Medicare Reform, New Drug Benefit
Signed into Law on December 8th

President Bush has signed into law legislation drastically revamping Medicare and giving its beneficiaries a new prescription drug benefit. The legislation was passed by Congress before Thanksgiving and signed into law on December 8, 2003.

The House approved the bill by a 220-215 vote just before dawn on November 22. Republican leaders used a three-hour voting window into the early morning hours—the longest roll call vote in history—to convince two lawmakers, Reps. C.C. Butts, Otter (R-Idaho) and Trent Franks (R-Arizona) to change their votes. Oter and Franks were convinced to vote in favor of the bill after negotiat

ing with leadership and receiving phony calls from President Bush.

Three days later, the Senate passed the Medicare bill by 54-44. The final vote came after the Republicans majority, with Democratic help, broke a filibuster led by liberal democrats to block the measure in favor of action next year on an alternative. The Senate also defeated a budget challenge to the measure.

The support of the AARP, announced in mid-November, was a key development in the eventual passage of the legislation. Republicans used the endorsement to counter Democratic criticisms of the proposal. Democrats opposed the bill for a variety of reasons including the use of private health plans and the gap in prescription drug coverage known as the "donut hole" (see below).

Some Democrats argued that the legislation was designed to conceal the actual costs older Americans would have to pay. Democrats also wanted to have more low-income seniors completely covered by the benefit.

Some AARP members were angered by the group's endorsement of the legislation. They complained on the AARP Internet message board and destroyed membership cards.

New Medicare Structure

The new law redefines Medicare's structure—it no longer is a universal program charging the same fees for service despite income levels. Instead, the size of benefits that beneficiaries receive will depend on their incomes. Starting in 2006, Medicare will no longer be available for Medicare benef
cenaries.

For Medicare Part B, wealthier seniors, with incomes of $80,000 or more, will have to pay higher premiums for doctor's visits and other outpatient services. The amount would increase on a sliding scale, dropping at 80% for people with incomes above $200,000. The annual deductible for outpatient care will rise from its traditional fixed rate of $100 to $110 in 2005, and continue to increase annually.

Prescription Drug Card

In 2004 and 2005, Medicare recipients will be able to purchase a drug dis
count card that is expected to save them 10% to 15% on their prescrip
tion costs. At least 20 different companies, charging different annual fees and prices for the same medicines, are expected to provide the competing cards.

The drug card will be the main benefit until the full benefit program starts in 2006. By then, plan partici
pants will be able to buy more pre
scriptions for the same money they spend today. This is because private companies providing the coverage may be able to negotiate lower prices with drug manufacturers based on the large volume in demand by beneficia
tes. This standard card will not be able to be used in nursing facilities.

Additionally, those with low incomes of $12,123 ($16,362 for couples) will get $600 a year for prescription drugs in 2004 and 2005. This transitional discount drug card will be available in nursing facilities.

Medication Therapy Management

Under the new Medicare law, pre
scription drug plans are required to provide medication therapy manage
ment services to targeted beneficiaries who take multiple drugs, have multiple chronic diseases, or incur significant drug spending. The medica
tion therapy management services will be designed to optimize therapeutic outcomes, improve medication use, reduce the risk of adverse events and drug interactions, and increase patient adherence and compliance with prescribed regimens. The language specifies that these medication therapy manages services may include special packaging for medications.

(See ASCP Report, page 76).

Role of Private Health Plans

Once the plan takes effect in 2006, beneficiaries will have two choices for coverage:

• New or separate policies for prescriptions
• Private health plans that also

Vol. 19, No. 1 January 2004 The Consultant Pharmacist 45
provide the rest of their care.

For any region that does not have one stand-alone drug plan and one private health plan, the government will provide the drug coverage.

**How Prescription Costs Are Covered**

Whether a beneficiary chooses a separate policy for prescriptions or a private health plan, all patients will pay an estimated $35 per month premium for the first year and an annual deductible of $230. The government will pay 75% of drug costs up to $2,250. At that point the coverage stops (the "donut hole") until the beneficiary pays $5,600 out of pocket in "catastrophic" prescription expenses. Then the coverage kicks in again, with the government paying 95% of the remaining costs for the year. Under these catastrophic provisions, beneficiaries would pay $2 for generic drugs and $5 for brand-name drugs, or 5% of the total cost of the drug, whichever is more.

**Generic Drug Provisions**

Prescription medications could get to the market faster under the new bill, which closes loopholes in the 1984 Hatch-Waxman Act. The new law limits the ability of pharmaceutical companies to block cheaper equivalents to their brand-name drugs.

