

**HUDSON
INSTITUTE**

**The
Medicare
Drug Benefit
Five Years Later
IS IT WORKING?**

Edited by Hanns Kuttner and Tevi Troy

DECEMBER 2011

The Medicare Drug Benefit Five Years Later IS IT WORKING?

Edited by Hanns Kuttner and Tevi Troy

**Based on a conference held at Hudson Institute,
Washington, DC, September 15, 2011**



© Hudson Institute 2011

Contents

Section I

Introductory Essay by Hanns Kuttner1

Section II11

Conference

Remarks by Sec. Michael Leavitt13

Panel Discussion20

Doug Badger

James C. Capretta

Mary Grealy

Jack Hoadley

Hanns Kuttner (Moderator)

Notes.....38

MEDICARE PART D: A PRESCRIPTION DRUG BENEFIT

Beneficiaries can get Part D benefits either through stand-alone prescription drug plans (PDPs) or by enrolling in a Medicare Advantage Prescription Drug Plan (MA-PD), an alternative to fee-for-service traditional Medicare that provides the entire Medicare benefit. In 2010, 38 percent of beneficiaries were enrolled in PDPs and 21 percent in MA-PDs.

Those who enroll pay a monthly premium, \$30 on average in 2011. Those who qualify for low-income subsidies (LISs) do not have to pay a monthly premium, nor do they face a deductible, and their co-insurance is a flat, per-prescription amount. About 36 percent of Part D enrollees had LISs in 2010. Those who get the LIS and want to avoid a premium must be attentive to the plan they choose. The average of what plans in a given area charge as a premium for their basic benefit determines a threshold. Those who choose a plan with a premium below this threshold pay no premium.

The Part D Benefit

The law created a standard benefit that serves as a reference point. Most beneficiaries are enrolled in plans that differ from the standard benefit in some way. For example, 68 percent of PDPs offered a tiered copayment schedule, with the copayment for a particular drug dependent on the “tier” to which it is assigned. The standard benefit includes a deductible, 25 percent co-insurance once an individual’s costs exceed the deductible, up to an initial coverage limit. Beneficiaries whose costs exceed a catastrophic limit enter the highest level of insurance, in which case they pay only \$5 or \$2.50 or \$6.30 per prescription. The following table shows the dollar levels at which these concepts apply, reflecting the impact of indexing on dollar amounts:

	2006	2011
Deductible	\$250	\$310
Initial coverage limit	\$2,250	\$2,840
Annual out-of-pocket spending threshold	\$3,600	\$4,550

The Affordable Care Act of 2010 provides a phased reduction in cost sharing over the range from the initial coverage limit to the coverage gap amount.

Those who enroll in a MA-PD obtain the drug benefit through a plan that provides the entire Medicare benefit. These plans have the ability to lower cost sharing by using dollars saved in the delivery of other parts of the Medicare benefit to provide lower cost sharing. For example, 83 percent of plans had no deductible in 2010.

Drug Plans

Over 1,000 PDPs and 1,500 MA-PDs enrolled Medicare beneficiaries in 2010. Among those enrolled in PDPs, nearly half were in the seven largest plans.

Plans serve as the intermediary between enrollees and benefits. They negotiate prices and dispensing fees with pharmacies and rebates with manufacturers. They establish formularies, the lists of drugs plans cover, and the terms under which they are covered. They set cost-sharing amounts that beneficiaries will face. They employ a range of utilization-management tools. The most common tools include step therapy (first trying to achieve a therapeutic goal with a less costly drug), setting and administering prior authorization requirements, setting and administering prior authorization requirements for some drugs, and operating a process to handle requests to cover drugs not on the plan’s formulary.

Plans submit bids to the federal government, and the lowest bids determine the amount the government will contribute towards plan costs. Beneficiaries pay the cost above the government contribution.

The Medicare Drug Benefit Five Years Later: Is It Working?

By Hanns Kuttner

*“The program has outperformed forecasts
that it would not work.”*

A prescription drug benefit became part of Medicare in 2006. With the benefit moving toward maturity, Hudson Institute convened a conference to assess its progress to date. At the center of the discussion was an assessment offered by former Secretary of Health and Human Services Michael Leavitt, who oversaw its implementation. Following that, a panel addressed the political and practical experiences of implementing the program.

How did this new component of Medicare come to be, and what lessons does it offer for thinking about Medicare’s future?

Both Secretary Leavitt and the panel found that the new drug benefit has been a success. This broad assessment benefits from low initial expectations. Critics on the left and right had suggested that the program would crack during implementation. At a minimum, the program has outperformed forecasts that it would not work and has become a full part of what people have in mind when they refer to “Medicare.” Disagreements centered on where the program gets a “needs improvement” grade.

A number of ideas for how Medicare could learn from its newest component also emerged in the discussion. Secretary Leavitt made the case that features of the prescription drug benefit provide a roadmap for Medicare to make the transition from

a program that is not fiscally viable in the long run to one that is.

This overview provides some background about the new drug benefit, places its origin and form in historical perspective, considers the challenges involved in implementing the program, and lays out lessons thus far for the program’s future from its newest part.

Why a Prescription Drug Benefit?

Medicare’s benefit structure reflects how political conflicts of the 1960s resolved using that era’s notions of what health insurance should be. The original Medicare law, signed by President Lyndon Johnson in 1965, created two programs. The first, which the drafters termed Part A of the law, created a new social insurance program to pay for hospital expenses. It would be financed by a payroll tax, just as the existing Social Security Act cash benefit programs were. The second, Part B of the law, created a voluntary health insurance plan, called supplemental medical insurance, which would cover a set of medical expenses in addition to hospital stays. These included services provided by physicians and services in hospital

outpatient departments. Financing for this program would come from a monthly premium, paid partly by the federal government and partly by those who enrolled. (The Part C designation became home to parts of the Medicare law relating to prepaid plans, first Medicare + Choice and now Medicare Advantage, leaving Part D as a place to put statutory language creating a prescription drug benefit.)

Neither Part A nor Part B provided any payment for the prescription drugs a doctor might prescribe to be taken after leaving the doctor's office or a hospital. This feature reflected the scope of health insurance at the time. Employer-provided health insurance was well on its way to becoming the dominant form of health insurance, and the typical plan did not cover prescription drugs taken at home.

Lack of coverage for prescription drugs was not unusual given the role of prescription drugs in health care at the time. It was before the era (which continues today) when large numbers of people began to take drugs for chronic conditions and could expect to take those drugs for extended periods, often for the rest of their lives.

As the era of maintenance drug therapy emerged, prescription drug benefits became more common in private plans that enrolled people under age 65. The nature of health insurance products purchased by and for those under age 65 changed, making Medicare's scope of benefits appear dated.

That did not mean that Medicare beneficiaries could not obtain a prescription drug benefit or coverage as an alternative to paying all drug costs out of pocket. After Medicare became law, insurers introduced products that would pay for costs or services Medicare did not ("Medigap" policies). Low-income beneficiaries who qualified for Medicaid had protection against prescription drug costs through that program. Employers who offered a retirement health insurance benefit to their employees often included a prescription drug benefit when they offered such a benefit to their current employees. When HMOs began to enroll Medicare benefi-

ciaries in exchange for a fixed payment in the mid-1980s, many HMOs offered a prescription drug benefit as an incentive for beneficiaries to enroll.

By the 1980s, not having a prescription drug benefit appeared more often on lists of things that were "wrong" with Medicare. President Reagan's call for restructuring Medicare to provide better protection against catastrophic costs provided an opportunity. A law drafted by the Democrat-controlled Congress, the Medicare Catastrophic Coverage Act of 1988, in response to Reagan's initiative included a prescription drug benefit. This new benefit would be administered by the government, just as it administered Part A and Part B. The drug benefit would be financed by a premium paid by enrollees.

It never took effect. Resistance to the prescription drug benefit and its premium structure spread. The next major piece of Medicare-related legislation was the Medicare Catastrophic Coverage Repeal Act.

A Prescription Drug Benefit at the End of the 1990s

A prescription drug benefit for Medicare got caught in the debate that followed President Clinton's call for widespread change in the health care system. After that debate concluded with no legislative action taken, a prescription drug benefit for Medicare could again be a stand-alone issue.

The next iteration of agitation about a prescription drug benefit had the splendid fortune of playing out in a markedly different fiscal environment. After nearly a generation dominated by the federal budget deficit, a sustained period of economic growth yielded federal budget projections that showed surpluses. Could a Medicare prescription drug benefit be one of the beneficiaries of this positive fiscal outlook?

