term solutions

The increased Part B premiums will help the Medicare budget somewhat, but it is unlikely to provide a full solution. At some point, Congress will need to come up with other solutions such as increasing the payroll Medicare tax, funding Medicare from general revenue, or fully overhauling the health-care system.

The last option is on the table. One of the concluding sections of the Medicare Prescription Drug, Improvement, and Modernization Act provides \$6 million for establishment of the "Citizen's Health Care Working Group," a 15-member body that is directed to conduct hearings and make a report that will include the level of benefits that should be provided and methods of financing health-care coverage, including for persons without health insurance. The Working Group is likely to begin its work in 2005 and complete its report and recommendations two years later. ■

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Where the Medicare money goes

Medicare was established in 1965. The program currently provides coverage for 40.8 million persons, 34.8 million of whom are over 65, and 6 million of whom are disabled (and under 65). Approximately 4.6 million Medicare beneficiaries are served by capitated managed care plans. The total amount of money the nation spends on health care is approximately \$1.3 trillion per year, and Medicare makes up 17.3 percent of that. (Financial figures are based on expenditures in 2000, reported in 2002.)

SERVICE	AMOUNT	PERCENT
Inpatient hospitals	\$87 billion	40.6
Physicians and other practitioners	\$48 billion	22.2
Capitation payments	\$40 billion	18.5
Outpatient	\$16 billion	7.6
Nursing facilities	\$10 billion	4.8
Home health and related	\$9 billion	4.1
Other	\$5 billion	2.3
TOTAL:	\$215 billion	100.0*

* Percentages total 100.1 percent because of rounding.
Source: [Centers for Medicare and Medicaid Services \(CMS\)](#)