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THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT: WHO WINS AND WHO LOSES?

Erich Andreas Drotleff*

INTRODUCTION

In December 2003, Congress amended Title XVIII of the Social Security Act (Medicare) by adding a voluntary prescription drug benefit, titled Medicare Part D.¹ The Medicare Part D prescription drug program took effect on January 1, 2006, and began providing some form of prescription drug coverage for millions of America's seniors, who historically had no such coverage under traditional Medicare Parts A and B.² Members of Congress argued that Medicare's traditional inpatient coverage did not effectively control healthcare expenses, and Medicare failed to effectively manage chronic conditions with outpatient prescription medications.³

The first part of this article provides a brief historical overview of the original Medicare program including program changes to the present. The article then focuses on the Medicare prescription drug program; specifically, the drug program's

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1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C.A. §§ 1395w-101 to -152 (Westlaw current through October 3, 2006)).

2. Edward F. McArdle, 2003-2004 *Survey of New York Law: Health Law*, 55 SYRACUSE L. REV. 1107, 1111-12 (2005).

3. LAWRENCE A. FROLIK & ALISON MCCHRYSAL BARNES, ELDER LAW CASES AND MATERIALS 233 (3d ed. 2003).

congressional history and politics, leading to the legislation's passage. Next, the article examines those interest groups benefiting from the drug program and analyzes whether the Medicare beneficiaries truly benefit. The article concludes with recent findings on implementation, as well as recommendations for different approaches to providing prescription drugs for Medicare beneficiaries.

HISTORY OF MEDICARE

Congress enacted Medicare in 1965 to address the healthcare needs of people over sixty-five, a group frequently without the means to pay for medical services.⁴ The program was designed to provide a limited and basic healthcare benefit.⁵ All beneficiaries pay the same for hospital and physician services, regardless of their income level or "ability to pay."⁶ Medicare provides healthcare coverage to virtually all seniors sixty-five and older, accounting for approximately 43.5 million Americans who receive Medicare benefits.⁷

For the first thirty-two years of its existence, Medicare remained consistent with its original benefit design. Medicare Part A provided "inpatient hospitalization and related benefits funded by an employee tax at no cost to the patient."⁸ Part B provided physician and some outpatient services for beneficiaries who elected such coverage and paid a monthly premium.⁹

The Balanced Budget Act of 1997 (BBA)¹⁰ created a new

4. McArdle, *supra* note 2, at 1111.

5. *Id.*

6. *Id.*

7. HENRY J. KAISER FAMILY FOUNDATION, MEDICARE BENEFICIARIES WITH CREDITABLE PRESCRIPTION DRUG COVERAGE BY TYPE (June 11, 2006), <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Medicare+Drug+Benefit&topic=Medicare+Rx+Drug+Coverage> (last visited Nov. 4, 2006).

8. McArdle, *supra* note 2, at 1111.

9. *Id.* at 1111-12.

10. Pub. L. No. 105-33, 111 Stat. 251 (codified as amended at 42 U.S.C.A. §§ 1395w-21 to -29) (Westlaw current through Oct. 3, 2006).

Medicare program called Part C, which was designed to offer a managed care option to Medicare recipients nationwide in addition to the traditional Medicare Parts A and B fee-for-service components.¹¹ Called Medicare + Choice under Part C, the BBA provided additional funding and revenue to Medicare Health Maintenance Organizations (HMOs) in order to incentivize and induce managed care plans to actively market and enroll Medicare Part A and B recipients into Part C.¹²

These Medicare Part C HMOs contract with the federal government and provide Medicare beneficiaries with hospital and medical services traditionally covered under Medicare Parts A and B.¹³ Additionally, they usually offer a pharmacy benefit in addition to the traditional Part A and B benefits, often without the beneficiary incurring any premiums, deductibles, or coinsurance.¹⁴ At that time, only Medicare HMOs offered an outpatient prescription drug benefit since outpatient prescription medications were not covered under Medicare Parts A or B.¹⁵

In the early 2000s, Congress, under pressure from seniors and public advocacy groups, decided to add a prescription drug benefit to traditional Medicare Parts A and B and to overhaul Medicare Part C to “reflect a market-driven approach.”¹⁶ As a result of increased drug costs and a movement away from hospital-based medical care to an outpatient and maintenance drug therapy approach to controlling chronic health conditions, lawmakers drafted a drug program that would be consistent with Medicare’s universal coverage.¹⁷

In December 2003, Congress passed, and President George W. Bush signed, the Medicare Prescription Drug Improvement

11. McArdle, *supra* note 2, at 1112.

12. FROLIK & BARNES, *supra* note 3, at 232.

13. *Id.* at 227.

14. *Id.*

15. *Id.* at 233.

16. McArdle, *supra* note 2, at 1111.

17. *Id.* at 1112.

and Modernization Act of 2003.¹⁸ Commonly referred to as the MMA, the Act's addition of a prescription drug benefit may represent "the most ambitious change in the history of the Medicare program."¹⁹

NUTS AND BOLTS OF THE MMA

The legislation creates the drug benefit; it makes significant changes to Part B finance and authorizes other market oriented initiatives in Medicare.

MEDICARE PART D PRESCRIPTION DRUG PROGRAM

The MMA provides a voluntary drug benefit under Medicare Part D for beneficiaries enrolled in Medicare Parts A and B and is administered through a prescription drug plan.²⁰ Drug benefits are provided through either stand-alone prescription drug plans (PDPs) for beneficiaries who elect to remain with traditional Medicare Parts A and B, or through Medicare Advantage (MA) plans that have incorporated Medicare Parts A and B benefits.²¹

The Medicare Part D PDP and MA plans must offer either standard prescription drug coverage, as defined in the Act, or "alternative prescription drug coverage with at least actuarially equivalent benefits and access to negotiated prices."²² Actuarially equivalent plans (either through a PDP or MA) may not have a higher deductible or higher out-of-pocket expenses than the standard drug coverage plan. However, PDPs and MAs may offer benefit designs with richer coverage (lower or no deductible and lower or no monthly premium) than available

18. Pub. L. No. 108-173, 117 Stat. 2066. The MMA became effective on January 1, 2006. § 1860D-1(a)(2).

19. McArdle, *supra* note 2, at 1111.

20. 42 U.S.C.A. § 1395w-101(a)(1).

21. *Id.* Under the MMA, Part C has been renamed "Medicare Advantage." § 1395w-101(a)(3)(B).