Momentum for the benefit grew. The March 1999 final report of the National Bipartisan Com-

mission on the Future of Medicare, also known as the Breaux-Thomas commission, recommended expanded coverage of prescription drugs for seniors as a means-tested benefit administered through the Medicaid program.¹ At the end of June, President Clinton offered his proposals for Medicare. They included both a prescription drug benefit that would be administered by the federal government and dedicating part of the budget surplus to shoring up the Medicare trust fund.²

The year before a presidential election is less a time for resolving policy disputes than for setting them up for possible action after the election. That was the case with a Medicare prescription drug benefit. By mid-2000, the Republicans who controlled the House of Representatives had moved a prescription drug-benefit bill to the House floor and passed it by a 217-214 vote. Senate Democrats tried but failed to add their proposal to an appropriations bill. Both major party candidates, Governor George W. Bush and Vice President Al Gore, endorsed proposals for a Medicare prescription drug benefit. Both parties went into the 2000 election cycle telling the American people they would deliver a Medicare prescription drug benefit.

Policy Choices

The policy debate of the late 1990s saw both parties buy into the idea that Medicare should have a prescription drug benefit, narrowed the range of policy options, and gave a partisan alignment to key design issues:

Who should run it? Democrats wanted to bolt a prescription drug benefit onto the existing Medicare chassis. The government would run the program similar to the way it ran Medicare Parts A and B, setting uniform, national rules and using a network of private contractors whose function would be administrative, not executive or strategic.

“Both parties went into the 2000 election cycle telling the American people they would deliver a Medicare prescription drug benefit.”

Republicans looked to private plans to deliver the prescription drug benefit. The federal government would set the rules of the game, organize the competition, and enroll beneficiaries—and those beneficiaries would choose plans. This approach derived inspiration in part from the Medicare + Choice option in Medicare. Beginning in the mid-1980s, prepaid health plans, such as HMOs, had been allowed to enroll Medicare beneficiaries on a fixed-payment basis. The plans, in turn, could use savings to offer more benefits to entice enrollees. The approach also echoed the one employed to set payment amounts using competition across delivery models—called “premium support”—that the National Commission on the Future of Medicare had embraced.

How Should the Benefit Be Structured?

Democrats wanted to extend the paradigm of universal social insurance. Everyone in the program would have the same benefit design. The versions they offered combined coverage for the first-dollar costs that many people could expect to face and insurance against the risk that an

individual would be one of the relatively small group who experience very high expenses. A Medicare beneficiary would begin the year with a benefit that required making a copayment on prescriptions; in President Clinton's plan, the copayment was set at 50 percent. Once costs reached some high cost threshold, the government would pay a larger share, providing insurance for those who faced the largest costs.

Congressional Republicans wanted to give more flexibility to private plans to decide the details of which costs got covered. Plans would decide how to structure a benefit. The rules facing any particular beneficiary would depend on the features of the plan he or she chose. The benefits would be assessed using a yardstick called "actuarial equivalence." A plan could offer many benefit designs that met or exceeded the actuarial equivalence test.

Both parties agreed that subsidies should be directed at those with lower income. They disagreed about how to deliver the subsidies. Democrats wanted uniform national rules administered by the federal government; Republicans wanted states to administer the subsidies.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003

President George W. Bush first embraced a Medicare prescription drug benefit in July 2001, when he advanced a set of principles for overall Medicare reform, principles that showed his desire that a prescription drug benefit be one component of a broader package of Medicare reforms.

The 2002 election created a new political configuration for Medicare reform: the presidency and both houses of Congress were in Republican control. The president's FY 2004 budget, released at the

"The approach Congress did choose contained far more risks but greater potential benefits as well."

beginning of 2003, included \$400 billion for the first ten years of a prescription drug program.

President Bush's proposal, announced in March, differed most from those that had advanced in Congress prior to his taking office in that it made a prescription drug benefit a carrot to bring about broader reform.³ He proposed giving beneficiaries a choice. Those who opted to stay in traditional Medicare would get free coverage of their catastrophic drug costs (i.e., costs that exceeded \$3,600 in a year) and a discount card that would harness the buying power of millions of beneficiaries to obtain price discounts. Beneficiaries who wanted a subsidy for prescription drugs could opt for comprehensive benefit plans that offered all the Medicare-covered benefits, not just prescription drugs

The Congressional response differed from the Bush proposal. Congress did not warm to the idea that a prescription drug benefit would be linked to enrolling in an alternative to Medicare's traditional fee-for-service model.

The deliberations that led to the law signed by the president on December 8 produced dramatic moments. The most dramatic was the last vote in the House of Representatives before the legislation reached the president's desk. While recorded votes in the House usually last fifteen minutes, the voting time in the House for this bill stretched into the pre-dawn hours of November 22, just before the Thanksgiving recess.

The 220-215 result showed partisan blurring. While the main body of Democrats opposed the final proposal, preferring an approach that would

have created a government-run benefit, eight Democrats supported it. Among Republicans, some were unreconciled to a plan adding to Medicare's cost; fifteen voted against the conference report.

Implementation

Had Congress opted to create a drug benefit that worked like traditional Medicare, implementation would have been simpler. The government would have written rules and selected contractors to administer the program, and the program would have been ready to go.

The approach Congress did choose contained far more risks but greater potential benefits as well. Its reliance on choice created multiple risks for things to go wrong. The first risk was that private-sector companies would decide not to enter the market. Stand-alone drug plans did not exist in the marketplace. Two RAND Corporation economists had offered this judgment: "Such a market is unlikely to develop."⁴ The Bush Administration had put forth a similar critique.

Beneficiaries posed another set of implementation risks. A large number might opt not to enroll. The program was voluntary, and anyone who enrolled was agreeing to pay a monthly premium. Those who expected high costs would face strong incentives to enroll, and if they were the only ones doing so, it would be a textbook case of what actuaries call adverse selection.

The program's commitment to choice also posed risks. An effective choice required distinguishing among similar drug plans to find the one that best fits an individual's priorities. Critics said the new benefit was "unnecessarily limited and complex."⁵ Picking a prescription drug plan would be something new for Medicare beneficiaries, and some warned that the process could be overwhelming. No process could guarantee that everyone made an

optimal decision. However, if enough beneficiaries were overwhelmed by the process, the program would be deemed a failure.

If these risks turned out adversely, there would also be political risks. To be both a financial and political success, the program needed enrollment from more than just those who expected high costs.

According to former Secretary of Health and Human Services Michael Leavitt, implementation required careful listening to learn what forms of engagement work with Medicare beneficiaries plus an almost campaign-like style of outreach, complete with bus tours and town hall meetings. The result was enrollment far above the level skeptics feared and a pattern of plan choices indicating that many beneficiaries had made the effort to determine which plan would serve them best.

The First Five Years

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) made a bridge product available in 2004; it was a discount card that also provided \$600 towards prescription drugs for low-income beneficiaries. Promoting the card provided a way to engage beneficiaries about Medicare and prescription drugs while the work of setting up the program was underway.

By 2007, 90 percent of Medicare beneficiaries were either enrolled in a Part D plan or had benefits as generous as Part D from another source.⁶

Coverage, whether through Part D or elsewhere, has remained at about 90 percent of beneficiaries. The diversity of coverage sources reflects choices beneficiaries made and program design features intended to restrain costs by keeping some people who already had coverage under that coverage. Overall, 59 percent had coverage through Part D in 2010, 38 percent in stand-alone prescription drug plans, and 21 percent through a Medicare Advantage plan. An

additional 29 percent had coverage equivalent to or more generous than the Medicare benefit through retiree health benefits, as a benefit provided by the federal government to civilian retirees and veterans, as active workers who had Medicare as a secondary payer to their employer's coverage, or through other sources.⁷ (See Figure 1.)

The cost has been substantially less than the Medicare Actuary predicted. Figure 1 shows the projections for the Part D benefit's cost in the annual report of the Medicare trustees. Figure 2 shows the evolution of projections of the total cost in the program's first decade, combining the actual costs for previous years with forecasts for future years. The ten-year cost as seen from 2011 is 47.8 percent lower than the projection made in 2004. While the panel did not agree on their relative contribution, three factors were identified as responsible for costs being lower than expected: less expensive generic

drugs substituting for more expensive name-brand drugs; the health plans' pharmacy benefit management; and fewer new drugs as well as fewer of them with "blockbuster" sales levels than in the period before Medicare had a prescription drug benefit. (See Figure 2.)

One widely expressed fear at the time the bill became law was that too few plans would compete for enrollment. The law included extensive plans for a government backstop to make sure they were available in all parts of the country should private plans decide not to serve some areas. These provisions proved to be unnecessary as plans entered all markets. The perceived importance of geography to entry decisions also proved unfounded: several plans decided to enter the market nationally and have come to dominate the market.