**Reimbursement**

The Medicare law also sets reim¬
bursement of medications. From Canada may occur only if the Secretary of the Department of Health and Human Services certifies that the drugs are safe. A reimbursement law already is on the books, but it was never implemented because HIPAA would not provide such certification. This remains a controversial issue because some lawmakers still see reimbursement as a good way to decrease prescription costs, despite warnings by the Food and Drug Administration that medications imported back into the United States from other countries could be counterfeit or tampered, and thus, unsafe.

**Impact on Dual Eligibles**

Beneficiaries who are eligible for both Medicare and Medicaid, otherwise known as "dual eligibles," will be moved into the Medicare program under the new bill. That means the could pay more out-of-pocket for their medications because some state Medicaid programs cover 100% of prescription costs. The new Medicare legislation requires copayments, which are optional for states under Medicaid coverage.

**Health Plan Competition**

One controversial provision of the bill is an experiment to have Medicare's original fee-for-service plan compete against private health plans for patients who elect to participate. Starting in 2016, this experiment will take place for six years in six metropolitan areas in which at least two private plans enroll at least 25% of Medicare beneficiaries. Some lawmakers believe it will foster greater market competition.

**Employer Incentives**

To prevent companies from dropping coverage of their retirees once the Medicare prescription drug benefit begins, the bill includes $86 billion in payments to employers who provide prescription coverage for their retired workers.

**Health Savings Accounts**

This provision will be available to all Americans, not just the elderly. People under the age of 65 who have medical policies with high annual deductibles of at least $1,000 for singles or $2,000 for families could establish "tax-free" health savings accounts. They or their employers could give them a pretax amount equal to the deductible. These accounts could be used to pay health care expenses, withdrawals would be tax free.

**Cost Concerns**

Some conservative lawmakers are concerned the Medicare bill will result in higher spending and a larger federal deficit. Due to the cost of antiterrorism measures, consequences of the war in Iraq, and recently passed tax cuts, the deficit is expected to reach $500 billion in the fiscal year that started October 1, 2003. The new Medicare benefits are expected to cost $400 billion dollars over the first 10 years and more than $1 trillion in the next decade. A cost containment measure in the bill requires congressional response if general revenue contributions exceed 45% of Medicare program spending.

**Boost to Pharmaceutical Industry**

Critics of the bill say the legislation is a boost to big pharmaceutical compa-
Medicare changed its rules for reimbursement, lowering its payments for some drugs used for hospital outpatient treatments by an average of 35%. The Medicare bill includes language sought by the biotech industry

**REPEAL BILL PROVISIONS**

Shortly after the Senate passed the Medicare bill, Minority Leader Tom Daschle (D-S.Dak.) took action to oppose some of its key provisions.

With the introduction of his own bill, the "Medicare Preservation and Drug Price Fairness Act," Daschle hopes to eliminate premium support—the experiment juxtaposing traditional fee-for-service Medicare against health plans in metropolitan areas for six years. He also wants to change the requirements for a fallback government-run drug plan, making fallback an option if there are not at least two stand-alone drug plans in a region. The fallback is triggered if there is not at least one stand-alone and one private plan available.

Daschle also wants to rescind $12 million in funding to encourage preferred provider options to expand regional coverage and revoke 26 million for health savings accounts.

**OTHER BENEFITS**

The Medicare legislation makes other changes that could benefit seniors, such as broadening coverage for pre-existing diabetes screenings. Additionally, beneficiaries who choose a private plan would have no lifetime limit for inpatient hospital care and would be protected against high bills for hospitalization.

However, the key issue in the legislation—coverage of prescription drugs—left some seniors skeptical that Medicare will end up reducing the costs of their prescriptions.

A more detailed summary of the new Medicare bill, as approved by Congress, is available on the ASCP website, www.ascp.com/public/gt/.

**SCULLY RESIGNS AS HEAD OF CMS**

Thomas Scully, the administrator of the Centers for Medicare and Medicaid Services, has resigned, effective December 16. Scully, one of President Bush's key advisors on Medicare, said that he stayed in the administration a year longer than

who has been a great friend and mentor," said Scully. "Watching the President and the Secretary drive the Medicare bill across the finish line in the last few weeks was a very rewarding culmination to a very exciting and He led an intensive effort to improve the responsiveness of the agency, with a new name, adopted from suggestions made by agency employees.

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