22. § 1395w-102. Alternative prescription drug coverage must be approved by the Secretary of Health and Human Services (Secretary). *Id.*

under standard coverage.²³

Moreover, effective January 1, 2006, Medicare beneficiaries may no longer purchase new Medicare supplemental policies that offer drug coverage.²⁴ However, Medicare beneficiaries with an existing supplemental insurance policy that includes drug coverage may renew their policies after January 1, 2006, provided they do not also select Medicare Part D coverage.²⁵

The initial monthly premium for the Part D coverage, was to average \$35 per month increasing to an average \$58 per month in 2013, depending on plan choice.²⁶ Late enrollees who select Medicare Part D after they are eligible for Parts A and B are assessed a permanent one percent penalty added to their monthly Part D premium for every month they are late in enrolling in Part D.²⁷ The deductible in 2006 was \$250 per year,²⁸ projected to increase to an average of \$445 in 2013.²⁹

The Part D cost sharing for enrollees is twenty-five percent of drug costs that exceed the deductible up to the initial coverage limit.³⁰ The initial coverage limit was \$2250 for 2006³¹ and is estimated to be \$4000 in 2013.³² Once the initial coverage limit is reached, enrollees are responsible for drug expenses until the stop-loss threshold is met.³³ The stop-loss threshold in 2006 was \$3600³⁴ and is projected to be \$6400 in 2013.³⁵ Once the stop-loss threshold is met, beneficiaries are responsible for the greater

23. *Id.*

24. *Id.*

25. *Id.*

26. HENRY J. KAISER FAMILY FOUNDATION, PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: A SUMMARY OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 2 (2003), <http://www.kff.org/medicare/6112.cfm> (last visited Nov. 4, 2004) [hereinafter KFF PRESCRIPTION DRUG COVERAGE].

27. § 1395w-113(b).

28. § 1395w-102(b)(1)(A).

29. KFF PRESCRIPTION DRUG COVERAGE, *supra* note 26, at 3.

30. § 1395w-102(b)(2).

31. § 1395w-102(b)(3).

32. KFF PRESCRIPTION DRUG COVERAGE, *supra* note 26, at 3.

33. §§ 1395w-102(b)(3)-(4).

34. § 1395w-102(b)(4).

35. KFF PRESCRIPTION DRUG COVERAGE, *supra* note 26, at 3.

of either five percent of the drug cost or a five-dollar co-pay for brand name drugs and two-dollar co-pay for generic; Medicare pays the remainder.³⁶ The federal government provides funding for the Part D benefit through existing employer and beneficiary subsidies, as well as through new subsidies (premiums, co-pays, deductibles).³⁷

The federal government subsidizes 74.5% of the Part D expenses, which are provided by monthly premium subsidies and reinsurance.³⁸ Annual deductibles and co-payments provide the remaining 25.5%.³⁹ Beginning in 2006, PDP and MA plans receive an average of eighty percent of the expected benefit costs from the federal government, and the remaining twenty percent is provided by the monthly beneficiary premiums and co-payments with additional adjustments in future years.⁴⁰

Additionally, the federal government provides annual deductible and monthly premium subsidies for the low-income Medicare population.⁴¹ The low-income population consists primarily of dual-eligible beneficiaries, those who qualify for both Medicare and Medicaid.⁴² Beneficiaries with incomes below 135% of the federal poverty line, and who meet an asset test, are eligible to receive a full premium subsidy.⁴³ All other beneficiaries with incomes that fall beneath 150% of the federal poverty line, and who also satisfy an asset test, receive premium subsidies established by a sliding scale.⁴⁴

The same poverty line criteria and asset test determine whether the beneficiary is responsible for the annual deductible.⁴⁵ Those "dual eligibles" with incomes below 135% of

36. § 1395w-102(b)(4).

37. § 1395w-115.

38. *Id.*

39. *Id.*

40. *Id.*

41. § 1395w-114.

42. *Id.*

43. § 1395w-114(a)(1).

44. § 1395w-114(a)(2).

45. § 1395w-114.

the poverty line pay no deductible but have co-pays between two dollars for generic and five dollars for brand-name medication.⁴⁶ Other beneficiaries below 150% of the poverty line pay a \$50 deductible and have co-pays between two dollars for generic medications and five dollars for brand-name medications.⁴⁷

The drug coverage under Medicare Part D, administered through either a PDP or MA plan, may include all outpatient prescription drugs approved under the individual states' Medicaid programs.⁴⁸ Medicare Part D does not include drugs used in conjunction with an inpatient admission or as part of an outpatient physician procedure, which have always been covered under Parts A and B.⁴⁹

PDP and MA plans may have formularies, so long as they satisfy certain standards, including the development of pharmacy and therapeutics (P&T) committees with appropriate representation of physicians, pharmacists, and geriatricians.⁵⁰ Moreover, PDP and MA plans must include at least two drugs within each therapeutic class and category as defined by their prescription drug plan.⁵¹ However, PDP and MA plans may change drugs within categories and classes at the beginning of each plan year.⁵² Enrollees must receive notice before a drug tier status change creates a change in availability or a different co-payment.⁵³ Enrollees in a PDP or MA plan may appeal the exclusion of a prescription drug from the plan's formulary only if the prescribing physician determines that the existing formulary drug would not be as effective for the treatment of the illness or condition or would have an adverse health effect on

46. § 1395w-114(a)(1).

47. § 1395w-114(a)(2).

48. § 1395w-104.

49. § 1395w-102(e)(2)(B); FROLIK & BARNES, *supra* note 3, at 233.

50. § 1395w-104(b)(3)(A).

51. § 1395w-104(b)(3)(C).

52. *Id.* More frequent changes accommodate new drugs. *Id.*

53. § 1395w-104(b)(3)(E).

the patient.⁵⁴

Because PDPs and MAs may establish which drugs are included on their formulary, they also may negotiate prices directly and independently with drug manufacturers and suppliers for all covered drugs.⁵⁵ Under the MMA, Medicare is prohibited from negotiating any drug prices on behalf of any PDP or MA.⁵⁶ Such negotiated drug prices for individual PDPs and MAs no longer require the drug manufacturers' "best price" requirements, as was required under the individual states' Medicaid drug benefit programs.⁵⁷

To maintain drug coverage under existing employee retirement benefit plans, the federal government provides drug subsidies to qualified retiree plans with a drug benefit, which is "actuarially equivalent" to Medicare Part D basic coverage.⁵⁸ These subsidies are equivalent to twenty-eight percent of the drug costs under the retiree program in excess of \$250 per year, up to a maximum of \$5000 per year in 2006.⁵⁹

ADDITIONAL MEDICARE REFORMS

The MMA also establishes a demonstration project for a competitive Medicare delivery system, called the Comparative Cost Adjustment Program (CCA), beginning in 2010.⁶⁰ The CCA will be a demonstration project linking fee-for-service Medicare and private non-governmental Medicare health plans.⁶¹ The CCA will be used to determine which delivery method (private MA plans versus traditional fee-for-service Medicare) provides better healthcare at lower cost.⁶²

Moreover, beginning in 2006, the Secretary will establish

54. § 1395w-104(h).