Most beneficiaries are satisfied with their prescription drug plan. Over the past five years, at least

FIGURE 1

Evolution of Medicare Actuary's Projections of the Ten Year Cost of the Prescription Drug Benefit

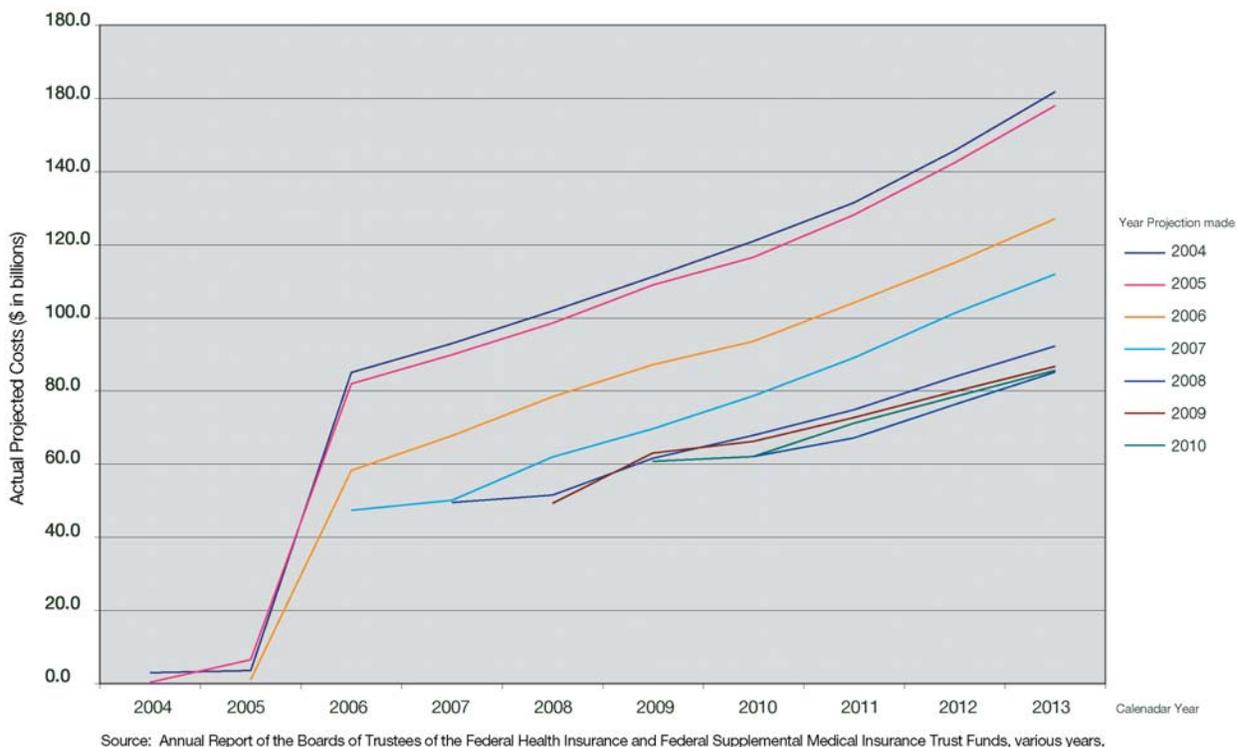
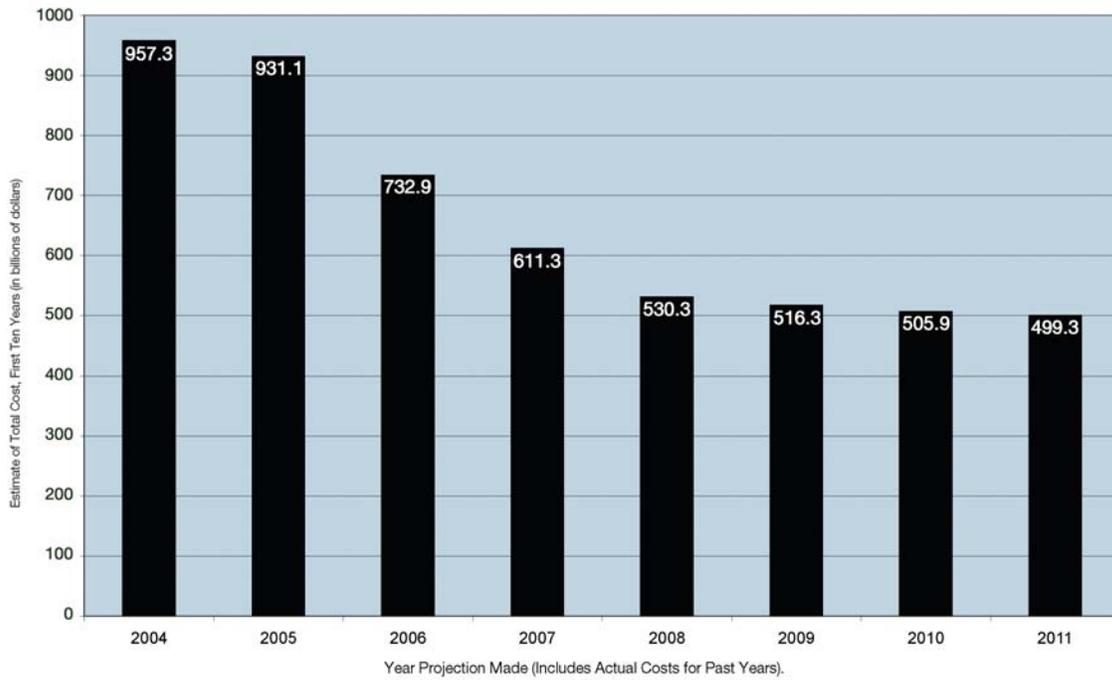


FIGURE 2

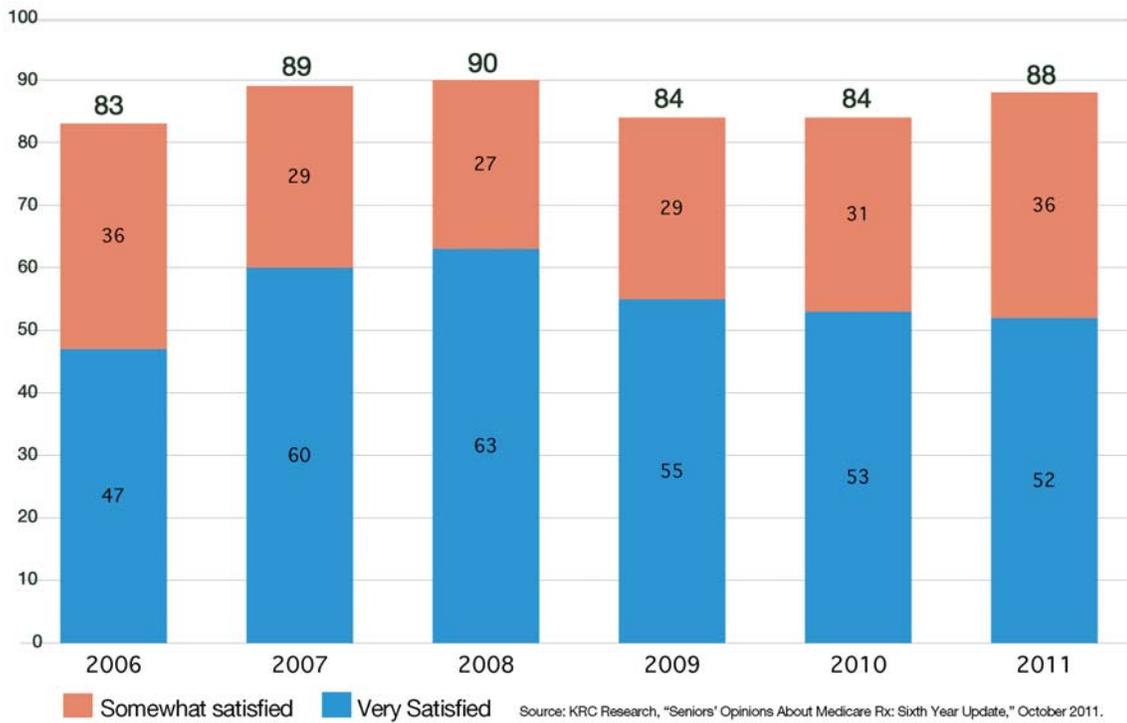
The Cost of the First Ten Years of the Medicare Prescription Drug Benefit: How the Medicare Actuary's Views Have Evolved



Source: Annual Report of the Boards of Trustees of the Federal Health Insurance and Federal Supplemental Medical Insurance Trust Funds, various years.

FIGURE 3

“Overall, how satisfied are you with your prescription drug coverage?”



Source: KRC Research, "Seniors' Opinions About Medicare Rx: Sixth Year Update," October 2011.

