

Insurers whack elderly to celebrate new year

What better way to start the new year than to sock it to grandma and grandpa with big price increases? That may not have been the exact nature of the conversation at the insurance companies that participate in the Medicare prescription drug plan, but it sure was the outcome, as premiums are scheduled to rise by an average of almost 25 percent in 2008. The sharp price hikes for 2008 could mark the beginning of the end of the relatively good news in the drug plan's first two years of existence.

The first two years could be viewed as reasonably successful, since most seniors were covered by the plan. According to the Centers for Medicare and Medicaid Services (CMS), nearly 80 percent of the eligible population either signed up for the plan directly or are covered indirectly through an employer-sponsored plan. While enrollment is 10 percent less than had been projected, and many of those enrolled had already been covered by employers or Medicaid, Part D still provided benefits to more than 10 million seniors who previously had to pay for their drugs out of pocket.

The cost of the plan in the first years has also been somewhat lower than had been projected by either the CMS or the Congressional Budget Office. Based on lower than expected costs, both agencies have revised downward their projections for the program's cost by more than \$100 billion over its first ten years.

Of course, even this good news is relative. The program still leaves many seniors with hefty drug bills. A recent study by the Kaiser Family Foundation found 8 percent of Part D beneficiaries had drug bills of more than \$300 a month and nearly one-fifth reported either delaying or not a filling a prescription due to the cost. Among beneficiaries with three or more chronic conditions, nearly a quarter either delayed filling a prescription or did not fill it due to the cost. In other words, for a very substantial portion of the elderly, Medicare Part D is proving insufficient to allow them to get the drugs they need.

This is especially unfortunate, because the program could have been far more efficient and effective if Congress had designed it to serve seniors instead of the insurance and pharmaceutical industries. The whole idea of stand-alone prescription drug insurance is an invention of Congress.

Stand-alone prescription drug insurance is like rear-end accident collision auto insurance. Such policies don't exist in the private sector for an obvious reason: They create needless complications and waste. It was a historic oversight not to have Medicare include prescription drug coverage when it was created in 1965. Congress

could have rectified this mistake by simply adding the money appropriated for Part D to the existing program and have it now include prescription drugs. The private plans that operate within Medicare could have also received this additional payment.

However, instead of creating a simple, efficient program, Congress wanted to stack the deck in favor of the insurance industry. Therefore, they required tens of millions of seniors to buy stand-alone drug plans, which would only be offered by the insurance industry, if they wanted assistance in paying for their drugs. This fragmentation process also pleased the drug industry, since it prevented Medicare from using its bargaining power, like the Veteran's Administration, to push down the cost of drugs. The unnecessary administrative costs, combined with high drug prices, are the reasons so many seniors still have difficulty paying for their drugs.

And the situation is about to get worse. It seems the insurers repeated the bait-and-switch approach from the mid-90s. When the Republican Congress created the "Medicare Plus Choice" program, many insurers entered the Medicare market with low prices in order to capture market share. They soon raised their prices to levels that allowed them to hit profit targets, or left the market.

The same process seems to be taking place with the insurers in the Medicare Part D program. It is not easy for seniors to change drug plans. In fact, they are locked into a plan for most of the year. They can change plans for the following year, during the last six weeks of the prior year. Most people had difficulty selecting their plan initially, with the typical enrollee taking more than eight hours to choose a plan. It is understandable most do not want to go through this process again, especially since they cannot be guaranteed they will end up with a better plan.

This explains the 25 percent premium increases we're seeing for 2008 and which we might see again in future years. Betting that beneficiaries are pretty much stuck with their existing plans, the insurance companies have adopted the whack-granny strategy. It might not be pretty, but it's healthy for the bottom line. At least someone can look forward to a good year.

With attribution to Dean Baker, co-director of the Center for Economic and Policy Research; article first appearing in the Jan. 7 issue of Truthout.

To find out more about HR.676, the proposal for improved and strengthened Medicare for All, visit www.healthcare-now.org.

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