55. § 1395w-102(d).

56. *Id.*

57. § 1395w-102(d)(1)(C).

58. § 1395w-132.

59. § 1395w-132(a)(3).

60. § 1395w-29.

61. *Id.*

62. *Id.*

between ten and fifty regional MA plans.⁶³ These MA plans are to include not only a traditional fee-for-service Medicare and HMO option but also PPO plans as defined in the legislation.⁶⁴ Such regional MA plans are designed to mirror the current fee-for-service Medicare Parts A and B and offer a single deductible for both Parts A and B coverage as well as catastrophic and out-of-pocket limits for Parts A and B.⁶⁵

Additional changes to Medicare under the MMA include modification of the Part B coverage benefit, deductible, and premium.⁶⁶ Since its inception, Medicare Part B has covered only “medically necessary” services.⁶⁷ Under the MMA, however, Medicare Part B covers some preventative care and physicals as well as cardiovascular and diabetes screenings.⁶⁸ Part B deductibles also increase from an average of \$115 in 2006 to \$166 in 2013.⁶⁹ Part B premiums will be adjusted on an income sliding scale beginning in 2007 for higher-income beneficiaries.⁷⁰ Over five years, higher-income beneficiaries will see the federal government’s share of their premium subsidies decrease from an average of sixty-five percent to fifty percent.⁷¹

The MMA also increases payments to MA HMO plans.⁷² Payments were increased beginning in 2004,⁷³ and a new payment methodology began in 2006.⁷⁴ MA plan payments are calculated based on regional benchmarks for each MA geographic service area.⁷⁵ Such payments are based according to the plan’s individual contract bid with the Secretary, which are compared to regional MA plan benchmarks established by the

63. § 1395w-27.

64. *Id.*

65. § 1395w-27(b).

66. § 1395r.

67. FROLIK & BARNES, *supra* note 3, at 224.

68. § 1395x(s).

69. KFF PRESCRIPTION DRUG COVERAGE, *supra* note 26, at 10.

70. § 1395r(b).

71. § 1395r(i).

72. § 1395w-23.

73. *Id.*

74. *Id.*

75. *Id.*

Secretary.⁷⁶

POLITICS AND PASSAGE OF THE MMA

The Bush Administration's original drug program proposed that Medicare offer drug coverage only to beneficiaries enrolled in private Medicare Part C plans and no such coverage to seniors who remained in the traditional fee-for-service components of Medicare Parts A and B.⁷⁷ However, after criticism from both Republicans and Democrats, the administration abandoned the idea of a different drug benefit depending on the beneficiary's plan enrollment.⁷⁸ The Bush Administration's original version also included a provision "establishing a permanent national system of direct competition between private plans and traditional Medicare that many Republicans strongly favored but Democrats detested."⁷⁹

Drafting the bill created rifts in both parties; drug bill proponents argued "it would expand Medicare and put it on a firmer financial footing," but opponents argued "the private-sector incentives went either too far or not far enough."⁸⁰ The initial bill passed by one vote on June 27, 2003, "only after a day of arm-twisting" by Republican House Speaker Dennis Hastert, Vice-President Dick Cheney, and Health and Human Services Secretary Tommy Thompson.⁸¹ Senator John Kerry, expressing views held by many congressmen, called the bill a "boondoggle for the pharmaceutical industry."⁸²

Finally, at 6 a.m. on November 22, 2003, the final version of the bill passed after the longest roll call (three hours) in House

76. *Id.*

77. John K. Iglehart, *The New Medicare Prescription-Drug Benefit: A Pure Power Play*, 350 NEW ENG. J. MED. 826, 827 (2004).

78. *Id.*

79. *Id.* at 828.

80. Helen Dewar & Amy Goldstein, *Medicare Bill Squeezes Through House at Dawn*, WASH. POST, Nov. 23, 2003, at A6.

81. Iglehart, *supra* note 77, at 827.

82. *Id.*

history with 220 yeas and 215 nays.⁸³ For more than an hour, when the first vote was taken at 3 a.m., the bill stood at 218 against passage and 216 for passage, and Democrats believed they had a victory.⁸⁴ However, while the roll call stood open for more than another hour, President Bush phoned Republicans, ear-twisting them to vote in favor of the bill.⁸⁵

On November 25, 2003, after only two days of debate, the Senate approved the Medicare drug bill and sent it to President Bush for his signature.⁸⁶ Senator Edward M. Kennedy said the House vote was “rigged,” and he accused Republicans of trying to “jam” the Senate by seeking a quick vote before their holiday adjournment.⁸⁷ Despite the substantial costs added to the Medicare program, “Republicans determined to break the long hold that Democrats had maintained on Medicare as a political asset seem to have achieved that goal by winning enactment of a drug benefit.”⁸⁸

Originally, the Bush Administration estimated in its 2005 budget that the drug-benefit program would cost \$530 billion over its ten-year term.⁸⁹ However, more recently, Congressional Budget Office director Douglas Holtz-Easkin testified that the program’s costs “would exceed \$1 trillion and could approach \$2 trillion” during the first decade of its existence.⁹⁰

WHO STANDS TO GAIN FROM MEDICARE PART D?

Widely considered to provide substantial financial benefit to the health care industry, the passage of the MMA also benefits senior advocacy group AARP.

83. *Id.* at 828.

84. *Id.*

85. *Id.*

86. *Id.* at 829.

87. Dewar & Goldstein, *supra* note 80, at A6.

88. Iglehart, *supra* note 77, at 832.

89. *Id.*

90. *Id.*

PHARMACEUTICAL INDUSTRIES

In negotiations over the Medicare prescription drug plan, no industry surpassed the pharmaceutical industry's lobbying efforts to secure a favorable benefit design and defeat proposals that would cut into their profits.⁹¹ For over a decade, pharmaceutical and insurance companies blocked Congress from adopting any sort of Medicare drug-benefit reform, even though the AARP [American Association of Retired Persons] and others advocating on behalf of seniors simply wanted Congress to act.⁹²

Finally, ten years after President Bill Clinton first proposed prescription drug benefits for Medicare, interest groups became aware that Congress was committed to changing Medicare, changes that involved adding some sort of drug benefit.⁹³ Before passage of the MMA, Chip Kahn, president of the Federation of American Hospitals, commented that "[t]here is a sense that people are shooting with real bullets" this time.⁹⁴ For many pharmaceutical industry lobbyists, the stakes were simply too big to ignore. Because the budget resolutions passed by the House and Senate set aside \$400 billion for Medicare reform, various groups wanted a piece of the action, creating "a frenzy of lobbying."⁹⁵ Not surprisingly, drug companies and manufacturers spent \$78.1 million on lobbying and employed a total of 623 different lobbyists in 2001.⁹⁶ Since the 2000 elections, the pharmaceutical industry contributed \$60 million in political

91. Ceci Connolly, *Drugmakers Protect Their Turf: Medicare Bill Represents Success for Pharmaceutical Lobby*, WASH. POST, Nov. 21, 2003, at A4 [hereinafter *Drugmakers Turf*].