80 percent have said they are either very or somewhat satisfied. (See Figure 3.) Satisfaction is greatest among those with the highest (above \$50,000) and lowest (below \$15,000) incomes, those who are older, and those who have enrolled in plans with monthly premium at or below \$30 per month.⁸

Learning from Medicare's Prescription Drug Benefit

Hudson's discussion produced an extensive set of lessons learned from the new prescription drug benefit. Perhaps the three most important were:

- Medicare beneficiaries can make decisions that serve their well being. More enrolled than did not. As plans change over time, questions have arisen about beneficiaries who stay in some plans, even as they change in ways that become less favorable to those beneficiaries. This conundrum applies to a discrete but identifiable minority. During the Q&A session, one questioner noted that sometimes factors that control choices are not part of easily observed plan features; e.g., living close to a particular pharmacy and valuing its relationship with a particular plan, making that plan best suited to the beneficiary's needs.

Plan choice as a means to increase consumer well being has distinct echoes in the Affordable Care Act signed in 2010. Like the Medicare prescription drug benefit, the ACA envisions people first enrolling and then choosing from among competing plans offered through a health insurance exchange. While sharing this core-design principle, the ACA then goes on to be more prescriptive in its relative lack of latitude allowed for consumer choice, with

requirements for plan design that show the prescription drug benefit's relative flexibility.

- Some people need help. Economists' models of consumer choice assume that consumers have the capacity to make informed decisions. Many who are limited in that capacity have relatives and friends looking out for their well being and helping them with decisions like plan choice. Socially isolated individuals need that kind of help. Reaching critical mass in enrollment requires people-intensive, shoe leather-heavy outreach done in a way that reflects lessons learned from listening to prospective enrollees.

Both of these lessons speak to how questions that were open at the time President Bush signed the law got resolved. A lesson that has proven more important relates to something that was not widely appreciated at the time.

- Being open to innovation matters. Traditional Medicare is closely governed by federal law and implementing regulations. Changing either requires successfully contesting interest groups that oppose the change. In contrast, the plans that deliver the Medicare prescription drug benefit have wide latitude to try out new models and approaches, subject not to their ability to get a law or the Code of Federal Regulations amended but to consumer acceptance.

The evolution of the Medicare prescription drug benefit shows "crowd sourcing" at work. Plans have tried out different features. Some have taken off, and some have sunk. What we see in how plans structure benefits reflects a back and forth dialogue between plans and sovereign consumers.

The fact that the Medicare prescription drug benefit has cost far less than originally projected owes much to the ability of prescription drug managers to

“The therapy management approaches used by the drug plans could become the basis for... the entire range of benefits provided by Medicare.”

substitute newly approved generic drugs for brand-name drugs whose patent terms expire. As former White House budget official James Capretta noted, these savings, which are surely in the tens if not hundreds of billions over the first ten years of the program, may have been less likely if more of the decision making had been in the hands of the federal government. The companies that lost sales because generic drugs got substituted could have pursued political remedies, through either changes in law or regulation, to protect those sales. With such decisions in the hands of the pharmacy benefit managers, and laws in some states mandating generic substitution, the political option was pointless.

Other lessons are only now becoming appreciated. The prescription drug benefit has shown positive spillover effects. Researchers have recently published a study in the *Journal of the American Medical Association (JAMA)* which shows that some health care costs are lower among those who were least likely to have prescription drug coverage before the law took effect.⁹

More time will be required to discern other effects. MedPAC, the eyes and ears of Congress on change in Medicare, has noted that the share of program costs rising most rapidly stems from coverage of catastrophic costs. Once a beneficiary reaches the catastrophic limit, he/she pays only the greater of five percent of costs or a flat amount under \$10. This has the potential to influence the drug development pipeline. Companies may prefer to focus their drug development efforts on chemical entities that provide a great deal of help to small numbers of people and can be sold at a price that puts the ben-

eficiary in the catastrophic cost range rather than candidate drugs that would provide some benefit with more common conditions but get priced at levels that do not reach the catastrophic limit. These incentives would result in more progress on cancer drugs and less on drugs to treat arthritis or reduce the risk of cardiovascular disease.

Secretary Leavitt has pointed to medication therapy management as both a successful innovation and a path to remaking Medicare more broadly, in a way that could achieve acceptance across the political spectrum. The structure of the Medicare prescription drug benefit created opportunities for drug plans to profit from providing medication therapy management. This term includes a broad and still evolving range of actions to guide beneficiaries to more cost-effective drug therapies. Examples include design features such as tiered benefits that provide a financial incentive for beneficiaries to seek a therapy in a lower cost tier and activities to engage prescribers to choose the approach that achieves clinical success in the most cost-effective way possible.

Secretary Leavitt has suggested that the therapy management approaches used by the drug plans could become the basis for plans that offer not just the Medicare drug benefit but also the entire range of benefits provided by traditional Medicare. The key to this approach would be beneficiary acceptance. The more stringent forms of managed care tried by employers in the 1990's ultimately failed because consumers did not like them. With Medicare, the potential for a beneficiary to switch to a different plan at the next open enrollment period disciplines how plans approach benefit management.

Regardless of how politicians approach concepts like “premium support” that have strong partisan identification, beneficiary acceptance and beneficiaries seeking to realize higher value would create a path out of the unsustainable trajectory of the current delivery system dominated by fee for service.

Finally, Leavitt sees time being on the side of change. More and more beneficiaries reaching the age of Medicare eligibility will have spent a larger share of their lives in health insurance arrangements that have plan choice and active care management. Thus a Medicare environment modeled after the prescription drug benefit, where getting the benefit requires choosing a plan, will seem usual rather than new and different. Time will make what seemed to be a radical reform both conservative and modernizing.

Broadening the scope of benefits covered by a plan makes it possible for the therapy manager to do more. For example, the *JAMA* article authors found feedback from the prescription drug benefit to other parts of the Medicare benefit package. Those who were likely to gain access to prescription drugs through the new prescription drug benefit saw lower rates of hospitalization. If the entire range of Medicare-covered benefits were part of the financial relationship, the therapy manager would have new incentives and opportunities to do well by doing better. The current arrangements, limited to prescription drugs, provide no incentive to reach across benefit categories.

Hospital costs would be lower if those who had congestive heart failure adhered more closely to the instructions they received from their doctors, particularly to their prescribed drugs. However, the current system of siloed benefits means that efforts to use medication-therapy management to reduce hospital inpatient costs will not be rewarded. What is not rewarded is not provided.

A wide range of voices have said that Medicare cannot be sustained in its current form. Some alternative to reliance on fee-for-service payment policies must emerge. The Medicare prescription drug benefit provides some suggestions for how that transformation will be accomplished. In contrast to the loud and shrill partisan wrangling over Medicare’s future, the evolutionary change in the prescription drug benefit has happened without broad notice. Broadening the scope of the win-win interaction between plans and patients to include the rest of the Medicare benefit package may, in the long run, be an important part of the story of how Part D’s advocates helped saved Medicare.

Raj Kannappan and Richard Ro provided valuable research assistance that pulled together relevant history. Tevi Troy and Doug Badger provided useful comments and helped avoid several errors; the remaining responsibility is the author’s.

CONFERENCE

The Medicare Drug Benefit Five Years Later: Is It Working?

(September 15, 2011 at Hudson Institute's Betsy and Walter Stern Conference Center)

When Michael Leavitt became Secretary of Health and Human Services on January 26, 2005, implementing the Medicare Prescription Drug, Improvement, and Modernization Act was the largest challenge before him. To him fell the responsibility for launching the most significant change in Medicare since the program began in 1966.

In his remarks, Leavitt offered seven lessons from Part D. The lessons he perceived focus on the role of Medicare beneficiaries as decision makers. Do I enroll in Part D or not? In a Medicare Advantage plan or a stand-alone drug plan? Which plan?

Leavitt suggested that the Part D approach, in which beneficiaries choose among competing plans, provides the foundation for remaking all of Medicare. Hudson Institute Senior Fellow Tevi Troy, who served as Leavitt's deputy, introduced him.

An edited transcript of the proceedings follows.

INTRODUCTORY REMARKS

TEVI TROY: Hello, and welcome to Hudson Institute. My name is Tevi Troy. I am a Senior Fellow here at Hudson, and I appreciate all of you coming to our conference about whether the prescription drug benefit is working. We're going to have a conversation today about that question.

I personally don't think it's an open question; but I guess I am somewhat biased based on my previous

experience. I've worked with Secretary Leavitt at Health and Human Services (HHS), and I have the privilege and honor of introducing him today.

We know many things about Secretary Leavitt from reading his bio. We know that he is smart and he is talented. He has been a three-term governor of Utah and the head of two cabinet departments, EPA and then HHS. He is a successful businessman. He's dashing and debonair, as you can see.

But there are some things that you can't really know unless you've worked with him, as I did when

I was Deputy Secretary. I saw up close just how hard working he was and how good he was to work with, how good he was with other people. And I think those are really important and undervalued skills.

