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# Perspective on the New Medicare Law

Medicine has seen remarkable changes in the past four decades that have resulted in our living longer, healthier lives. But for senior citizens in the United States to receive the benefits of modern medicine, it literally took an act of Congress. The Medicare Prescription Drug Improvement and Modernization Act of 2003, signed by President George W. Bush on December 8, 2003, delivers on the promise to provide the best health care to our greatest generation.

This landmark legislation would not have become law without compromise. No single lawmaker saw his or her ideal bill become law. However, we successfully enacted a law that will dramatically improve health care for seniors. In his State of the Union address on January 20, 2004, President Bush vowed to veto any bill that would limit seniors' choices or take away their drug coverage.

Congress transformed Medicare, at its core, from a bill-paying program for sick patients to one designed to keep seniors healthy. For the first time, Medicare will cover a physical examination when seniors enroll in the program in order to establish a solid foundation for ongoing treatment. Seniors will also receive regular cardiovascular and diabetes screenings to preemptively diagnose health problems before they become chronic or severe. These screenings are critical, since more than 60 percent of seniors have chronic conditions, and nearly two thirds of all Medicare funds are spent on seniors with five or more chronic conditions. Medicare will establish new disease-management programs to identify patients at risk, coordinate care, and encourage self-monitoring by patients in order to improve health outcomes.

The new law addresses Medicare's most fundamental flaw: the absence of a prescription-drug benefit. Too many low-income seniors have gone without their prescriptions, and many middle-income seniors with high drug costs have been threatened with economic ruin. In addition, seniors without prescription coverage often pay the highest prices even though they consume the most drugs.

Private insurance plans have voluntarily covered prescription drugs in order to prevent, treat, or manage diseases more cost effectively and less invasively than can be done with such alternative treatments as surgery. Medicare, however, has not kept pace with modern medicine. With the enactment of this modernization bill, Congress has made a fundamental breakthrough in health care for seniors.

Fourteen million low-income seniors (defined as those with an annual income of $15,400 for an individual or approximately $20,000 for a couple) will now have comprehensive drug coverage. When these seniors go to the pharmacy, they will pay $1 or $2 for generic drugs and $3 to $5 for brand-name drugs; they will have no monthly premium and no gap in coverage. Low-income persons will receive this additional help through Medicare rather than through a patchwork of varying state Medicaid programs, including some that have been limiting prescriptions to three per month or restricting access to popular drugs. Congress believes that all seniors in the United States — no matter where they live — should have a drug benefit of the same quality.

All seniors, regardless of income, are entitled to a voluntary prescription-drug benefit, which will provide protection against catastrophic costs and good coverage for those with moderate costs. The

new law covers three quarters of the first $2,250 in drug costs after a $250 deductible and 95 percent of drug costs after a beneficiary spends $3,600 out of his or her own pocket. The nearly two thirds of beneficiaries who have annual drug costs of less than $2,250 will have no gap in coverage. The catastrophic protection is critical, since future cures for conditions such as Alzheimer's disease and arthritis are likely to be expensive. To provide immediate help to seniors, a drug-discount card will be available by this summer. The card will provide all seniors with real savings and low-income seniors with $600 in additional assistance with drug costs. Already, more than 70 companies have expressed interest in sponsoring the cards.

The new law provides a 75 percent subsidy for the drug benefit — similar to that offered to government workers and legislators by the Federal Employees Health Benefits Program. Congress deliberately did not establish in law the dollar amount of the premium, because more efficient drug plans that aggressively negotiate with pharmaceutical manufacturers for lower prices should be allowed to charge a lower premium. The new law also provides tax-free subsidies to employer-sponsored and union-sponsored retiree plans so that seniors can keep the coverage they have today.

The new law does more to cut drug prices than any other action ever taken by Congress. The Generic Pharmaceutical Association endorsed the law because it will expedite the entry of cheaper generic drugs into the market. According to the nonpartisan
Congressional Budget Office, the law saves seniors between 20 and 25 percent, because plans will have both the tools and the incentives to negotiate lower prices. Indeed, the office estimated that one particular provision, which exempts Medicare prices from the Medicaid "Best Price," will save $18 billion by encouraging steep discounting by pharmaceutical manufacturers. Finally, the law reforms the corrupt "average wholesale price" payment system for drugs that are currently covered by Medicare. Before this reform, seniors' 20 percent copayment often exceeded the entire retail cost of the drug. Furthermore, physicians were encouraged to prescribe drugs on the basis of the biggest difference between the average wholesale price and the actual acquisition price, rather than focusing on what was clinically best for the patient.