92. Jonathan Weisman, *Prescription Bill Fuels Lobbying Blitz on Hill: Competition Fierce for \$400 Billion Pot*, WASH. POST, June 13, 2003, at A6.

93. *Id.*

94. *Id.*

95. *Id.*

96. Public Citizen, *The Other Drug War II: Drug Companies Use an Army of 623 Lobbyists To Keep Profits Up*, http://www.citizen.org/congress/reform/drug_industry/contribution/articles.cfm?ID=7908 (last visited Nov. 6, 2006) [hereinafter *Other Drug War II*].

donations.⁹⁷

PhRMA increased their lobbying expenditures from \$7.5 million in 2000 to \$11.3 million in 2001, spending more than any other drug industry organization in 2001.⁹⁸ PhRMA, however, was not the only pharmaceutical organization sending lobbyists to Capitol Hill. Pfizer employed eighty-two lobbyists; Bristol-Myers Squibb, seventy-six lobbyists; and Eli Lilly and Amgen, fifty-eight lobbyists.⁹⁹ Individual pharmaceutical companies also significantly increased their lobbying expenditures from 2000 to 2001: Glaxo SmithKline, a twenty-eight percent increase; Eli Lilly, a twenty-three percent increase; Hofflam-LaRoche, a twenty-three percent increase; and Johnson & Johnson, a seventeen percent increase.¹⁰⁰ The lobbying efforts of the pharmaceutical industry paid off handsomely. In 2001, although overall profits of Fortune 500 companies dropped fifty-three percent, the top ten drug companies increased profits thirty-three percent from \$28 billion in 2000 to \$37.2 billion in 2001.¹⁰¹

Because of the passage of Medicare Part D, pharmaceutical companies generated millions of new customers who previously lacked prescription drug coverage.¹⁰² Moreover, the pharmaceutical industry defeated the reform measures they feared most: legalized importation of lower-cost medicines, governmental price controls, and easier market access for less expensive generic drugs.¹⁰³

The shift of 6.4 million people from state-administered Medicaid programs to the new federal Medicare drug benefit plan boosts the drug companies' annual revenues by as much as two billion dollars.¹⁰⁴ Under Medicaid, drug companies are

97. *Drugmakers Turf*, *supra* note 91, at A4.

98. *Other Drug War II*, *supra* note 96.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Drugmakers Turf*, *supra* note 91, at A4.

103. *Id.*

104. Tony Pugh, *Drug Plan Means \$2 Billion in Extra Profits: Companies Winners in Medicare Program*, SAN DIEGO UNION-TRIB., Jan. 3, 2006, at A1.

required to charge their lowest or "best price" for medications and prescriptions to those enrolled in state-administered Medicaid programs.¹⁰⁵ But under the MMA, pharmaceutical companies need no longer pay states the drug rebates required under the individual states' Medicaid program or offer private drug plans the former Medicaid "best price."¹⁰⁶

By eliminating the "best price" provision under Medicare Part D, pharmaceutical companies keep the discounts they normally gave to the states under Medicaid.¹⁰⁷ "The net effect over ten years is probably closer to \$40 billion in extra profit," said Stephen Schondelmeyer, a pharmaceutical economics professor at University of Minnesota.¹⁰⁸ Schondelmeyer studied approximately forty Medicare plans in Minnesota and found that the prices for the top twenty-five drugs are similar to retail drug prices, but most plans' prices were twenty to thirty percent higher than Medicaid prices.¹⁰⁹ A pharmaceutical analyst at Lehman Brothers agreed that Medicare will pay higher drug prices than Medicaid and estimated a sales windfall of between \$1.8 billion and \$2 billion for drug companies.¹¹⁰

HEALTH SERVICE COMPANIES AND HEALTH INSURERS

Another key lobbying group active in developing the Medicare prescription drug bill was the health insurance and health services industry.¹¹¹ Accounts of "strong-arm tactics to push [the bill] through the House by pharmaceutical and healthcare companies showering campaign gifts on key lawmakers, and cozy arrangements for those who wrote the bill and then departed for lucrative jobs as lobbyists" were

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.* at A12.

110. *Id.*

111. Dana Wilkie, *Lobbying Ills Shine Through in Medicare Law: Watchdogs Say Congress Caved*, SAN DIEGO UNION-TRIB., Feb. 16, 2006, at A3.

common.¹¹² According to the Center for Responsive Politics, HMOs, health service companies, and health insurer “gave some of their largest campaign gifts to lawmakers who wrote key parts of the legislation, or who were leaders on committees responsible for passing it.”¹¹³

Ten companies, including PacifiCare, collectively contributed \$6.5 million to congressional candidates over six years, and these companies were granted federal contracts to offer nationwide Medicare coverage.¹¹⁴ According to critics, those nationwide contracts “ensure[] the profits of drug and healthcare companies at the expense of the taxpayer.”¹¹⁵

The Medicare plans are administered by private health insurers, which have taken a keen interest in the potential profits.¹¹⁶ Cigna HealthCare views the Medicare drug program as significant new business that is simply “too big to ignore.”¹¹⁷ According to Terri Swanson, vice president of senior products for Cigna HealthCare, “[t]he 40 million or 42 million people who’ve become eligible for Medicare Part D represent a very large block of business, obviously, and so we saw that as a very compelling reason to participate in Medicare Part D.”¹¹⁸

The potential for new business, however, comes with the risk of excessive drug costs, given that seniors tend to be high consumers of prescription medications. Older Americans tend to consume more prescription drugs and are not as profitable as younger Medicare beneficiaries.¹¹⁹ Additionally, profits depend on efforts to convince beneficiaries to change from brand-name to generic drugs and the bargaining power of insurers.¹²⁰

112. *Id.*

113. *Id.* at A17.

114. *Id.*

115. *Id.*

116. *Morning Edition: Insurers Eye Potential Profits in New Medicare Program* (NPR radio broadcast Nov. 9, 2005) (transcript on file with MARQUETTE ELDER’S ADVISOR).