Let me tell one quick story about that: when I began at HHS, I was told that I was going to go on a trip with Secretary Leavitt to talk about food safety. There were concerns about some products that had been tainted, and some people had gotten sick. We were going to do a nationwide tour to promote the safety of our food system and to talk about our efforts to make sure that the system was working well, how we were examining it and doing a major report on it, and revising FDA regulations.

We had a very small window to do this tour—only two days. At Secretary Leavitt’s urging, in less than 48 hours we went to Los Angeles, Nogales, Phoenix, Cincinnati, Kansas City, and we would have gone to Alabama if they hadn’t cancelled on their end. So he knows how to pack a lot into a trip. But he also knows how to use a trip wisely.

At each of these events, Secretary Leavitt would enter, give a speech—a really rousing, funny, but also informative speech—about the safety of our food system and why people shouldn’t be concerned

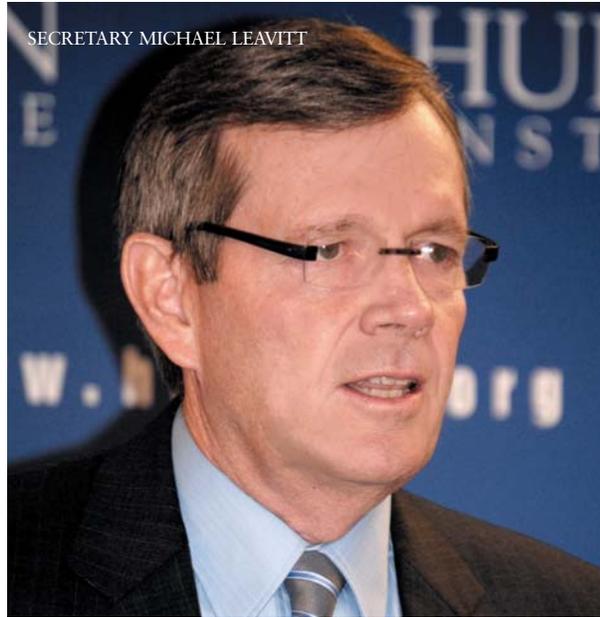


“[T]here were all sorts of skeptics about a health care bill and its implementation and how difficult it was going to be.”

but also about all the efforts that we were undertaking to make sure the system was safe. Then he would lead a community roundtable, where we’d talk about the food system and address community concerns.

Well, after I saw him do this two or three times, we got off the plane in one of the cities, and he looked at me and said: “OK, Tevi, you’re doing the next one.” I didn’t have a lot of preparation, although I had a great model in terms of watching him. I must say I was a little nervous because I hadn’t done that much of that before. I had just been confirmed. But I not only did the event, I learned a great deal about doing it. Secretary Leavitt understood that sometimes the best kind of training is the on-the-job variety.

That really helped me understand how to do the job better, and he understood that I could only do the job if I knew how to achieve that kind of personal interaction with a large crowd. So I really appreciated his efforts. After the bill passed, we had an implementation period. Not unlike what we’re seeing today, there were all sorts of skeptics about a health care bill and its implementation and how difficult it was going to be. In this particular case, there were skeptics on the left and on the right who were saying that the new program would cost too much, that seniors wouldn’t sign up, that they wouldn’t



SECRETARY MICHAEL LEAVITT

make choices. Secretary Leavitt knew that these observations were not accurate.

So he rolled his sleeves up and got to work. He went to the Centers for Medicare and Medicaid Services (CMS) to work on the rules and the regulations and on the marketing materials that would go to seniors to make sure they were aware of their options. And I had senior people at CMS say to me: We've never seen a Secretary at the CMS offices in Baltimore before, and we certainly never saw one on a Saturday.

He also worked very hard on the Medicare Part D implementation tour, the bus tour where he went around the country to make sure that seniors were doing what they were supposed to do in terms of signing up, that they recognized they had choices, that it wasn't a one-size-fits-all government benefit but one enabling them to pick the plan best for them. That was the whole point behind the design of the program.

Then, after the successful implementation, he continued to work on Part D to make sure that seniors were doing what they needed to do. Every year after that, we made a trip when it was time for the Part D open-enrollment period. Secretary Leavitt would insist that all of the senior staff at HHS be

deployed to senior centers around the country to encourage seniors to sign up for the benefit, to look at the options, and make the best choices.

At one of these planning sessions, I just happened to notice that in the dead of winter on these trips, Secretary Leavitt was going to places like Miami, Dallas, Los Angeles, while *my* itinerary included places like Wichita, Providence, and Albany—fine cities all, but less pleasant in February than any of those Secretary Leavitt was going to. So I said to him: "Well, sir, it's an interesting itinerary. Why am I going to Wichita, Providence, and Albany?" And he put his big hand on me and said: "Tevi, that's why you're the deputy secretary."

Now, here we are five years later, and Part D, I believe, is successful. And it is successful, I would argue, A) because of its market-based design; but also, B) because of the hard work this man, Secretary Leavitt, put into it.

I just want to make this final point, that the conversation we are having here today would be a very different conversation about Part D without the efforts of the man that I am about to introduce, Secretary Mike Leavitt. Thank you very much.

SECRETARY MICHAEL LEAVITT'S ADDRESS

Thank you, Tevi. And may I just acknowledge that Tevi has become not just a former colleague but a dear friend, and I want to thank him for that. And I want to greet a number of other friends that I see here today and thank them for the time that they've taken.

I also want to thank Hudson for organizing such an important forum on this topic and to congratulate you on the 50th anniversary of your operation. You've obviously become a very important part of Washington debate and the policy discussions all over the country.

You have framed today an important subject—

Part D, has it worked? I am with Tevi. Yes, the answer is yes. And I'd like to talk today about the reasons that I see that being an important discussion as we go forward. Perhaps I could take 15 minutes or 20 minutes and talk about that in three different contexts.

One, the environment in which we are now operating and how it's changed and why Part D, I think, is an important discussion on not just is it working but what have we learned from it. And second, specifically what have we learned? What lessons can be drawn both positive and negative that can be applied into the future? And lastly, how could we apply those lessons going forward as we face some daunting challenges in the context of reform?

Could I begin with this observation? If we were to look back over the last 60 years in health care, I think it is reasonable for us to say that virtually every policy decision that's been made, either in legislation or regulation at the federal level or in implementation at the state level, has been fundamentally grounded on one significant ethic, and that is human compassion.

We have chosen to live in a country where people are cared for when they are sick or when they are injured. And it is an ethic that we cannot allow to be lost in our country. It is something that is part of our ethos and the moral fabric of the nation.

Having said that, there is a new entry into this discussion. And although it does not necessarily diminish or cast less importance on our ethos, the new piece of this conversation is what I will call *dispassion*—global economic *dispassion*.

So we're going from a period where the dominant thought has been about *compassion* to one where there is a new entry, and that is global economic *dispassion*. It can be well illustrated by what's happening in Greece as an example.

Greece, a year or so ago, declared to the world that they were on the brink of default on their bonds. They reached out to the European Union and pointed out clearly that they needed help. The European Union understood that, without its involvement, not only

would Greece economically tumble but also it could have a profound effect on the EU. What we saw in all of those countries operating was this sense of global economic *dispassion*. It was forcing events that were causing them to do things that were not necessarily a political decision or a choice. It was global markets putting pressure. We're now seeing that all across Europe. You see what has occurred in Greece just as one example of many.

Greece obviously was given a bailout of the equivalent of \$158 billion. Greece was also told that if you're going to get this in three tranches, you're going to have to do certain things to create a new level of austerity. It was very hard. Greece responded on the first tranche because it was the easy part. The second tranche was harder, and there were serious questions. There's still a third tranche, and we're seeing that play out all across the world as people deal with this debt problem.

The point I would like to make is that we in the United States of America find ourselves in a position where we, not unlike Greece, have now had the quality of our debt begin to be questioned. We now have to sell \$125 billion a month in new debt. There are significant questions about who is it that will buy that debt. We are facing a new set of circumstances in the context of what will drive the health care debate. And I'd like to suggest that health care reform is no longer simply about what happens on Capitol Hill with the Affordable Care Act.

Health care reform has become a question of economic policy. This is now an economic reform debate, not just a health reform debate, and this global economic *dispassion* will drive us as a country to do things that in the past didn't occur because we always had the capacity to add it to our debt structure. We are rapidly coming to a close in terms of our capacity to do that.

So the first thing I wanted to say is that we're in a new era in terms of what is empowering change in health.

The second point moves to Medicare Part D. I've

“[V]irtually every policy decision that’s been made ... has been fundamentally grounded on one significant ethic, and that is human compassion.”

answered the question for myself. I think it’s clear that this has worked. Is it perfect? No. Is it getting better? Yes. Will it continue to be refined? Absolutely. But I believe there are at least seven important lessons that we can learn from the rollout of this new benefit.

