FCS 5400/6400
Family & Econ Policy

Medicare

Presented by:
Flavio Canelada
Hua Zan

Overview

- **Tuesday:**
  - History and components of Medicare
  - Financial mechanism and challenges with Medicare
- **Thursday:**
  - Basics of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA/Part D)
  - Impact on people
  - Issues with drug reimportation and etc.

History of Medicare

- 1935 - the first health insurance bill was introduced in Congress
- President Lyndon B. Johnson on July 30,1965, to sign the Medicare to provide health and economic security to seniors
  - Expanded in 1972 to cover younger beneficiaries with permanent
  - Videos: http://www.kff.org/medicaid/40yearsvideo.cfm

Facts about Medicare

- Largest Social Insurance program in US
- Largest public payer of health care, with 20% of all health care spending
- In July 1966 19 million enrolled

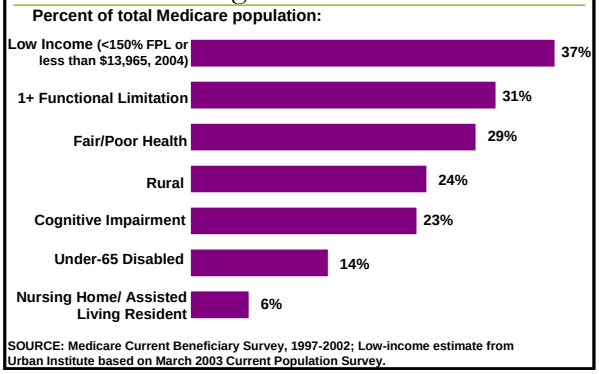
Eligibility

- Generally, you are eligible for Medicare if you or your spouse worked for at least 10 years in Medicare-covered employment, you are 65 years old, and you are a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant).

Coverage

- Covers 41 million people
  - 35 million elderly, 6 million under-65 disabled
  - Of the 6 million beneficiaries with functional limitations—measured as needing assistance with one or more activities of daily living (ADL) such as eating or bathing—two-thirds(65 percent) are women.

Medicare Covers a Population with Diverse Needs and Significant Vulnerabilities



SOURCE: Medicare Current Beneficiary Survey, 1997-2002; Low-income estimate from Urban Institute based on March 2003 Current Population Survey.

Compulsory Hospital Insurance (Part A)

- Part A: The basic Medicare coverage is also referred to as Part A compulsory hospitalization insurance. It's financed through payroll taxes that are shared by employers and employees alike. It's provided free to anyone who qualifies for Medicare benefits
- Helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Certain conditions must be met to get these benefits.

Supplemental Medical Insurance (Part B)

- The next layer of coverage, referred to as Part B supplementary medical insurance, covers most of what isn't covered by Part A and is paid for by the insured individual via an enrollment program.
- For 2003 the monthly premium is $58.70 and the coverage also involves a $100 annual deductible and a 20 percent per service co-insurance.

Part B cont.

- Helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.
- Cost: The Medicare Part B premium each month **($78.20 per month in 2005**). In some cases, this amount may be higher if the beneficiary didn't sign up for Part B when they first became eligible.
- Caution: If the beneficiary didn't take Part B when they were first eligible, the cost of Part B will go up 10% for each full 12-month period that they could have had Part B but didn't sign up for it, except in special cases. They will have to pay this penalty as long as they have Part B.

Medicare Advantage Program (Part C)

- Medicare + Choice is a newer program initiated in 1997 and referred to as Part C. If a beneficiary chooses Part C, it takes the place of Parts A and B.
- Is offered by private companies, who contract with the federal government, to cover the same or better benefits than the Original Medicare Plan (Parts A and B). Some Medicare Advantage plans include the new Medicare prescription drug coverage (MA-PD plans), others do not (MA plans).
- Part C is basically a Medicare HMO plan. In 2000 several carriers ceased offering this type of coverage and those individuals who had elected to go with a Medicare HMO had to backtrack and re-enroll in the original Medicare fee-for-service program (Parts A and B).