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

Despite these challenges, many insurance companies believe they will have a profitable mix of enrollees by enrolling large numbers of seniors.¹²¹

Other healthcare experts, however, believe that the traditional insurance model will not lead to profits from Medicare Part D. According to Robert Laszewski, from Health Policy and Strategy Associates, "[t]he basic principle of insurance is that you get the sick people and the healthy people coming together in the pool, and the healthy people paying for premiums into the pool and offsetting the costs of the sicker people."¹²² Because the drug program is voluntary, Medicare beneficiaries may not be signing up as quickly as the federal government had originally budgeted.¹²³ Therefore, insurers may not have the premiums of healthy seniors to offset the cost of sick seniors. Despite this risk, insurers can "take comfort from the fact that if [their] profit calculations are wrong, the government will protect them from large losses, at least for the next two years."¹²⁴

AMERICAN ASSOCIATION OF RETIRED PERSONS

The AARP's endorsement of the Medicare prescription drug bill surprised many Democrats¹²⁵ and likely led to the bill's passage. The House and Senate minority leaders sent letters to AARP chief executive William Novelli expressing their "profound concern" and demanding an explanation from the AARP for its decision, while other Democrats predicted that Novelli would regret the AARP's endorsement.¹²⁶ However, according to the Bush Administration and the AARP, which represents thirty-five million members age fifty and older, the

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. David S. Broder & Amy Goldstein, *AARP Decision Followed a Long GOP Courtship*, WASH. POST, Nov. 20, 2003, at A1.

126. *Id.* at A14.

AARP's endorsement was the product of mutual cultivation over several years.¹²⁷

The AARP's support for the bill, however, came at a price, especially among its own membership. Only eighteen percent of its members agreed with the organization's endorsement.¹²⁸ Some AARP members protested outside the organization's Washington, D.C., headquarters, tearing up their membership cards.¹²⁹ Other members clogged the AARP's website and bulletin board with angry messages.¹³⁰

Why did the AARP endorse a drug program that only one in five members supported? AARP officials acknowledged the program was far from perfect, but assert it provided "the best chance in years to begin offering badly needed help to seniors in buying prescription drugs."¹³¹ Additionally, the AARP indicated that Congress and the Bush Administration addressed many of the AARP's concerns in exchange for its support.¹³² Such concessions included larger financial incentives to prevent employer-sponsored retirement programs from dropping benefits for retirees, additional financial assistance for low-income Medicare beneficiaries, and a promise that the new system of price competition from private health plans be an experimental, rather than permanent, program.¹³³

In contrast, some believe the AARP supports the drug program to protect its own interests as an insurance entity.¹³⁴ The AARP softened its support of drug importation legislation after announcing recent analysis that Medicare Part D could save beneficiaries more money than prescriptions imported from

127. *Id.*

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. *See id.*

133. *Id.*

134. Henry J. Kaiser Family Foundation, *AARP Analysis Finds Medicare Drug Benefit Will Save Seniors More Money Than Prescription Drug Reimportation*, Jan. 4, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=34589 (last visited Nov. 7, 2006).

outside the U.S.¹³⁵ Democratic Representative Sherrod Brown commented, the "AARP is selling Medicare drug coverage, so it's not surprising that they're pushing their own product."¹³⁶ The AARP worked with UnitedHealth Group, a nationwide health insurer which recently completed the acquisition of PacificCare Health Systems, to offer a joint AARP-UnitedHealth Medicare drug plan, in which it already has more than two million beneficiaries enrolled.¹³⁷ Representative Brown further alleged, "[n]ow [the AARP is] making an apples-to-oranges comparison between Medicare drug coverage and Canadian drug prices."¹³⁸

IS MEDICARE PART D DELIVERING WHAT WAS PROMISED?

States and some beneficiaries, particularly beneficiaries eligible for both Medicare and Medicaid, cite unanticipated and unwelcome costs. The Bush administration, however, asserts the drug benefit is functioning as intended.

A STATE'S GAINS TURN INTO LOSSES

In 2006, the new Medicare prescription drug program was expected to save California taxpayers an estimated \$120 million in drug costs for its Medicaid recipients.¹³⁹ However, the state had to allocate approximately \$150 million for drug coverage for low-income Californians.¹⁴⁰ Although "dual eligibles" should have been switched from Medicaid to Medicare Part D, this did not occur because of various "bureaucratic foul-ups."¹⁴¹ In early January 2006, California's Governor Arnold Schwarzenegger signed a \$70 million emergency relief bill to allow the state's one

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.*

139. Bill Ainsworth, "Double Whammy" Drug Program Turns Projected Savings to a Loss, SAN DIEGO UNION-TRIB., Jan. 21, 2006, at A1.

140. *Id.*

141. *Id.*

million “dual eligibles” to purchase their prescriptions.¹⁴²

Additional costs related to the Medicare drug benefit may be long-lasting. Assuming the implementation problems are resolved, “it is projected to cost [California] an additional \$59 million this fiscal year and more money in each subsequent year because of flaws in the federal funding formula.”¹⁴³ State officials project that by fiscal year 2008-09, “California will have paid a total of \$918 million more than if the program didn’t exist.”¹⁴⁴ Stan Rothstein, a deputy director for the California Department of Health Services, argued the “state should be getting 10 percent savings” because that is “what Congress said when it passed the program and the president said when he signed the bill.”¹⁴⁵ State assemblyman Dario Frommer concluded the drug program is a “double whammy” because the program is “seriously flawed” and costs more than the state’s Medicaid program.¹⁴⁶

Moreover, some argue that the loss of one million “dual eligibles” to the Medicare drug program will adversely affect California’s ability to negotiate reasonable drug prices for the remaining six million Medicaid beneficiaries.¹⁴⁷ Considering these factors, some believe that both “California’s budget and low-income seniors and disabled [persons] would be better off without Medicare Part D.”¹⁴⁸

MORE EXPENSES AND LESS COVERAGE

Of the forty-three million senior Americans eligible for the new Medicare drug program, it is estimated that up to twelve million of those beneficiaries with employer retirement benefits could end up worse off if they do sign up for the Medicare drug

142. Cheryl Clark, *Governor Offers \$70 Million for Medicare Relief*, SAN DIEGO UNION-TRIB., Jan. 13, 2006, at B1.

143. Ainsworth, *supra* note 139, at A1.

144. *Id.*

145. *Id.* at A1, A14.

146. *Id.* at A14.