I’d like to enumerate them and talk about them because I believe they have application to the future.

The first lesson: when you provide good options and you provide clear information, most people are not just willing to consider it but also are capable of making thoughtful, smart, and self-interested decisions as health consumers. You will recall that when we rolled out Part D, there were serious questions about whether or not people could make those decisions or would make them. And it wasn’t something that was automatic. It was in many cases a learned behavior, and what we now have, in my judgment, is a generation of not just informed but also savvy health consumers. They have learned to shop, and they have learned to be effective consumers. That’s a very important discovery, in my view, on how we deal with government-funded health benefits.

The second lesson is related: that it is essential that there is extra help available to a certain part of the population who may not have family, may not be part of a faith community, or may not have a local pharmacist or someone else who can help them. Part of our learning is that you’ve got to create the infrastructure of additional help for the minority of people who need it.

And you’ve got to have a fundamental infrastructure that helps everyone. The advent of the Plan Finder on the Internet has empowered in many ways

the selection of plans, and it provides, I believe, a very important part of the innovation of Part D. So the second lesson, just to be clear, is that it is essential to have additional help for some subpart of the population.

The third lesson: multiple competitive plans create a means of being able to inject effective competition into the market. Organizing the market in terms of plans will create a capacity for consumers to see alternative outcomes or alternative tools that they can match to their own needs, and the plans form the basis of an efficient competition.

Now, I think that’s evident because part of the reason we can say that Part D worked is that it saved money. There’s no dispute over the fact that if you take the estimates that the government actuaries created at the beginning and look at what’s occurred, there has been a dramatic savings. And while there are many reasons for that, it is underpinned by the value of competition in an organized market.

This is a fundamental shift that was made from one-size-fits-all Medicare to Part D. We changed the role of government from being an organization that operates the system to one that organized the system—a fundamental difference.

And the program created savings. It became clear that it also improved quality, and may I just underscore a point here that will play a big role in my latter comments: there are actual and scorable savings based on this program.

Number four, the income-sensitive defined contribution is workable and positive in publicly financed benefits. That was a significant breakthrough, because never before have we created a facility where it could

be tested. And we are now five years into this process.

Many of you will remember that Part D did have a standard benefit construction. Some of you will also be aware that 6 percent of the entire 40 million-person population who selected a plan actually selected that particular benefit construction, meaning that 94 percent used a construction that included a defined contribution instead of a defined benefit and used it to select a plan that fit their needs; and we did it in a way that provided them with an opportunity to get something different if they wanted to. If you want a plan that's all generic brands, you can get it. If you would like one that has all name brands, you can have that. If you don't want to have a donut hole, you can do that, too.

But we were sensitive to the capacity of people to pay. That was a progressive policy, but we maintained in the course of it our capacity to limit how much was spent; again, a very important scorable feature of health care reform.

Number five, it became clear that one-size-fits-all is unnecessary and that we have the capacity to use mass customization in the future. Obviously, from what I just said, the number of people who made a selection based on what was of value to them shows the nature of this. And I believe it can be clearly demonstrated that people buying a plan that is customized to them is good for their health and will in fact contribute to value in the overall system.

Lesson number six is that consumers will reward value. And as I've mentioned, they will spend their own money to upgrade in that value. I think this is important because the magic of the invisible hand was at play here: instead of having one benefit, we had many different organizations doing consumer research to figure out what consumers wanted and needed.

When those prescription drug plans were placed in the marketplace in an organized way, people voted with their feet and with their dollars and rewarded value, which can only have the impact of *increasing* value.

“Many people ... will in fact be entering Medicare from an integrated care environment.”

And finally, lesson number seven: consumers like this. By every measure, people are pleased with their plan, and one of the magical features of this is that if you don't like your plan, you have an alternative. You can go find another one. And over time, people become very good at finding the plan they want.

So let me just quickly review. First, we found out that given good options and clear information, people can be good consumers. Second, we found out that it's essential to help others who don't have that capacity, that it's a reasonable role of government to organize systems to do that. Third, competitive plans turned out to be a very good way to organize a market in a meaningful way. The savings were evident, the quality was better, and it was scorable. Income-sensitive, value-added contributions were workable, very important; one-size-fits-all doesn't have to be the case. We can mass customize, and the consumers will reward value and the consumers like it. Those are the seven things.

Let me move to the third module I introduced, which is: what do we do with these lessons? Could I suggest that Congress today, with its “Committee of Twelve,” has come to the conclusion that global economic dispassion will require Congress to act?¹⁰ The members have imposed upon themselves now a requirement to act and they're out looking for the places in which they could come up with some kind of bipartisan agreement that would in fact drive savings. I would like to just say from my observation of where Republicans come from and where Democrats come from that there are two places where

their thinking appear to me to have a confluence.

The first is in the principle of integrated care delivery, in some configuration. And the second is in the need for us to begin to move toward some kind of risk-based payment. Now, we tend to talk today a lot about ACOs. I think that's essentially a label that covers a very broad spectrum. A better definition in my view might be this idea of integrated care with risk-based payment in some configuration.

I think it is predictable that we will begin to move toward that kind of solution to bend the cost curve, if for no other reason that it comprises the two things Republicans and Democrats tend to agree upon. Now, I would like to just speculatively ask the question, what would occur if we were to make Medicare Part A and Medicare Part B very similar to Medicare Part D, if we were to require at some point in the future that Medicare beneficiaries, as they enter the system, in addition to having to select not a Medicare Part D plan, also had to select a plan for Medicare Parts A and B that represented an integrated system of care?

Many people—I think it is bordering on most—will in fact be entering Medicare from an integrated care environment. So as it is today, we're saying to them: you're now accustomed to integrated care. You're selecting and working with networks. You're in a process that is more closely being managed. So today we're going to say we're going to take you out of that and put you into a fee-for-service system of Medicare. It makes little sense, because both people have learned to use it, and we're getting better at it.

What if we said at some point—pick an age, say 55—that if anyone now younger, when they reach Medicare age, will select not only their Part D plan but also their plan for Parts A and B plans. Would it work? Well, I would suggest to you that not only are they going to be accustomed to that, but that it would present—again, I'll emphasize—scorable savings because we now have a five-year track record on what has occurred when you integrate care and put it into an active method of competition.

I think you could easily argue that Medicare Part D—when added to medication therapy management, which is now part of every Part D plan—essentially is integrated care with a risk-based payment. So if you expanded that to Parts A and B, you would have a system in which every person would by default have to select an integrated plan. There would be competition which would bring those benefits. There would be choice.

We would not be saying to anyone who is now on fee-for-service that they have to change, though I think it would be a viable thing to invite them to do so because they would likely get a better system of care. Let's apply the same lessons from Medicare Part D and try to project whether that would work. First of all, we know from five years' experience with Part D that people can be efficient medical consumers. In fact, we have more and more people who are in a system like Part D, and there's no reason to have them age out of that coverage into something that is new and foreign to them—fee-for-service medicine. We now know that those people, or at least some of them, need help. Could we provide that? Absolutely.

Would it be a good thing for us to sit down with people on occasion and say, let's talk about your health, and let's talk about how in fact we're going to have an insurance plan that lines up with that? That is a lesson of Part D. Would it be valuable to have multi-plan competition? We know it would, because it would drive savings and quality, and it would be scorable. Would it be valuable to our country in balancing our budget to be able to ultimately transition from the unlimited entitlement that we have in Medicare to a defined benefit to a defined contribution? It would. Could we do it? We know we can because we now do it in Part D. It is an income-sensitive defined contribution. Do we have a destiny in our country to march forward with a one-size-fits-all plan or can we begin to harness the same technology tools that allow us to have a mass, customized system? Absolutely. Would consumers reward value? Yes. Would con-

sumers like this? I think you can look at Medicare Advantage today and say consumers like it.

So my answer to the question “is Medicare Part D working?” is “yes.” Not only is it working, there are lessons that we can learn from it for the future, and I would urge the Committee of Twelve to take a hard look at implementing changes in Medicare that will in fact drive change in the system.

I’d like to end by telling you the most important thing I learned about health care reform in four years as secretary of Health and Human Services. If you’re going to reform the health care system, you have to change Medicare. It’s the only system that pervades the entire health care environment: every doctor’s office, every pharmacy, every medical device, every clinic, every hospital, every insurance company, every payer has organized its system around Medicare.

If we move Medicare toward an integrated care model with risk-based payment, we’ll have scorable savings, higher quality, better value, and the Committee of Twelve can make serious progress. And the fastest way to do that is to use the lessons of Part D.

So with that, Tevi, if I haven’t stimulated a little controversy, I’m going to be really disappointed. I’d like to have some conversation about the ideas that I have laid out. Who would begin our discussion?