Just as important, the law promotes higher quality. All drug plans must use pharmacy therapy-management programs to avert adverse drug interactions. Incentives to prescribe medications electronically will help ensure that patients receive the right prescription and will reduce the volume of unnecessary paperwork and calls between pharmacists and physicians. If a plan uses a formulary, it must be established by practicing physicians and pharmacists relying on peer-reviewed medical literature. Seniors will be informed about the way in which these formularies operate and what specific drugs are covered or preferred. All seniors are entitled to both an internal appeal and an independent external appeal for the coverage of drugs that are not on the "preferred" list.

Even as Congress adds a new benefit to Medicare, the fiscal challenges facing the program are substantial. Before the enactment of this law, Medicare spending was expected to double over the next decade, as 77 million baby boomers begin to retire. That is why another feature of the Medicare law is the expansion of opportunities for seniors to participate in integrated health care plans under Medicare. Congress believes that private plans and competition will help to drive down the explosive growth of Medicare spending.

Currently, about 12 percent of seniors are enrolled in private plans. Many seniors prefer these plans because they often offer better coverage and coordinated care than traditional fee-for-service Medicare. However, some private plans have withdrawn from Medicare because reimbursements have been

erratic and the government generally has not been a reliable business partner. In addition, people in most rural areas have not had access to these plans.

The new law ties the increased payments received by these plans to the costs of the traditional Medicare program. In 2006, the law will encourage the participation of regional, multistate preferred provider organizations. When plans submit bids to provide integrated care below a set benchmark price, there will be shared savings, with 75 percent going to the beneficiary in the form of lower premiums or better benefits and 25 percent going to taxpayers. Thus, taxpayers will share in the savings as seniors make rational choices.

However, because the payment benchmarks will increase with the growth of fee-for-service programs, the payment formula does not permit bids by private plans to slow the growth rate of Medicare. The bill passed by the House included a more dynamic competitive system, which would pay plans according to a weighted-average formula. The promise of this reform is that as beneficiaries en-roll in more efficient plans, those plans will have greater influence in establishing the weighted average in the subsequent year, thereby allowing competitive forces to change the growth rate. Unfortunately, the conference ultimately agreed only to a pilot program testing this type of direct competition in six metropolitan areas.

Another critical reform that will help to extend the life of Medicare is "income relating" on the Part B premium. This marked change for Medicare recognizes that not all beneficiaries have the same needs or resources. When Medicare was first enacted, 50 percent of Part B was financed through beneficiary premiums and 50 percent was paid for by taxpayers. Today, the cost sharing has shifted to a 75–25 split, with taxpayers picking up the extra 25 percent. Clearly, the wealthiest 3 percent of seniors do not need the same assistance as low-income and middle-income seniors. Therefore, under the new law, persons with an income of more than $80,000 or couples with an income of more than $160,000 will receive a smaller subsidy starting in 2007.

The new law also reforms the payments to and regulation of the providers that serve Medicare. One key reform is to pay more to those hospitals that provide Medicare with data on quality outcomes. This policy will enable seniors to comparison shop among hospitals on the basis of widely recognized measures of quality. In addition, the law blocks a scheduled 4.5 percent cut in payments to physicians. Third, physicians, hospitals, and home health care agencies operating in rural and underserved areas will receive long-overdue and needed payment increases. Fourth, payments for durable medical equipment (such as wheelchairs, bedpans, and hospital beds) will move from a government-set fee schedule to competitive bidding — a reform that will save beneficiaries and taxpayers billions of dollars. Finally, the bill streamlines Medicare's confusing and voluminous regulations so that physicians and other providers can spend more time on patient care and less time on paperwork.

A new health care law of this magnitude requires that seniors receive complete information about the changes. That is why Congress provided $1.5 billion to the Department of Health and Human Services to implement the new law and provide comprehensive information to Medicare stakeholders. The new law will markedly improve the health care of 40 million seniors and begin making Medicare more efficient and responsive to the beneficiaries, providers, and taxpayers it serves.