147. *Id.*

148. *Id.*

program or if their former employer drops prescription drug coverage from its retirement plan.¹⁴⁹ In the wake of Medicare Part D, employers may continue their existing drug coverage, let their retirees drop the drug coverage and keep the remaining hospital and medical benefits, or end their drug coverage and force their retirees into the Medicare drug program.¹⁵⁰ If employers drop drug coverage, those retirees could face higher out-of-pocket expenses for drugs.¹⁵¹ However, a recent survey shows that most employers are retaining their drug benefit.¹⁵²

For Medicare beneficiaries who do not qualify for low-income subsidies, monthly premiums, an annual deductible, and coinsurance must be paid to obtain benefits under the Medicare drug program.¹⁵³ To qualify, beneficiaries must pay a monthly premium of \$35 and a \$250 annual deductible, for the first year.¹⁵⁴ After meeting the deductible, beneficiaries are responsible for twenty-five percent of drug expenses up to a benefit limit of \$2250 in 2006.¹⁵⁵ For example, in 2006, seniors spending \$2250 on drugs will face a total out-of-pocket expense of \$1,170 under the Medicare drug program.¹⁵⁶ If the beneficiary's drug costs exceed \$2250 a year, there is no additional benefit until total out-of-pocket drug expenses exceed \$3600.¹⁵⁷ Medicare beneficiaries are completely responsible for these drug costs until the \$3600 threshold is met, and this uncovered liability is referred to as the Medicare Part D

149. *All Things Considered: New Medicare Drug Benefit Not a Boon to All* (NPR radio broadcast Dec. 9, 2005) (transcript available at <http://www.npr.org/templates/story/story.php?storyId=5046843> (last visited Nov. 4, 2006)).

150. *Id.*

151. *Id.*

152. *Id.*

153. Edward Walsh & Bill Brubaker, *Drug Benefit's Impact Detailed: Many Will Face Big Out-of-Pocket Costs*, WASH. POST, Nov. 26, 2003, at A10.

154. *Id.*

155. *Id.* This initial coverage limit will increase to \$4000 in 2013. KFF PRESCRIPTION DRUG COVERAGE, *supra* note 26, at 3.

156. Walsh & Brubaker, *supra* note 153, at A10. ($\$35 \times 12$) + \$250 + (0.25 × \$2,000).

157. *Id.* This limit will increase to \$6400 in 2013. KFF PRESCRIPTION DRUG COVERAGE, *supra* note 26, at 3.

“doughnut hole.”¹⁵⁸ Thus, beneficiaries will be responsible for an additional \$1350, calculated as the \$3600 less the \$2250, in out-of-pocket expenses. Once yearly drug expenses exceed \$3600, the program’s “catastrophic drug coverage” provides ninety-five percent coverage for drug expenses exceeding the \$3600.¹⁵⁹ For example, a beneficiary with \$6000 (\$500 per month) in drug expenses would be responsible for \$2640 of those expenses.¹⁶⁰

The Congressional Budget Office estimates 2006 average drug spending by Medicare beneficiaries at \$3245.¹⁶¹ At that level of spending, a beneficiary’s out-of-pocket expenses total \$2415, which includes the \$250 deductible, twenty-five percent coinsurance on the remaining \$2000, monthly premiums of \$420, and \$1245 to cover the entire cost of drugs exceeding the \$2250 benefit limit.¹⁶² Consumer advocates estimate that 29.5 million of 43 million total Medicare beneficiaries will reach or exceed the \$2250 benefit limit in 2006 if they elect to participate in the Medicare drug program.¹⁶³ Therefore, more than seventy percent of Medicare beneficiaries in 2006 could have a significant portion of their drug expenses fall into the “doughnut hole.”

FEWER BENEFITS FOR THE POOR

Twelve million low-income Medicare beneficiaries receive Medicare drug program subsidies, in which premiums and deductibles are significantly lower.¹⁶⁴ Consumer advocates argue, however, these beneficiaries will see a smaller benefit under Medicare Part D than under Medicaid.¹⁶⁵ Although these low-income beneficiaries do not pay the standard Medicare

158. Walsh & Brubaker, *supra* note 153, at A10.

159. *Id.*

160. $(\$35 \times 12) + \$250 + (0.25 \times \$2000) + \$1350 + (0.05 \times \$2400)$.

161. Walsh & Brubaker, *supra* note 153, at A10.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

prescription drug premium and deductible, they paid no premiums or deductibles under Medicaid.¹⁶⁶ Under Medicare, low-income beneficiaries face higher co-pays than existed under Medicaid.¹⁶⁷ Approximately one-half of the twelve million low-income Medicare beneficiaries are dual eligibles under both Medicare and Medicaid, and this population faces significant challenges under the Medicare drug program.¹⁶⁸

The Medicare drug program was intended to improve access to prescription drugs, and to improve overall healthcare for millions of senior Americans, but 7.2 million "dual eligibles" have reduced benefits under the new program.¹⁶⁹ Before the MMA, state Medicaid programs provided a low-cost and comprehensive prescription drug program for "dual eligibles."¹⁷⁰ Ten states required no co-payment, and others required co-payments ranging from fifty cents to three dollars, depending on whether the drug was generic or brand-name.¹⁷¹ Moreover, prior authorization was required for only a few select "high-cost" drugs.¹⁷²

Under Medicare Part D, even if the deductible and premium are waived, dual-eligible beneficiaries will still be responsible for a co-payment ranging from one to five dollars.¹⁷³ Moreover, research shows that policies implementing (even minor) medication cost-sharing techniques reduce the use of essential medications, which compromises patient health.¹⁷⁴ Health advocates argue that the extension of drug benefits to "dual eligibles" "was supposed to help the sickest of the sick – the blind, disabled and low-income, many of them with

166. Cheryl Clark, *New Medicare Law Trips Up the Poor: Doctors, Pharmacists Say Some Will Die for Lack of Medicine*, SAN DIEGO UNION-TRIB., Jan. 12, 2006, at A1.

167. *Id.* at A14.

168. Walsh & Brubaker, *supra* note 153, at A10.

169. Rachel A. Elliott et al., *Benefits and Consequences for the Poor and the Disabled*, 353 N. ENGL. J. MED. 2739, 2739 (2005).

170. *Id.*

171. *Id.* at 2740 tbl.

172. *Id.*

173. *Id.* at 2740.