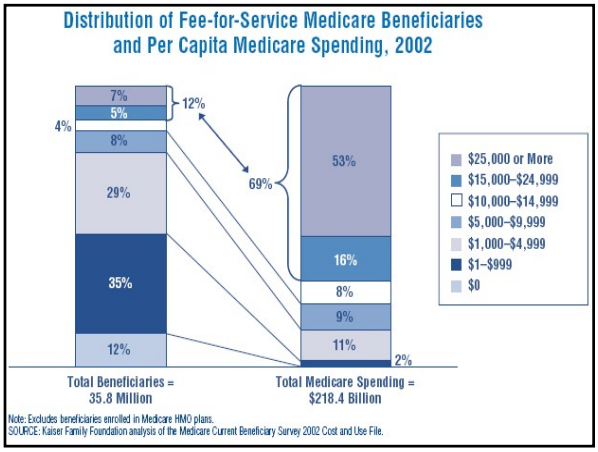
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (part D)

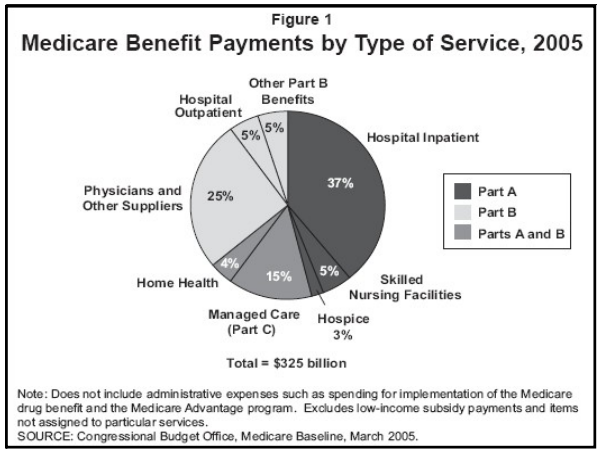
- In 2003, Congress signed into law the Medicare Prescription Drug, Improvement and Modernization Act.
- Everyone with Medicare can get this coverage
- Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium.
- Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (part D)

- You will pay a monthly premium. Insurers in Utah are offering 45 prescription plans with premiums ranging from $6.33 to $68 a month
- • You will have to pay the first $250 of your drug costs each year. This is called a deductible. Some plans offer a lower or no deductible.
- • After you pay the deductible, Medicare will pay 75% of the next $2,000 of your drug costs. You pay 25% of these costs or $500.
- • After **total** drug costs reach $2,250, you will pay 100% of drug costs on the next $2,850. This is called the coverage gap or doughnut hole. Once your out-of-pocket drug costs, not including premiums, reach $3,600 ($250 deductible + $500 coinsurance + $2,850 coverage gap) Medicare will start paying 95% of your drug costs. (See chart below)

