# ...New Medicare drug plan costs taxpayers $32.1 billion

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month for the first year.

However, the subsidy program seems to favor employer-sponsored retiree drug plans over union-sponsored plans. That's because the subsidy is a tax-free grant given directly to the "plan sponsor." Union benefit trusts are already tax-exempt. But companies pay taxes on ordinary income. That means that all other things being equal, a large company would get a bigger rebate sponsoring its own plan than contributing to a union plan.

It's not clear the subsidy will work in any case. In 2005 the Kaiser Family Foundation sponsored a survey of 300 large employers that provided retiree drug coverage. About 10 percent said they intended to drop coverage in the first year of the new program. An equal number planned to supplement government-sponsored plans with additional coverage. Expectations of remaining in the subsidy program dropped each year for the next few years.

Kathryn Bakich, head of National Health Compliance for Segal Company, the largest benefits consulting firm in the U.S., said it was impractical for unions and employers to change what they were doing in the first year, because details of the new plans weren't announced until September 2005.

"Most of our clients are taking the subsidy," Bakich said.

The Medicare Modernization Act leaves almost no private health care entity unhelped. After the employer subsidy, there is gravy for others lower on the food chain: rural hospitals, medical equipment manufacturers, auditors, actuaries, doctors. In every case, the vision is to use government regulation, and taxpayer dollars, to assist the private sector.

"There are certainly contexts where the private sector is markedly more efficient," says Yale University political science professor Jacob Hacker. "But in this case. essentially what the government is providing is insurance, and when it comes to insurance, there's a very strong rationale for the government to be the primary insurer because it's so much better at spreading these risks and doing it in a more efficient way."

HMOs and PPOs have lost credibility as efficient ways to finance health care, adds the Urban Institute's Berenson.

"Health plans have failed in the private sector," Berenson said. "They're passing on all the cost increases mostly to workers in the form of increased co-payments. And in the face of that record, Congress goes and says we now want them to solve Medicare's problems."

Last year, the Congressional Budget Office estimated that the new Medicare drug benefit will cost taxpayers $32.1 billion in 2006. That outlay is expected to triple in seven years.

But unlike original Medicare, which was largely self-funding, the drug benefit is a new expense without any plan for new revenue. There is no equivalent plan to raise taxes, on the rich or anyone else, to pay for the program. In fact, the Bush Administration has been dismantling old taxes and breaking all previous records for running up deficits. That means that the overpriced drugs it's subsidizing for today's seniors will be paid for, with interest, by tomorrow's taxpayers.

The bill will eventually come due.

# Medicare drug program mindbogglingly complex

**By DON McINTOSH**
**Associate Editor**

There's a new government benefit available for senior and disabled citizens who are eligible for Medicare — subsidized prescription drug coverage.

That's the good news. The bad news is: The program is insanely mindbogglingly complex.

In a nutshell, here's how the new program works, from the beneficiaries' standpoint: Senior and disabled citizens who are eligible for Medicare — and who don't have existing drug coverage — have until May 15 to sign up for a Medicare-approved private insurance plan.

Participation is voluntary, but if they don't sign up by May 15 and later want to join, they face a late penalty of higher premiums. The penalty is 1 percent each month.

Medicare says the new drug coverage will pay about half the cost of drugs for the typical senior. Though some plans are more generous than others (and may have higher premiums) plans have to offer at least a basic minimum benefit. The minimum benefit looks like this: Beneficiaries pay the first $250 (a deductible). From $250 to $2,250 they pay 25 percent of drug costs (a co-pay). From $2,250 to $5,000 they pay 100 percent of the drug costs (this is termed a coverage gap or "donut hole"). And for costs above $5,000 a year, they pay 5 percent.

Formularies — lists of covered drugs — also differ among plans and can change at any time. But the plans are required to offer at least two drugs in each of 43 therapeutic categories.

In Oregon, there are 71 Medicare-approved private prescription drug insurance plans to choose from; in Washington, 73. Each plan is different, with different monthly premiums, deductibles, co-pays, different drugs covered, and different pharmacies participating. Some plans are "stand-alone" plans that go with traditional Medicare. Others are "Medicare Advantage" plans that have added a drug benefit to a set of other benefits. Medicare Advantage plans are like government subsidized HMOs. But they replace "traditional Medicare" so you can't have both at the same time.

In the Northwest, the average premium cost of a new Medicare stand-alone drug plan is $32 a month. That would be in addition to the $88.50 monthly premium for basic Medicare.

By visiting the Medicare Web site and plugging in preferred pharmacy and the list of prescription drugs currently taken, seniors can narrow the list of choices down to just 6 or 10.

But then, a 2005 poll by the Kaiser Family Foundation found that 73 percent of seniors had never gone online at all. So they'll need someone else to do it for them — relative, friend, co-worker, neighbor, or government-provided volunteer.

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