174. *Id.* at 2741.

behavioral or psychiatric diagnoses,” and “[t]hese patients are the least likely to fight for themselves.”¹⁷⁵ “Dual eligibles” are the poorest and sickest Medicare beneficiaries (eighty-three percent report fair to poor health versus fifty-seven percent of those not dually eligible).¹⁷⁶ Additionally, “dual eligibles” report a higher rate of mental illness than those not dually eligible (thirty-three percent versus twelve percent).¹⁷⁷

Transitioning “dual eligibles” to the Medicare drug program raises several concerns. Because “dual eligibles” are sicker and poorer than the general Medicare population, these “high-risk” beneficiaries face problems transitioning coverage and negotiating the Medicare system.¹⁷⁸ Beneficiaries with dementia or psychiatric illness (as many as 2.4 million people) are particularly at risk for challenges moving from the state-run Medicaid system and negotiating the prior-authorization system for certain restricted medications under Medicare Part D.¹⁷⁹

In California, “dual eligibles” encounter circumstances similar to the rest of the nation’s 7.2 million “dual eligibles.”¹⁸⁰ California has one of the highest populations of “dual eligibles,” at more than one million, and San Diego County is home to nearly 66,000.¹⁸¹ Many plans operating in California do not cover basic prescription medications needed to treat glaucoma, diabetes, high cholesterol, arthritis, and other common health problems.”¹⁸² Maria Puig, a San Diego area doctor, said in January 2006:

[B]y the end of the month, I’ll be able to get you stories of patients who drop dead in the streets because they can’t get their heart medication. And if they don’t die, they’ll just get sick, go to the emergency room and be

175. Clark, *supra* note 166, at A1.

176. Elliott et al., *supra* note 169, at 2739.

177. *Id.* at 2739.

178. *Id.* at 2739.

179. *Id.* at 2740.

180. Clark, *supra* note 166, at A1.

181. *Id.*

182. *Id.* at A6.

hospitalized. This is a total and complete disaster.¹⁸³

Greg Knoll, a healthcare advocate, added, "[t]he patients are in tears, and the pharmacy people are in tears."¹⁸⁴ Such alarming accounts indicate that beneficiaries do not understand the new Medicare drug program, and they may need to switch medications if their new drug plan does not offer the same drugs as their previous Medicaid drug plan.¹⁸⁵ According to Knoll, this is "one of the greatest public health disasters in our history in a group that never had problems getting medicines before, but are suddenly forced to choose between food and co-pays they shouldn't have to pay."¹⁸⁶

BUSH ADMINISTRATION SAYS PROGRAM WORKING

The Bush Administration's drug program was designed to provide a comprehensive framework that would simultaneously strengthen Medicare's guarantee to provide healthcare access to all seniors while providing an affordable prescription drug benefit to all of America's seniors.¹⁸⁷ Under the new Medicare program, seniors have a choice of drug coverage, and no senior will be forced into a governmental-administered prescription drug plan.¹⁸⁸ By freeing up drug programs from federal government bureaucracy, seniors have immediate access to modern drugs currently available as well as new drug treatments that are in the pipeline.¹⁸⁹

According to the Department of Health and Human Services, those countries with government-run prescription drug programs do not guarantee seniors access to new, cutting edge,

183. *Id.*

184. *Id.*

185. Elliott et al., *supra* note 169, at 2740.

186. Clark, *supra* note 166, at A6.

187. White House of President George W. Bush, *Fact Sheet: Framework To Modernize and Improve Medicare*, <http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html> (last visited Nov. 4, 2006) [hereinafter *Framework*].

188. *Id.*

189. *Id.*

and potentially life-saving prescription drug therapies.¹⁹⁰ In an effort to control drug costs, coverage for new drugs in those countries often is delayed while a government-appointed committee decides which patients, if any, should have access to the new drug.¹⁹¹ Moreover, such drugs often are restricted or denied if they do not meet the government's criteria for application and therefore are not included in the governmental drug formulary.¹⁹² However, under the new Medicare prescription drug program, competition allows seniors to select from hundreds of drug plans to suit their own prescription drug and budgetary needs.¹⁹³

The Bush Administration says the new Medicare drug program is doing exactly what it was designed to do: provide seniors with wide access to affordable prescription drugs.¹⁹⁴ Within ten weeks of Medicare Part D becoming effective, "[m]ore than 26 million people have coverage, more than a million prescriptions a day are being filled, and every week hundreds of thousands more people are enrolling in the program."¹⁹⁵ According to Dr. Mark McClellan, a Center for Medicare and Medicaid Studies administrator, a survey released in early March 2006 showed that "seniors overwhelmingly are having no or little difficulty using their new coverage for the first time."¹⁹⁶ The survey found that once seniors connect with a drug plan and utilize the prescription benefit, they typically save fifty percent or more on their drug costs.¹⁹⁷ Studies show that seniors could save an additional twenty to thirty percent if they

190. White House of President George W. Bush, *Strengthening Medicare: Highlights of the New HHS Report, Securing the Benefits of Innovation for America's Seniors*, <http://www.whitehouse.gov/infocus/rx-medicare/page3.html> (last visited Nov. 4, 2006).

191. *Id.*

192. *Id.*

193. *Framework*, *supra* note 187.

194. White House of President George W. Bush, *Press Gaggle by Scott McClellan*, <http://www.whitehouse.gov/news/releases/2006/03/20060314-5.html> (last visited Nov. 4, 2006) [hereinafter *Press Gaggle*].

195. *Id.*

196. *Id.*

197. *Id.*

switch from brand-name to generic prescription drugs under their plan, which creates a savings under Medicare Part D of as much as eighty percent.¹⁹⁸

Because of fierce competition between various drug plans, seniors have access to drug programs that have filled the "doughnut hole" coverage loss, thereby eliminating seniors' financial exposure once their drug costs exceed the benefit limit of \$2250 per year.¹⁹⁹ Seniors can enroll in drug plans that provide a continuum of prescription drug coverage with no additional financial exposure other than the monthly premium and co-pay.²⁰⁰ Finally, the 2006 cost of the Medicare drug program is about one-fifth lower than expected for taxpayers and about one-third less for seniors.²⁰¹ Despite the White House's admission to bumps and bruises in launching the Medicare prescription drug program, the Administration says such a benefit was needed for the forty-one-year-old universal health insurance program for America's seniors.²⁰²

CONCLUDING FINDINGS AND RECOMMENDATIONS

An inventory of the program's considerable shortcomings may yield useful amendments.

MEDICARE PART D SHORTCOMINGS

Little reliable information about the Medicare drug benefit exists to make an accurate assessment of its overall performance thus far. However, immediate opinions from both its proponents and opponents are clear. Opponents argue that the privatization of a Medicare drug benefit has led to pricing inefficiencies, and the inability to allow drug importation,

198. *Id.*

199. White House of George W. Bush, *Ask the White House*, <http://www.whitehouse.gov/ask/20051117.html> (last visited Nov. 4, 2006).

200. *Id.*

201. *Press Gaggle*, *supra* note 194.