Medicare Benefits, Spending, and Financing

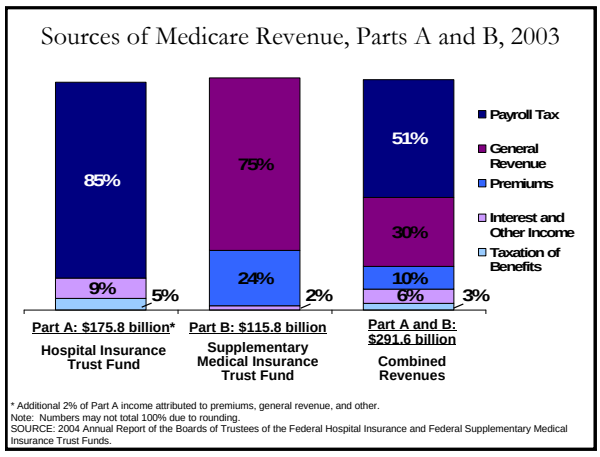


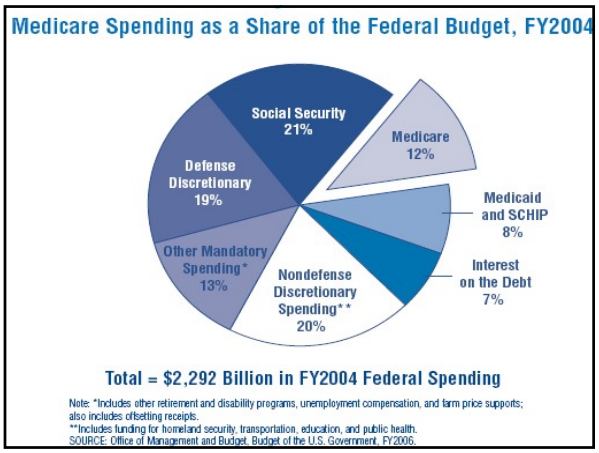


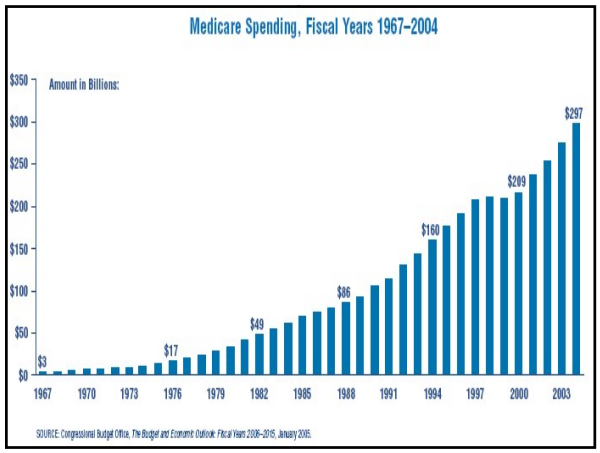
Major Funding Source for Part A & B

- Part A (HI): Mandatory payroll tax (85%*)
- Part B (SMI): Beneficiary payments and general tax revenues

* Note: data in 2003







Issues/Challenges with Medicare

Assumptions for Medicare Reform:

- •The aging of the baby boomers will bankrupt Medicare
- •Unable to control its costs
- •Forecasts of Medicare's future require that it be transformed
- •To mirror current private health insurance plans

Possible Ways to Help…

- Scaling back Medicare's drug program into an affordable program targeted at low-income seniors without drug coverage.
- Accelerating means-testing for all medical services throughout Medicare.
- Replacing the existing defined-benefit system with a new defined-contribution system for the baby-boomer generation.

Source: Robert E. Moffit. "The President's Modest Medicare Budget Proposal". Available at: http://www.heritage.org/Research/HealthCare/wm993.cfm

Assumption1: Aging of the Baby Boomers

- Aging will produce "unsustainable" expenditures for Med.
- Marmor (2001):
  - No correlation between aging and spending on Med (Figure1).
  - The argument ignores other factors, such as dependency ratio (Figure2)
  - Aging may cause greater financial demand, yet it does not mean these needs are unaffordable.

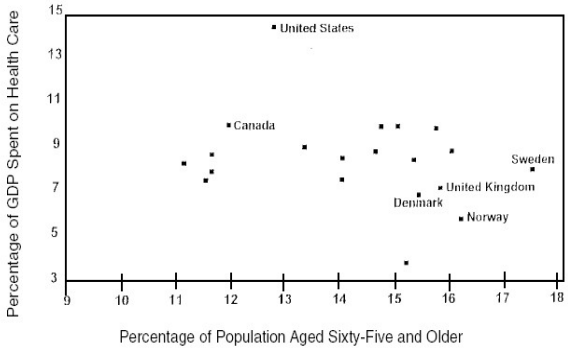


Figure 1 Relationship between Age of Population and Health Spending, OECD 1994

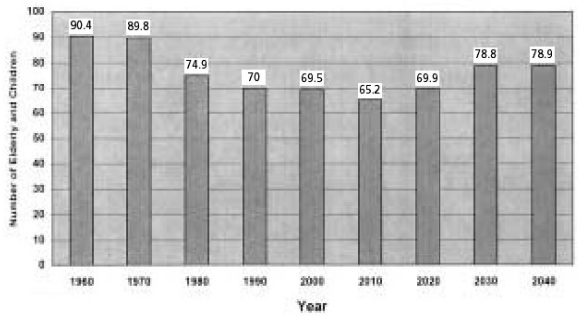
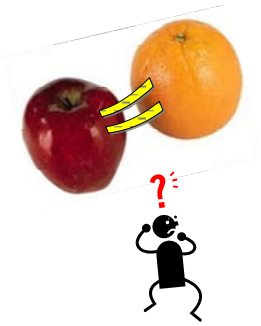
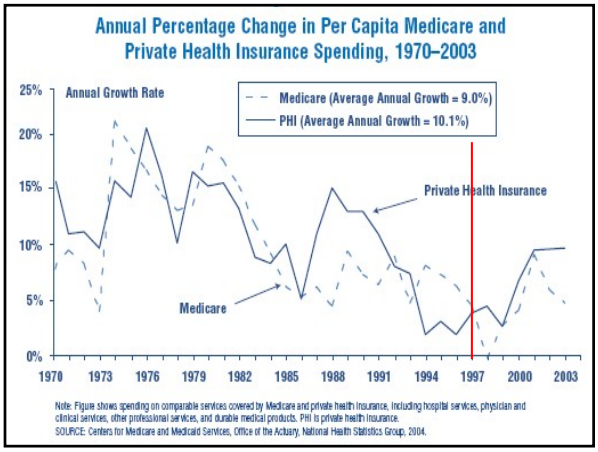


