US Medicare reform: why drug companies and private insurers are smiling

In early December, President George W. Bush signed into law the most sweeping reform of publicly funded health care in the United States since Medicare's inception in 1965: the Medicare Prescription Drug, Improvement and Modernization Act of 2003.[1] The most-touted feature of the Act is a new prescription-drug benefit for senior citizens. However, the design of this new program — whose provisions, critics fear, will eviscerate public Medicare in the long run — has lead many to view the new legislation as a diamond in the rough for private insurers and the pharmaceutical industry and a lump of coal for seniors.

The US legislation is likely to have implications for the Canadian context, and not only by staunching the flow of prescription drugs to American seniors seeking cheaper prices from pharmacies north of the border. For policy-makers contemplating recommendations for extended pharmacare in the Romanow and Kirby reports, the Act holds important lessons in how *not* to design a drug benefit program. Ultimately, the US legislation may even have implications for Canadian drug pricing policies.

A lump of coal

The new prescription-drug benefit will unquestionably provide much-needed assistance for the very poor and the very sick among US seniors who currently have little or no drug insurance. But that relief will be modest: most seniors will still face substantial out-of-pocket costs, and many (including some on low incomes) will actually be worse off financially under the new program. Unlike public drug plans to which Canadians are accustomed, the new US drug benefit will be voluntary, privately delivered and complicated by a labyrinthine schedule of means-tested premiums, deductibles and exclusion criteria.

The plan employs a "doughnut" design intended to make it sufficiently tempting to patients with modest drug costs and provide coverage against truly catastrophic costs, while limiting the government's financial exposure. A typical beneficiary's out-of-pocket costs would include a monthly premium of $35, a $250 annual deductible, 25% of the next $2000 in drug costs, 100% of the next $2850 (the hole in the insurance doughnut), and 5% of costs above $5100. The Act prohibits private insurers from selling policies (commonly referred to as "Medigap" insurance) to cover these gaps in Medicare drug coverage. The combination of premiums and cost-sharing makes the purchase of Medicare drug insurance unattractive for anyone whose expected drug costs are less than $1000; those with costs of $3000, $5000 and $7000 per year would still be liable for 64%, 78% and 60% of their drug expenditures respectively. Low-income seniors are eligible for lower premiums and reduced cost-sharing, but these subsidies will be not only means tested but asset tested, to the point where owning a car would rule out most subsidies. The new program also provides many low-income seniors with less coverage than they currently enjoy under state Medicaid programs (which they would have to forfeit). The complexities introduced by the Act will require many seniors seeking reasonably comprehensive coverage for hospital, physician and drug costs to hold multiple insurance policies: Medicare Part A for hospital insurance, Medicare Part B for physician services, Medicare Part D for drug coverage, along with private "Medigap insurance" for cost-sharing under parts A and B (but not part D). Not surprisingly, support for the Act has not been overwhelming: a recent poll suggests that, although support among all Americans is evenly split, among seniors opposition outweighs support by 16 percentage points.[2]

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A small measure of reform. US President Bush speaks at the White House in July 2003 on the 38th anniversary of Medicare. The new drug benefit program signed into law in December offers only modest relief for most American seniors.

A private insurer and drug company's best friend?

The real winners under this legislation are private insurers and drug companies. Rather than providing the public drug benefit directly, the Act uses public funds to subsidize seniors' purchases of private insurance within the multipayer US system. In addition, the Act provides nearly $90 billion in subsidies to employers to maintain existing employer-sponsored private drug insurance outside Medicare. Such coverage has been shrinking as employers, in the face of rising drug benefit costs, have scaled back or dropped drug coverage for retirees. Beyond the drug benefit program, the Act also introduces new provisions to shore up Medicare Part C, (called "Medicare + Choice") an existing option that allows beneficiaries to choose (with public subsidy) a private plan for hospital and physician insurance rather than traditional Medicare. Enrolment in these plans has been shrinking in recent years as the cost to beneficiaries has increased. Lastly, for private insurers, the Act authorizes a demonstration project to pilot a competitive market approach to insurance for seniors; this features a considerably expanded role for private insurance within the Medicare program.

For drug companies, the welcome news is a prescription drug program that will be utterly ineffective in controlling drug costs. By mandating a market-based drug insurance system, the program entrenches the fragmented, multipayer system of financing, which allows drug companies to pursue pricing policies tailored to specific segments of the market. Moreover, the Act explicitly prohibits the federal government from engaging in price negotiations and other cost-control strategies. Drug companies get an expanded market for subsidized drugs purchases without the onerous controls that might arise from a truly national Medicare program. The Act also contains important provisions with respect to drug imports from Canada or any other country, which will be conditional on certification by the Secretary of Health and Human Services, that the imported drugs meet safety and cost-savings standards. The Secretary is mandated to conduct a comprehensive study of issues associated with drug importation, and these may ultimately serve as a basis for severely limiting the practice. Furthermore, the Act directs the Secretary of Commerce to conduct a study of drug pricing policies in OECD countries. The intention is to identify whether any such policies employ nontariff barriers with respect to trade in pharmaceuticals; to assess the impact of such pricing policies on a range of factors, including prices in the US and intellectual property laws; and to analyze whether "bilateral or multilateral trade negotiations present an opportunity to address these price controls." In plain language, not only has the US failed to implement effective cost controls in its own program, but it may well use trade policy to weaken pricing policies in other countries. If, as has been suggested previously,[3] the probable effect of a policy on drug costs can be gauged by the tone and vigour of the industry's response, the unequivocal support of this Act by the pharmaceutical industry[4] speaks volumes.

Jeremiah Hurley
Centre for Health Economics and Policy Analysis
Department of Economics
McMaster University
Hamilton, Ont.
Steven Morgan
Centre for Health Services and Policy Research
Department of Epidemiology
University of British Columbia
Vancouver, BC

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