VIEWPOINTS

Medicare Part D in the Face of Health Care Reform

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As the health care reform debate continues to dominate news during this period, it may be instructive to consider the most recent major health care insurance proposal enacted in the past 5 years. This is of course the Medicare Part D Drug Benefit. Constructed during the previous administration and now in place since January 1, 2006, the Medicare Part D program has a muddled track record of outcomes. In many ways, it provides an excellent case study of how not to implement a change in health care insurance. The Medicare Part D Program is a market-based model of a government subsidized health insurance program component.

This program was enacted with much hype and very high expectations. The program has helped many Medicare recipients, provided a much needed impetus for pharmacy education and pharmacists to focus on outpatient pharmacy services necessary for patients, and provided an incredibly profitable program for health insurance companies providing Medicare Part D and/or Medicare Advantage Plans.

A Kaiser Family Foundation analysis¹ indicates that the number of prescription drug plans available for low-income Medicare recipients decreased over a 3-year period between 2006 and 2009. In effect, 2 million low-income patients are now paying for coverage previously provided within the benefit, while close to 2 million other patients were reassigned to a different plan.¹

PHARMACY PARTICIPATION

The percentage of pharmacy participation in Medicare Part D is very high; however, not all pharmacies are participants in each of the Medicare Part D prescription drug plans. The relatively low reimbursement rate, coupled with delays in payments for services provided, have challenged participating pharmacies.²

Patient Benefit

For the period of 2006-2009, the median premiums paid by beneficiaries increased by 35%.¹ During 2008-

2009 alone premiums increased by 17%.¹ Cost-sharing requirements for recipients also increased by 35% over the 3-year period.¹

The Future

The release of the latest Medicare Annual Report projects the Medicare hospital insurance (HI) trust fund will be exhausted by the year 2017.³ The annual updating report from 2008 indicated solvency of the HI trust fund through 2019, so in a 1-year period (June 2008 to June 2009), a 2-year decrease has been projected. Medicare Part D, along with Medicare Part B, is funded through a supplementary medical insurance (SMI) fund that is separate from HI. Although SMI is projected to be solvent over the same time period as Medicare HI, the state of the economy, increased demand for services, and looming health care reform could change the metrics of SMI very quickly.

Considering the viability of Medicare Part D in the context of the current health care milieu is one thing, however, with prospects of health care reform moving forward at an accelerated pace, current funding and future funding options might be dramatically challenged.

HEALTH CARE REFORM

The discussion of health care reform in the United States is carried out in a uniquely American context. The discussion is a parochial one, and examining systems in place internationally seems to be not an option. Curiously, successful options for care in the United Kingdom, Canada, Australia, and elsewhere have not been seriously considered. Change in options is okay if and only if current systems or insurers are retained in a "new" system.

When other countries have revised their health care systems, existing systems in place elsewhere were considered in crafting a new delivery and insurance structure. For example, Taiwan looked at the best options available in numerous systems when reforming its system of insurance and delivery of care.⁴

Eight elements of health care reform receiving attention in the current US debate have included elements of the following:

- Universal coverage (horizontal equity in health economics terms).

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- Placing a cap on the amount insurance companies can spend administratively.
- Somehow limiting insurance company profits.
- No elimination of coverage for patients with pre-existing health conditions.
- Standardizing care coverage at different levels (vertical equity in health economics terms).
- Ensuring that all plans cover a range of benefits.
- Allowing for comparisons between plans by consumers in an easier fashion than currently available.
- Eliminating premium markups based on differing levels of health status.
- Minimizing premium variations based on age.

Discussion of the final form that a revised health care system would have remains a fierce debate. Changes suggested to be possible include eliminating the tax free status of health insurance coverage, reduced profits for providers and institutions, expansion of coverage for the current underinsured and uninsured, and penalties for corporations and businesses who do not participate in the revised plans.

Congressional debate and subsequent plans for health care reform in both the House of Representatives and the Senate is not necessarily bipartisan in nature, this alone has been suggested to be extremely problematic.⁵ With the Obama Administration intent on passing legislation reforming the US health care system, how specific patients, providers, and insurers will fare is anyone's guess. Estimates placing the cost of a revised health care system amounting to \$1.2 trillion or more over a 10-year period lead to the conclusion that hospitals, providers, and health professions' education will see unprecedented turmoil over the near and long-term future.⁵

Impact on the Academy

The exact impact of health care reform on pharmacy education is most uncertain at this juncture. State support

for higher education, private institutional financial health, and funding for research remain in a dramatic state of flux at present. The influence of the state of the economy, the economic health of the institutions, and pharmacies providing clerkship support for our programs and students, and the viability of our schools and colleges in the future suggest that changes will be dramatic in our programs. Regardless of how specific programs may be flawed, how these programs, such as Medicare Part D, provide coverage for patients could change in a matter of months. These changes will dramatically influence how pharmacy services are provided.

Justifying our existence currently and in the future might be the most prominent focus for the academy as we face an uncertain future in our higher education systems, health care delivery points of care, and changes in payment programs for insurance and provision of care in the clamoring climate of health care delivery and insurance for such in the United States.

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