Figure 2 Past and Projected Number of Dependents per One Hundred Workers Aged Twenty to Sixty-Four. *Source*: Board of Trustees of the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds 1999.

Assumption 2: Unable to control its costs



- Remaking Medicare in the image of private health insurance to better control the cost.
- Marmor (2001):
  - Compare apples to apples, not to orange!



Assumption3: Forecasts of Medicare's future require that it be transformed

- **Forecasts:** program's aggregate cost, number of elderly beneficiaries, depletion of the Medicare Hospital Trust Fund, and etc.
- **Marmor(2001):** Extended forecasts cannot and should not be the dominant justifications for reform. Lots of variables affecting forecast; skeptical attitude toward forecast.

  E.g. the prediction of Medicare expenditure is affected by factors such as economic growth, projections of the number of elderly, their state of health, their preferences for medical care, the types and cost of medical services in the future, technological advances, and etc.

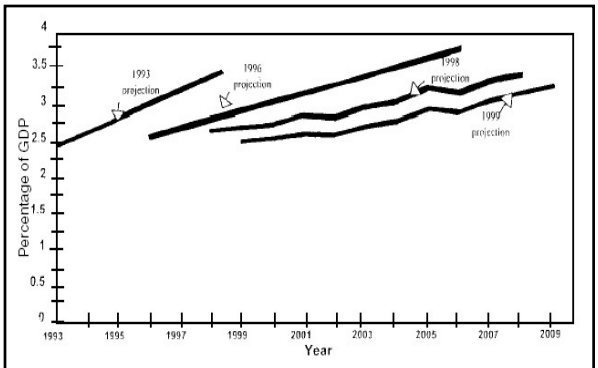


Figure 4 Medicare + Medicaid Spending, CBO Projections, Selected Years. *Source*: Aaron 1999: 21.

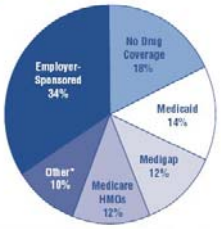
Assumption4:To Mirror Current Private Health Insurance Plans

- Bring Medicare more in line with the structure of private health insurance markets.
  - Historical parallelism from the birth of Medicare
  - Call for "equal treatment"
- Marmor:
  - Complaints about private "managed care" plans
  - no evidence that younger age cohorts support changes to remake the program in the image of much-criticized managed care.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA/Part D)

Presented by:
Flavio Canelada
Hua Zan

Prescription Drug Coverage Among Non-Institutionalized Medicare Beneficiaries, 2002



Total = 39.4 Million Non-Institutionalized Medicare Beneficiaries, 2002

- In 2002, nearly half of all Medicare beneficiaries lacked drug coverage for at least part of the year; 18%-full year; 27%-part of the year.
- Other Sources of accessing drug

Why Part D?

- Who are at greatest risk of being without drug coverage for the full year?
  - Beneficiaries with income between $10,001 and $20,000
  - Beneficiaries age 85 and older (compared with younger counterparts)
  - Beneficiaries living in rural areas (compared with urban areas)
- Drug affordability

Purpose of MMA

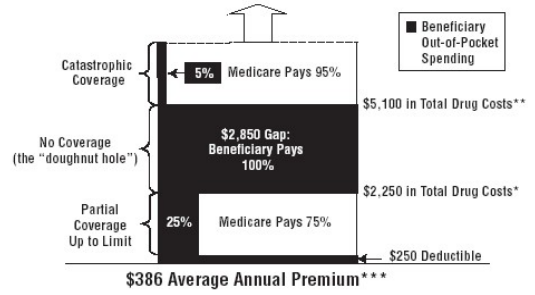
- MMA was enacted to extend coverage for prescription drugs to the Medicare population and to ease the financial burden of prescription drug spending for beneficiaries, esp. those with low incomes or extraordinarily high out-of-pocket drug expenses.