QUESTIONS AND ANSWERS

Q: How is the A/B option that you just described different from Medicare Advantage? Isn’t that just requiring everybody to go into Medicare Advantage?

SECRETARY LEAVITT: It’s not. Let’s just acknowledge that. But it might not be as easy for the Committee of Twelve to agree upon it if you said, Look, let’s just have everybody have Medicare Advantage.

If we had to invent something even slightly different, the principle is, let’s start managing A and B the way we now manage D. Medicare Advantage, frankly, is the perfect vehicle for that because if you break an ACO down, it is Medicare Advantage.¹¹ It’s integrated care with someone running it who has a financial interest in making certain it turns out in the best possible way, with value best deployed. So your point is a very good one and my description of it is really to deal with it more in principle than in program.

Q: Well, I have lots of questions about the data. First of all, I think five years doesn’t mean much. I think of Mao Zedong’s famous statement when they asked him, What do you think the implications of the French Revolution have been? He said it was too early to tell.

So I think a lot can go wrong, especially with a government program. But I also question the whole premise that there should be, as you put it—and you think there’s a great deal of agreement about this—a confluence of the idea that we need an integrated care delivery.

I’m thinking, what if we had an integrated food-delivery system to Manhattan? We probably know what would happen. We’d probably starve. I mean, the real question is, Does government have a role in this at all?

I know you’re on the inside. You’re a government insider looking at this. But I think that for those of us who haven’t been in government, there’s a real question.

SECRETARY LEAVITT: Thank you. It’s been a while since I’ve been referred to as a government insider. I spend my time these days working with those who are struggling to navigate this system and to try and figure out where it’s going.

But you’re raising the food issue, which is a really valuable insight. I would argue that we have an integrated care model in the food system—the

whole idea of just-in-time processing. If someone takes a can of pork and beans off the shelf at a Wal-Mart, it sets off a series of actions that go all the way across the world in terms of when people start to pick beans and when they ship them and how they get processed and how they're then delivered.

The modern supermarket is a miracle of modern integration, with its capacity to deliver food in a very plentiful way at a low cost. I think it is a great argument for integration. I would also argue that it's a very good model on what the role of government ought to be.

I am a small-government conservative. I argue routinely that government ought not to be playing a large role here. But I need to acknowledge, and I believe we all do, that many of these things, given the circumstances, will require government participation. And I would argue that much of this is about the discussion of what government's role could be.

Look at food. There we have a system based on policies that encourage a plentiful amount of it. We have an organization at FDA and at the Department of Agriculture that determines if it's safe and keeps it safe, and if not, those agencies respond. We have a system that says if you can't afford it, part of our social policy is we want to subsidize it. We don't go to the grocery store and buy it for you. We let you go make those choices yourself. And we have Meals on Wheels if you can't cook for yourself. You can argue with parts of that. But what we've done is use government as a tool to organize a system. And you can look at other things government does. You can look at defense. Government operates defense and for good reason. It would be bad to have two militaries. They would compete. The second reason is because we need someone to decide where it's going to be deployed and how much. We're having a discussion right now about whether health care should be more like the food system or more like the national defense system.

I'm here to argue that government's got to play a

role. It'd be far better to have it organizing an efficient system than owning it. And I think the situation that we're moving toward now in the Affordable Care Act is clearly about government operating the system, and Medicare ought to be in the lead.

You didn't ask about all that, but I enjoyed saying it. Thank you. Next comment?

Q: Hi, thanks for your speech. Could you talk a little bit more about the risk-based payment idea you were referring to and also give some examples of where that's been tried or suggestions you may have for it?

SECRETARY LEAVITT: Yes. You know, we used to call this managed care. We don't call it that anymore for reasons that are a piece of history. If you look at the history on this, you go back to the 1980s, when we had health care costs that were going like this [arm gesture indicating upward slope]. We had a political flashpoint. We tried to do health care reform in the early 90s. The legislation failed, but sort of magically the costs started going down.

Why? Well, I would argue it's because we did start doing managed care. But people hated it. And there was another political event. They had the Patient's Bill of Rights; managed care diminished substantially, and what occurred? We began to see costs go up again. We had another flashpoint. We did health reform again. And consequently, we've begun to move in a different direction. We don't call it managed care. But now we have things like accountable care organizations and medical homes and bundled payment where the provider of the care begins to be at risk in some way to produce value instead of just volume.

And that's what I mean by risk-based payment. You know, I think it's important to realize that one of the things we learned from the collapse of "managed care" earlier is that people hated insurance companies telling them what they could have and

they couldn't have. I think we may have learned from that because in the future, instead of having an insurer tell us, we're moving toward a place where we're going to have our doctor or our hospital heavily involved. But part of that conversation with the doctors is, "If you want to make a decision on how that's going to occur, you also need to be part of the risk structure."

The consequence is that we're seeing a different version. We're not calling it managed care. We're calling it integrated care. We're calling it risk-based payment. But the difference is this: the physician is now far more involved in how that's going to work.

Q: Could you comment on what I see as the Democratic Party's approach to these issues, which has a large role for comparative effectiveness research, which I might think of as sort of managed care from a panel of experts?

SECRETARY LEAVITT: Your question is a good one. It prompts me to basically make the observation that this entire debate—I indicated I think it's moved from health reform to economic reform—boils down to two fundamental questions, and we're now examining both of them.

The first is "What is the role of government?" and the second is "How much can we afford to spend?" And I guess I would reverse the order and ask, "How much can we afford to spend?" and "What's the role of government in making that decision?" I would argue that the global economic marketplace is now beginning to say there's a limit on the amount you can spend and still remain viable.

And that big question may be answered more in a dispassionate way. People are going to be exercising their financial best interest, down from the level of the country all the way to ordinary consumers. This is clearly coming down on the side of there being a limit on what we can afford to spend.

What's the best way for government to be involved? In the same way that I believe that creating

and organizing an effective marketplace will produce the efficiencies far more quickly in Medicare, as it has done in Part D, I think the same is true in the area of "comparative effectiveness."

I need to insert a caveat here. I believe we have not yet figured out how to do this very well, either in the government sector or in the private sector. And I would argue that the next ten years is going to be the era of the value proposition. It's going to be a period during which an entirely new category of innovation is opened up. In the past, innovation has been a new molecule, a new device, or a new protocol. In the future, innovation will be, How can I demonstrate in quantitative terms so sufficiently clear and predictable that I can say to someone who is writing a check for health care, "If you give me a dollar today, I will save you two tomorrow"?

I want to suggest that I don't think government does that as well as markets do. But I don't think the markets have yet created a structure around which we can begin to judge this, and I think that has got to become a major element of innovation over the course of the next decade.

Now, Tevi, the time you allotted has concluded. May I just say thank you again to you for your work on this as well as thanking the Hudson Institute for sponsoring this forum, and I look forward, with all of you, to finding ways we can apply the lessons of Part D to the future. Thank you.

PANEL DISCUSSION

The panel brought together a group of people who had played diverse roles in bringing about Medicare's prescription drug benefit. At the time Part D became law, *Doug Badger* was President Bush's key staffer for working with Capitol Hill to produce a legislative result and then for implementing the law. *James Capretta* offered the view of someone who helped shaped the Bush administration's proposals and had to deal with the fiscal implications as the

senior health person in the White House's Office of Management and Budget. *Mary Grealy* was and is president of the Health Leadership Council, providing the experience of the health industry in the implementation period. *Jack Hoadley* has had a long-term involvement with research on prescription drug use by Medicare beneficiaries, something he continues to follow through research for such groups as the Kaiser Family Foundation and the Medicare Payment Assessment Commission (MedPAC). Hudson Institute Visiting Fellow Hanns Kuttner moderated.

HANNS KUTTNER: Thank you, Secretary Leavitt, both for taking this as an opportunity to address the narrow topic of Part D and for helping us evaluate it as a way to think about Medicare going forward.

We're going to go alphabetically through our panel, which will put Mr. Badger first. And we're going to start off with an opportunity to frame this question of "five years later, is it working?" How do you think about this question?

DOUG BADGER: Thank you. I'm going to offer the perspective of someone who was involved in the implementation of the law as well as in its drafting. I want to go back and consider a moment in which a president signs into law a measure that he calls historic. During that signing ceremony, in another part of town, protesters were gathered to decry the law.

Critics on the left called it a giveaway to insurance companies. Critics on the right called it an unaffordable boondoggle. And even before it was implemented, the administration faced what seemed a daily barrage of assault in the media, pointing out some new deficiency in the law, even as folks in the administration were working to try to implement it.

I think I've described what is probably occurring right now in both the White House and the administration as they try to implement the health reform law. And it certainly was the case when we were involved in trying to implement the Medicare drug benefit seven years ago. I want to talk about it in terms of

something we couldn't express at the time, and that our successors in the administration can't express at this time, which is the doubts we had that this thing was ever going to take off and get off the ground.