202. *Id.*

because of patents protecting such drugs, has created a captive American drug market.²⁰³ Proponents point out that the plan is working well; competition is driving prices down because of contracts negotiated with drug manufacturers.²⁰⁴

However, according to a recent report released by Public Citizen, a national non-profit public-interest organization, “[p]roposals relying on private sector plans to offer prescription drug coverage to Medicare beneficiaries would be vastly inferior to a drug benefit offered directly by Medicare.”²⁰⁵ This report found that Medicare HMOs offering drug coverage significantly increased their premiums.²⁰⁶ The report found that Medicare HMOs in fourteen states increased the average premium by more than 100% from 1999 to 2003, and Medicare HMOs in eight states increased premiums by more than 300%.²⁰⁷ Reportedly, the biggest contributor to drug expense increases was the federal government’s inability to contract directly with drug manufacturers.²⁰⁸

The Democratic staff of the House Government Reform Committee reported that drugs purchased under Medicare Part D cost more than through other high volume programs.²⁰⁹ This report stated that prescriptions purchased through the Medicare prescription program are eighty percent higher than if purchased through the Department of Veterans Affairs (VA), sixty percent higher than if purchased through Canadian pharmacies, and three percent higher than if purchased through

203. Andrew Harris, *Recent Congressional Responses to Demands for Affordable Pharmaceuticals*, 16 LOY. CONSUMER L. REV. 219, 234 (2004).

204. *Press Gaggle*, *supra* note 194.

205. Public Citizen, *Covering Medicare Prescription Drugs by HMOs and Insurance Companies Would Be Unreliable and Costly, Study Shows*, Sept. 26, 2002, <http://www.citizen.org/pressroom/release.cfm?ID=1227> (last visited Nov. 4, 2006).

206. *Id.*

207. *Id.*

208. *Id.*

209. Henry J. Kaiser Family Foundation, *Daily Health Policy Report: Medicare Prescription Drug Benefit Will Not Offer Prices as Low as Those Through VA, Canada, Democratic Report Says; Medicare Officials Dispute Findings*, Nov. 23, 2005, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=33933 (last visited Nov. 4, 2006) [hereinafter *Kaiser Daily Health*].

major U.S. pharmacies, such as Costco or Drugstore.com.²¹⁰ The report also found that the main contributor to lower prices through the VA and Medicare programs is the federal government's negotiating power to leverage cost efficient contracts, while the private sector (Costco and Drugstore.com) cannot harness such deep discounts.²¹¹

Proponents of drug importation argue that such a ban should be lifted under the MMA, citing drugs from Canada are safe and have saved Americans millions of dollars.²¹² For example, before the MMA's drug importation ban, Springfield, Connecticut, was the first city in the nation to sponsor such a drug importation program for its city employees.²¹³ Under the importation program, Springfield's 3200 city workers opted to have their prescriptions filled from a licensed Canadian pharmacy that saved the city \$2.5 million in the first year.²¹⁴ Several other cities quickly followed Springfield's lead, ignoring warnings from the Bush Administration that such drug purchases made outside the U.S. were dangerous and illegal.²¹⁵ Feeling pressure from the lower-priced Canadian pharmacies, drug manufacturers quickly responded by tightening sales to Canadian pharmacies and warning that cities importing Canadian drugs were exposing their citizens to the risk of potentially harmful drugs from outside the U.S.²¹⁶

PROPOSED SOLUTIONS

Whether the issue concerning prescription drugs is price, quality, patient safety, or consumer choice, the current Medicare Part D prescription drug program under the MMA is in need of refinement. Overall, the Medicare drug program is a step in the

210. *Id.*

211. *Id.*

212. Ceci Connolly, *Drug Reimportation Plan Saves City \$2.5 Million*, WASH. POST, July 15, 2004, at A3.

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

right direction in providing access to much-needed prescription drugs at reasonable prices that most seniors can now afford. However, the current program has failed to consider the population most at risk under the new Medicare drug program, America's dual eligible seniors who are poor, disabled, or mentally impaired.

Several steps should be taken to maximize the drug benefit for the "dual eligibles" and to ease the switch from state Medicaid drug programs to the new federal Medicare drug program. There should be a longer transition period for those "dual eligibles" whose medications were previously covered under Medicaid and will not be covered under Medicare.²¹⁷ A transition period of twelve months would allow the "dual eligibles" to continue their current medications and slowly transition to an equivalent drug covered under a Medicare MA or PDP plan that the beneficiary chooses.²¹⁸ This transition period would include prescribing-education programs to improve patient awareness of drug equivalent differences, which would ensure patient safety and drug efficacy.²¹⁹

Nonetheless, even if a long transition period is allowed for those "dual eligibles," this population likely will discontinue taking its medications if the Medicare drug program makes the drugs themselves cost-prohibitive.²²⁰ In keeping with the spirit of market-driven forces under the Medicare drug program, individual states can maintain their existing MA or PDP plans available for the general Medicare population but limit the plans available for dual eligible beneficiaries. "Dual eligibles" can select from a handful of PDP or MA plans that closely mirror the individual state Medicaid program, including price, formulary, and overall benefit design. These mirrored plans for "dual eligibles" will ensure higher prescription drug compliance, less confusion, and greater patient safety.

217. Elliott et al., *supra* note 169, at 2741.

218. *Id.*

219. *Id.*

220. *Id.* at 2740.

The MMA's market-driven forces for the Part D drug benefit also require reform. If the Bush Administration wants to privatize senior healthcare, using market forces to drive down and control drug costs, then the administration needs to remove those obstacles that impede such competitive market forces. Specifically, importation of drugs from Canada or Europe should be allowed, if not encouraged. Provided that such countries ensure drug safety and efficacy, which can be enforced by the Food and Drug Administration before such drugs are released into the U.S. marketplace, importation would encourage competitive drug pricing and sales among U.S. drug manufacturers. The current system of protectionism for America's pharmaceutical industry under the MMA does nothing more than continue price floors for domestic drug manufacturers, who know they are shielded from competition.²²¹

Finally, the current scheme of excluding the federal government from bidding and negotiating directly with drug manufacturers under the MMA leads to market inefficiencies. There must be a direct, government-regulated pricing scheme, similar to that used in Canada and Europe. Studies show that the federal government leverages deeper drug discounts for individuals with VA benefits than are possible for individual private health insurers who negotiate independently with drug manufacturers.²²² When the federal government represents and negotiates drug benefits for all Medicare beneficiaries, drug companies will offer competitive drug prices. Under the current market-driven approach of the MMA, pharmaceutical companies use "divide and conquer" methods to set prices with individual health insurers as they see fit.

Congress's effort to fix America's prescription drug problem with the MMA was an attempt to lower the individual's cost for drugs. Unfortunately, the program was designed with several flaws, and its goal of lower pharmaceutical prices for America's seniors will not be fully

221. See Harris, *supra* note 203, at 234-35.

222. Kaiser Daily Health, *supra* note 209.

realized. It was drafted with an eye toward interest groups, who will be the true winners. Until Congress addresses the root problem, the pharmaceutical companies' hold on drug prices and importation market forces, America's Medicare beneficiaries will be the losers.