Facts about MMA

- Established in 2003, the biggest change since 1965.
- Actual benefit begins from Jan. 2006
- Medicare drug discount cards during the period from 2003 to Jan. 2006, provided through private firms
- Two types of private plans to provide Med. drug benefit:
  - Prescription drug plan (PDP)-34 Regions
  - Medicare Advantage plans that cover prescription drugs (MA)-26 Regions
- Standard MMA benefit

Figure 1

Standard Medicare Prescription Drug Benefit, 2006



Note: *Equivalent to $750 in out-of-pocket spending. **Equivalent to $3,600 in out-of-pocket spending. ***Annual amount based on $32.20 national average monthly beneficiary premium (CMS, August 2005).
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit described in the Medicare Modernization Act of 2003.

Figure 2

Medicare Prescription Drug Benefit Premiums and Cost-Sharing Amounts for Selected Years

	2006	2010	2014
Average Monthly Premium*	$32.20	$48.49	$64.26
Annual Deductible	$250	$331	$437
Initial Coverage Limit	$2,250	$2,980	$3,934
Coverage Gap (difference between initial coverage limit and catastrophic threshold)	$2,850	$3,774	$4,984

Note: *2006 premium amount is national average monthly Part D beneficiary premium, based on bids received from Medicare prescription drug plan applicants (CMS, August 2005); 2010 and 2014 premium amounts are estimated monthly national averages.
SOURCE: CMS; 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Figure 3

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligibles Income <100% of poverty ($9,570/individual; $12,830/couple)	$0	$0	$1/generic $3/brand-name; no copays after total drug spending reaches $5,100
Full-benefit dual eligibles Income ≥ 100% of poverty	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Institutionalized full-benefit dual eligibles	$0	$0	No copays
Individuals with income <135% of poverty ($12,920/individual; $17,321/couple) and assets <$6,000/individual; $9,000/couple	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Individuals with income 135%–150% of poverty ($12,920–$14,355/individual; $17,321–$19,245/couple) and assets <$10,000/individual; $20,000/couple	sliding scale up to $32.20*	$50	15% of total costs up to $5,100; $2/generic $5/brand-name thereafter

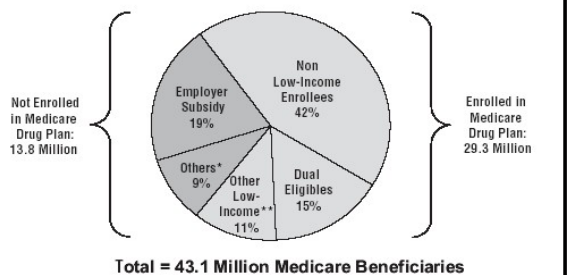
Note: Poverty level dollar amounts are for 2005. Additional assets of up to $1,500/individual and $3,000/couple for funeral or burial expenses are permitted. *$32.20 is the national monthly Part D base beneficiary premium for 2006.
SOURCE: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2006.

Interaction with Other Programs

- Employer-sponsored plans
- Medicaid
- Medicare Advantage
- Medigap
- State Pharmacy Assistance Programs

Figure 4

Estimated Medicare Prescription Drug Benefit Participation, 2006



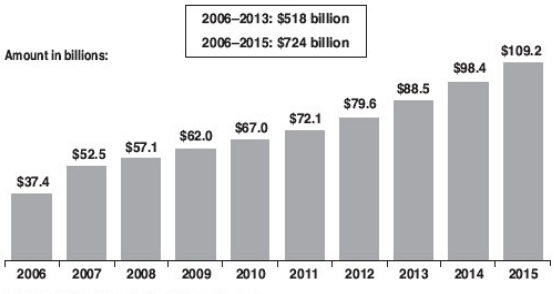
* "Others" not enrolled includes federal retirees with drug coverage through FEHBP or TRICARE, and those who lack drug coverage. ** "Other Low-Income" includes non dual eligibles with incomes <150% FPL.
SOURCE: HHS OACT, MMA Final Rule, January 2005.

