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Unresolved Health Care Issues for Utah's Elderly Population

by Rob Ence, AARP Utah State Director

With the passage of the Medicare Modernization Act of 2003 (MMA) a prescription drug benefit was made available to all Medicare beneficiaries. It officially began January 1, 2006. Many advocacy groups worked for years to accomplish adding Rx benefits to Medicare and although the final legislation was far from perfect, most would consider it an important first step in assisting millions of individuals with affordable access to necessary medications.

The MMA was the single largest piece of legislation since the inception of Medicare in 1965. To provide a comprehensive benefit for all Medicare beneficiaries would have cost in excess of $1.4 trillion over ten years. Only $400 billion was supported by the Bush administration so the priority was to design a system to help the neediest individuals with their prescription expenses while offering some relief to middle and upper income wage earners.

The Medicare prescription drug program, also known as Medicare Part D, offers special financial assistance to individuals and couples earning at or below 150% of the Federal Poverty Level (FPL) and has transferred the individuals who received their drugs from the state Medicaid programs onto the Medicare rolls. These individuals pay little or no premium or co-pays and have no gap in coverage. Everyone else who is eligible for Medicare can voluntarily enroll in one of several private insurance sponsored plans with monthly premiums averaging $30 and most co-pays at 25% of the prescription price. The standard plans have an annual gap in coverage where the insured must pay 100% of the cost of their medications, usually after $2,250 in total insurance-shared costs. The plans do provide for catastrophic coverage for high annual drug expenses.

Of the over 40 million Medicare-eligible beneficiaries in the United States, about 240,000 reside in Utah. Over half of these individuals already had some form of creditable drug insurance coverage with benefits equal to or better than what the new Medicare program offers. The existing coverage comes from those insured through federal employees’ retirement programs (Tricare, FEHBP), employer retiree benefits, and the estimated 21,000 Utahns receiving drug benefits through Medicaid. Another 30,000 – 35,000 had some form of supplemental private insurance to assist with the cost of their medications. Most of the supplemental drug insurance buyers will find a better bargain with the new Part D program.

The initial enrollment period for Part D ends on May 15th, 2006. With few exceptions, those who are eligible and do not enroll by the deadline, will pay a penalty for late enrollment. With two weeks to go, there are still about 33% or 80,000 eligible Utahns without coverage. Some have chosen not to participate. Others are uncertain or are still uninformed in spite of the monumental efforts by state and local agencies, community partners and volunteers, pharmacists, and others in the medical and aging network to help inform people of their options.

Early feedback from those who have enrolled in the program indicates a positive impact from the new drug benefit. In a recent AARP poll, 78% of the new enrollees in the Medicare drug program, including about 50,000 Utahns, indicated that they are satisfied with the new coverage and savings are being realized. USA Today reports that two in five are experiencing significant savings and another two in five are experiencing modest savings or are breaking even. One in 5 report spending more.
This latter group with more out-of-pocket spending includes low-income beneficiaries transferred from state Medicaid drug programs where they had little or no co-payments for drugs under Medicaid but now pay $1 to $5 per drug under Medicare Part D. Some individuals had been receiving free medications from pharmaceutical drug company programs but with the advent of Part D, those have been discontinued. Others may have been moved from less expensive employer retiree coverage. There are also individuals with little or no current drug expense who signed up for a Medicare plan as insurance against future uncertainty.

The future success of the Medicare Part D program will, in large part, deal with the collective will of Congress to reign in and contain the rising costs of drugs. Even with a pared down Part D program, the original $400 billion allocated will likely exceed $700 billion dollars in the next ten years. One rationale for having multiple insurance providers and plans to choose from (45 plans in Utah) was that market competition would keep prices low. The only result so far has been confusion for consumers. There is certain to be natural attrition as some providers drop out for lack of adequate market share. A greater concern with the program design is that there are few safeguards to monitor and contain rising drug costs. Each Medicare-contracted Part D provider negotiates its own pricing structure for its drug list or formulary.

The issue of drug prices continues to be controversial and is a continuing concern of states, employers, individuals, and others outside of Medicare. Prescription drug costs continue to place an increasing financial burden on Americans. According to a May 2004 study, Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Older Americans, 2000 through 2004, published by AARP's Public Policy Institute, authors David Gross and Susan Raetzman of AARP with Stephen Schondelmeyer of the University of Minnesota, found that “retail purchases of prescription drugs account for an estimated 11.6 percent of U.S. health expenditures in 2004, and they have been the fastest-rising component of health care spending since 1998.”

The AARP report also shows that “on average, drug manufacturers have been increasing the prices of widely used brand name prescription drugs well above the rate of inflation in each of the past four years (calendar years 2000 through 2003). For the subset of drugs on the market for the entire four-year period, the average cumulative manufacturer price increase was 27.6 percent, compared to a general inflation rate of 10.4 percent over the same period.” This trend holds true for all brand name drug manufacturers and therapeutic categories.

AARP instigated an Rx Watchdog project to monitor pricing and its impact on the MMA. The April 2006 report found that drug pricing continues to increase at a rate far above general inflation.

So just how does the drug manufacturing industry and their powerful association, PhRMA, justify the fact that prices for brand name drugs have increased 40 percent on average over the past six years, while inflation rose only 17 percent?

United States citizens spend over $250 billion per year on prescription drugs. While the proper use of medication can help maintain a higher quality of life and aid in certain medical treatments, there are some deep, dark secrets about the industry that demand attention.

The industry maintains that pricing practices and high profit margins are needed because it costs so much to develop a new drug. Overstatements of research and development costs have become the mantra for many in Congress. Here are a few items about the industry to consider:

- The pharmaceutical industry has been the most profitable in our country for over twenty years.
- Pharmaceutical Research and Manufacturers of America (PhRMA) spends about $200 million each year on lobbying state and federal legislators.
- Top selling drugs will often have price increases multiple times in one year even when the
cost of production has gone down.

- People with no insurance pay the highest prices as they have no bargaining power.
- Research and development expenses are a small part of the company budget when compared to marketing and administrative expenses.
- Most new research is tax-payer funded at small biotech companies, universities, and the National Institutes of Health (NIH).
- Most new drugs in the market are variations of older drugs or “me-too” drugs.
- The industry is granted monopolies by the government in the form of patents and FDA approved marketing rights.
- The industry continues to manipulate patent law to extend the time for bringing less expensive generic products to market.
- It is not uncommon for the annual compensation of a drug company chairman or CEO to approach or exceed $100 million per year (salary and stock options).

We need a stable pharmaceutical industry, but not one that is driven by greed and profits. We need new research with meaningful drugs, not just variations of drugs with no demonstrated improvements.

Congress should reconsider its hands-off approach to regulating this industry and should authorize the Secretary of Health and Human Services to negotiate pricing in Medicare. It is the only insurance system in the industrialized world that doesn’t negotiate pricing. State legislators should consider preferred drug lists in Medicaid programs and bulk purchasing arrangements with public entities to maximize their purchasing power.

Medicare may have been a temporary windfall for the drug industry but without cost containment the ability to maintain a solvent drug program is bleak. The drug companies should be concerned. People are angry. State governments, Medicaid programs, private insurers, and the public have had enough.