Financing and Expenditure of MMA

- Financial Sources: premiums paid by beneficiaries, state contributions ("clawback"), and general revenues
- Projected net federal cost:
  2006-2013: $518 billion
  2006-2015: $724 billion

Figure 5

Projected Net Federal Cost of the Medicare Prescription Drug Benefit



SOURCE: Administration's FY 2006 Budget.

What do you think of MMA

•Pros:

With regard to the elderly and the low-income people who are more dependent on drugs, benefit helps cover a vital need.

•Cons:

- it offers little actual coverage, and add more financial burden on the Medicare system
- MMA prohibits Medicare from using its purchasing power to negotiate lower drug prices for beneficiaries.
- Efficiency concerns: complexity of MMA

●Debates about:

"Doughnut Hole" & "Health Saving Accounts".

Doughnut Hole

- **Pros:**
  - gaps in coverage could cause Medicare beneficiaries to restrict the use of necessary medications (avoiding "Moral Hazard")
  - **Moral Hazard**: an economic concept that represents the possibility that persons will be less willing to avoid something when they know that it is covered by insurance. In a health care context, moral hazard represents the risks that therapies or drugs will be chosen that are either redundant or unnecessarily costly because of the availability of insurance coverage.

Doughnut Hole (cont.)

- **Cons:**
  - The structure of MMA leaves many beneficiaries, esp. those with a heavy burden of chronic disease, with little incentive to add new medicines because of their position in doughnut hole.

Health Savings Accounts (HSAs)

- HSAs offer a tax free shelter for those with high deductible insurance.
- Pros: HSAs will encourage people to more closely monitor their health care spending and bring down medical cost.
- Cons:
  - It will add federal budget deficit (could cost $6.4 billion over the next decade)
  - It removes the owners of these accounts from the shared risk that has been the core of the health insurance system.
  - The tax shelter will benefit the wealthy and draw young, healthy workers out of health care plans.
  - It would be hard to reform the health care system if a large number of people are self-insured.

How it could affect vulnerable people

• The purpose of MMA

•Study of Walid F. Gellad et al. (2006):

- Relationship between race/ethnicity, income, and chronic health conditions and projected total drug spending
- Out-of-pocket drug spending changes before and after the drug benefit takes effect

EXHIBIT 1
Distribution Of Projected Drug Spending Under The Standard Medicare Drug Benefit For Vulnerable Populations, By Annual Spending Amount, 2006

Doughnut Hole

	Percent spending various amounts each year[a]			
	<$250	$251–$2,250	$2,251–$5,100	>$5,100
Total population	23.2%	46.6%	21.0%	9.2%
Race/ethnicity[b]				
Hispanic	27.5	45.0	20.4	7.1
African American	29.0	46.0	14.9	10.1
White	22.3	46.9	21.5	9.3
Household income[c]				
<$21,450	22.6	46.4	21.2	9.8
$21,451–$34,289	20.4	46.3	22.5	10.8
$34,290–$55,285	24.0	46.4	20.7	8.9
>$55,285	26.3	47.4	19.3	7.0
Chronic conditions[b]				
0	55.2	36.3	7.0	1.5
1	20.3	56.5	18.6	4.5
2	8.6	53.4	27.1	11.0
3 or more	3.3	38.6	34.9	23.1

SOURCE: Authors' analysis of data from the Medical Expenditure Panel Survey, 1996–2000.
NOTES: Weighted percentages. N = 5,996, representing 22,973,595 individuals. Rows might not add to 100 percent because of rounding. Data for Asians and other groups are not presented because of small sample sizes.
[a] Using 12 percent inflation factor, including those with employer-sponsored coverage.
[b] $p \leq .005$ for trend.
[c] $p \leq .05$ for trend.

Mean Annual Out-Of-Pocket Drug Costs Before And After The Implementation Of The MMA Standard Medicare Drug Benefit

	Annual out-of-pocket drug costs			
	Pre-MMA	Post-MMA	Absolute difference	Adjusted difference[a] (95% CI)
Total	$1,192	$ 966	$226	
Race/ethnicity				
Hispanic	1,018	843	175	−142 (−265, −19)
African American	1,050	872	178	−106 (−238, 27)
White	1,212	979	233	Reference
Household income				
<$21,450	1,375	1,008	367[b]	72 (−52, 197)
$21,451–$34,289	1,259	1,051	208	8 (−99, 115)
$34,290–$55,285	1,122	951	171	−14 (−127, 100)
>$55,285	976	825	151	Reference
Insurance coverage				
No supplemental coverage	1,345	884	461	Reference
Employer sponsored	857	989	−132[b]	−576 (−664, −489)
Self-purchased	1,540	1,041	499	20 (−89, 128)
Chronic conditions				
0	445	347	98	Reference
1	959	764	195[b]	84 (21, 147)
2	1,403	1,173	230[b]	135 (59, 210)
3 or more	2,191	1,774	417[b]	332 (197, 468)

SOURCE: Authors' analysis of data from the Medical Expenditure Panel Survey, 1996–2000.
NOTES: Data for Asians and other groups are not presented because of small sample sizes. CI is confidence interval.
[a] Adjusted difference represents savings with the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 after adjusting for other variables in the model. Savings are compared with the reference group, and a positive number

Mean Annual Out-Of-Pocket Drug Costs Before And After The Standard MMA Medicare Drug Benefit, For Seniors Without Employer-Sponsored Coverage

	Annual out-of-pocket drug costs			
	Pre-MMA	Post-MMA	Absolute difference	Adjusted difference[a] (95% CI)
Total	$1,427	$ 949	$478	
Race/ethnicity				
Hispanic	1,075	825	250[b]	−$237 (−396, −78)
African American	1,195	874	321[b]	−237 (−422, −52)
White	1,461	960	501	Reference
Household income				
<$21,450	1,482	957	525	53 (−134, 241)
$21,451–$34,289	1,490	1,030	460	11 (−164,187)
$34,290–$55,285	1,419	943	476	35 (−156, 226)
>$55,285	1,250	825	425	Reference
Insurance coverage				
No supplemental coverage	1,345	884	461	Reference
Self-purchased	1,540	1,041	499	−20 (−130, 89)
Chronic conditions				
0	531	337	194	Reference
1	1,153	751	402[b]	193 (110, 277)
2	1,627	1,188	439[b]	257 (154, 360)
3 or more	2,710	1,742	968[b]	769 (562, 977)

SOURCE: Authors' analysis of data from the Medical Expenditure Panel Survey, 1996–2000.
NOTES: Data for Asians and other groups are not presented because of small sample sizes. CI is confidence interval.
[a] Adjusted difference represents savings with the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, after adjusting for other variables in the model. Savings are compared with the reference group. A positive number therefore represents more savings, and a negative number represents smaller savings, than the reference group.
[b] $p \leq .05$ for absolute difference compared with reference group.

Findings

MMA's drug benefit might produce modest declines in out-of-pocket drug spending for most seniors, yet the savings might not be equitably distributed.

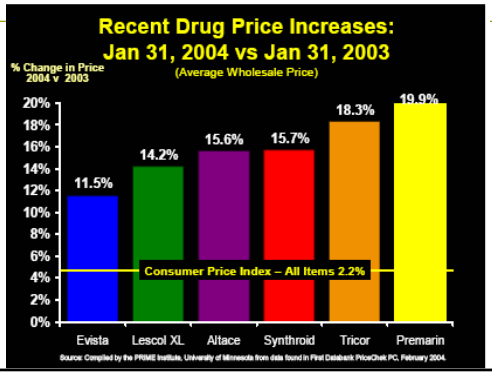
Drug price problematic.

Drug Re-importation

Importing prescription drugs to the United States will lower prices here and, in the long run, force Europe to pay more drug research and development costs. The best way to break down price controls is to open up markets.

Source: Stephen W. Schondelmeyer, Pharm.D., Ph.D.
Professor and Director, PRIME Institute Head, Dept. of Pharmaceutical Care & Health Systems
College of Pharmacy
University of Minnesota

Drug price



Drug Price Comparison

DRUG	U.S. PRICE	EURO. PRICE
Allegra 120	$69.99	$20.88
Atarax	$28.62	$4.20
Biaxin 250	$113.25	$61.74
Claritin	$63.06	$16.05
Coumadin	$37.74	$8.22
Glucophage	$30.12	$4.11
Lipitor	$52.86	$41.25
Premarin	$17.10	$9.90
Prozac	$71.94	$44.10
Zestril 5	$25.92	$5.52
Zithromax 500	$486.00	$176.19
Zyrtec	$50.10	$17.73

Drug Costs Not Lower Through Part D – who is paying the price?

Comparing Drug Prices

Drug	Dosage Quantity	Plan D Average*	VA	Canada	drugstore.com	Costco
Advair Diskus	250/50 60	$156.22	$92.35	$89.29	$147.99	$153.97
Aricept	10 mg. 30	142.87	88.07	139.92	134.99	144.39
Celebrex	200 mg. 30	85.08	50.20	44.63	83.99	82.67
Fosamax	70 mg. 4	69.72	41.11	42.83	69.99	68.08
Lipitor	10 mg. 30	71.27	41.57	55.51	68.99	68.35
Nexium	40 mg. 30	125.23	81.64	67.37	123.99	137.07
Plavix	75 mg. 30	127.60	74.06	76.63	116.99	119.66
Prevacid	30 mg. 30	134.86	70.85	63.42	124.99	127.80
Protonix	40 mg. 30	113.45	21.11	64.42	111.12	102.67
Zocor	20 mg. 30	131.81	69.27	73.10	135.99	131.29
Totals		$1,158.11	$630.23	$717.12	$1,119.03	$1,125.95

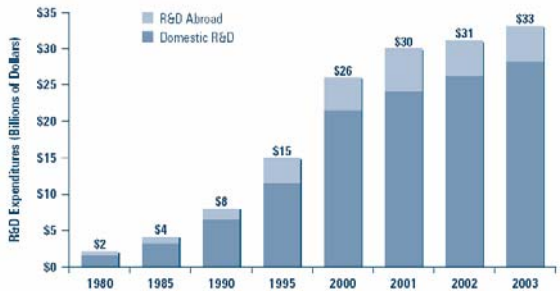
*As calculated from prices provided by Medicare. Source: US House of Representatives Committee on Government Reform - Minority Staff, Special Investigations Division.

A report from the House Government Reform Committee found that drug prices offered by the Medicare drug plans are more than 80% higher than prices negotiated by the federal government for the Department of Veterans Affairs and 60% higher than prices paid by consumers in Canada.

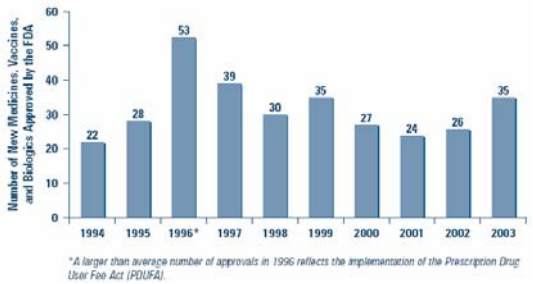
2003 Pharmaceutical Sales by Region

World Audited Market	2003 Sales ($ billion)	% of Global sales ($)	% Growth (constant $)
North America	229.5	49%	11%
European Union	115.4	25%	8%
Rest of Europe	14.3	3%	14%
Japan	52.4	11%	3%
Asia, Africa and Australia	37.3	8%	12%
Latin America	17.4	4%	6%
TOTAL	**$466.3**	**100%**	**9%**

Growth in R&D

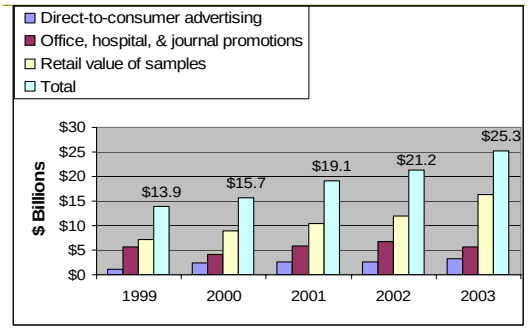


Number of Drugs Approved by the FDA Each Year



Source: U.S. Food and Drug Administration, January 2004.

U.S. Marketing Expenses



Source: http//:www.phrma.org (2004)

Final Question

- So putting together all those data about the growth in in research and development, the size of Us market compared with the rest of the world and the marketing expenses of drug companies and drug price differences acroos countries.
- Would you be in favor of drug re-importation? Or why do you think Pharmaceutical Drugs needs to be a closed market?

Any Questions?