I can talk about four areas in particular, things that we worried about. I do that from the perspective of seeing, really, none of those fears actually come to fruition. And at least from that narrow perspective, I would argue that the law has worked.

The first question we faced is, would plans show up? We all knew that this idea of a stand-alone drug benefit didn't exist in nature, but suddenly, through the creation of this program that the secretary has very well described, they were going to materialize.

There were all sorts of reasons why they wouldn't, and precisely, they go to the questions of the extent to which people's risks are actually predictable and whether drug coverage was an insurable event. I must say that the particular mechanism the secretary described to make it easier for beneficiaries to choose among competing plans actually made it more complicated from the plan's position. We essentially created an adverse selection machine where, if anyone's worked this through with a senior, either on the website or by calling the 1-800-MEDICARE number, you tell the person or punch into the machine exactly the medicines you're taking, exactly which pharmacy you want to pick it up at, and the dosage you're taking, and all of a sudden it spits out which plan will be the cheapest for you, not just in terms of premium but also cost sharing, with a little chart to show what your expenses would be on a month-by-month basis.

So we put together a machine that showed people how to select against plans and hoped the plans showed up. Obviously they did. The fallback was never needed. And to that extent, things worked better than we feared some days.

The other question, of course, was would *seniors* show up? What seniors were hearing was confusing, that it wasn't really going to save them money, that they could get their drugs cheaper on *drugstore.com*

and that this whole law was constructed as a way to generate profits for the insurance companies and the pharmaceutical industry.

Well, if you hear that and you're 73 years old, you're not very excited about signing up for this benefit. But, again, in part—I would argue in large part, because of the secretary's effort and Tevi's willingness to winter in Albany—people did sign up.

The message that was continually sent through the media was relentlessly negative—and, I think it's fair to say, just as it is today for many aspects of the health reform law. And what they did was actually construct a political campaign. They got on buses and went not to the major media markets, but to small, warm-weather towns and cold-weather towns throughout the winter. And when you came into a town of that size, you dominated the local television news and the other local media. People turned out to come to the Medicare bus and sign up and so on and so forth. And essentially they constructed what again would look a lot like a presidential campaign. Mr. Secretary, I don't know why you're not running this country. You built the model to actually find alternative ways to reach out to seniors, and as a result, they did show up.

I will say with respect to adverse selection that I have colleagues on this panel who are serious researchers, unlike me, and I apologize to you in advance. It's true that the first time you sign up you do get that information, and you may well gravitate to the least expensive plan. The churn from year to year is about 6 percent, which looks a lot like the Federal Employees Health Benefits Program. Most people in FEHBP end up with Blue Cross Standard Option, even though—and I don't mean to offend anyone from Blue Cross—it's a stupid plan for most people. Everybody just renews in that plan rather than taking advantage of the fact that year after year they can select plans that make more economic sense. But people tend to stay put. If they're happy with what they have, why go through the disruption of changing? And that may well have

mitigated some of the adverse-selection problems.

The third thing we worried about was Medicaid. The administration and Senate approaches advocated for just leaving people where they were. If you were getting your drugs through Medicaid, stay in Medicaid. Let's not spend money to buy people out of that system. The House ultimately prevailed on that point in saying that people are seniors first, and all seniors should be in Medicare. That created enormous disruptions in the early days of the program, particularly for patients who were in nursing homes, where the logistics of having different patients in different plans with different formularies and so forth were truly insane and caused a great deal of disruption. It also gives rise to the continuing argument that's going on even now in the Supercommittee that, Well, wait a minute—if we've got all these people in Medicaid, now on Medicare Part D, why don't we bring the Medicaid rebates with them into the Part D program? So it's become an ongoing political debate.

And finally, we worried about whether employers would stay in the game. Employer-provided retiree health coverage had been on a consistent decline over time, and what we didn't want was something that would exacerbate that decline. Ultimately what was decided was to give a subsidy to employers who continue to provide coverage. We made sure that the subsidy was smaller than the average cost of the subsidy in the Part D program, and probably the last matter decided in the conference back in 2003 was to say that this subsidy would not be taxable to the employer. That really did keep employers in the game and at least slow the decline of employer-sponsored coverage.

One of the curious things of the health reform law is that it took away that tax deductibility, and now employers are announcing they're going to drop their coverage. I found that curious because the authors of that legislation have gone to such great lengths to at least convince the Congressional Budget Office that employers won't drop coverage

once subsidized insurance is available through the exchanges. So they obviously saw the value of having employers stay in the game; but, for whatever reason, they took away that deduction.

So, that said, again, from a very narrow perspective of getting up every morning and worrying what would go wrong next with the Part D program, the program has certainly performed much better than we'd expected.

MR. KUTTNER: Jim Capretta, how do you think about this question, is it working?

JAMES CAPRETTA: Thank you, Hanns. Thanks for Hudson for organizing this. And I hate to sort of be an echo of what we've already heard from Secretary Leavitt and Doug, but of course my answer to the question is yes, that it has been a success.

In the time here I have available, I'd like to focus a little bit on why that's the case, and maybe pose the counterfactual: It can't be proven, but, you have to sort of think of these things as, "What's the alternative, really?"

I think what this gets down to is a question of political economy. What we need in American health care, and also in the drug benefit and the rest of the system, is more productivity in the health sector. We need to be able to deliver higher value at a moderating rate of cost growth. Otherwise we're going to bankrupt everybody.

And so the question becomes, how can that be brought about? How can you bring some kind of a productivity principle back into the American health sector so that it actually does deliver more for less over time? That's a political-economy question, really, based on where we are. The government is already knee-deep involved, so the question is, which direction do you take to try to make that happen more readily going forward?

There are basically two paths you could take. You can try to do something like the Part D benefit, but the alternative is you could try to legislate cost

controls in some way. And I believe it's instructive to think about what's happened in the Part D benefit versus what might have happened otherwise. The theory is that if the government actually was setting prices, and perhaps even mandating generic substitution, we might have gotten an even less expensive Part D program that was operating even more efficiently than what we have today—and consumers would be just as happy.

“How can you bring some kind of a productivity principle back into the American health sector so that it actually does deliver more for less over time?”

But I think you have to then ask, How would you introduce that into the political process we have in the United States, and what would happen when you did so? And I think it's pretty predictable what would happen.

Let's assume that the government said, We're going to mandate certain levels of generic substitution, which is really what has happened a lot in Part D. A lot of that has involved encouraging seniors in huge numbers to take up effective generics, when available, to substitute for a branded drug. It's happened throughout the marketplace, but it's happened at an even more accelerated rate in the senior population.

And that's happened without the government mandating it. But let's assume that we didn't do the

Part D benefit the way we did it, but instead had the government running everything and tried to mandate generic substitution.

We might have gotten some provision halfway into law in doing so, but it would have been with lots of caveats. I'm sure the representatives of the branded pharmaceutical industry wouldn't be all that keen on having the government mandate generic substitution for all their products. You would have a hue and cry about that and all the exceptions about why it isn't appropriate in this case or that case. Furthermore, you'd have huge fights about the level of reimbursement for the generic substitutes. So, looking at that going forward, it's not at all clear that that approach could easily have gotten through the political process without it being worse—much, much worse—than the design that ended up in the Part D programs themselves.

Why do I bring this up? Because it's relevant to the rest of Medicare as well. If the Part D model is working well, it's in large part because at the beneficiary level they have an incentive for a low premium plan. The government's contribution, by law, in Medicare Part D, as Secretary Leavitt pointed out, is determined on a defined contribution basis.

They take the weighted average bids of all the Part D plans in a region and say, "The government is going to take the average of those, and here's your entitlement. If you want a more expensive Part D plan, you pay more. If you want a less expensive Part D plan, your premium will be less." So the beneficiaries have, by definition, a pretty strong incentive with that kind of a design to get into a low-premium plan, and the fact that they may not be wild about the government telling them that they have to be in generics may have been one thing. But if it can save them ten bucks a month on a premium by a Part D plan organizing a system of formulary and coverage so that they have a pretty strong incentive to use generics instead of branded drugs, they sign up in droves for that.

So the kind of delivery-system change—the kind

of change we want throughout the health system, producing more efficiency and higher productivity, more for less—was brought about in Part D without the government requiring it. And if the government ever required it, it probably would have backfired.

If you look at the rest of the Medicare program, it does backfire. It happens all the time. There are all these efforts underway in the larger Medicare program to have the government engineer higher productivity in the health system, but the truth is that the way they cut costs in that program is never by that method. They end up cutting costs by just paying everybody less, at an across-the-board payment-rate reduction. And that doesn't bring about any kind of productivity improvement.

I think it's quite clear from all the evidence we've already talked about, which Secretary Leavitt laid out, that Part D is working quite well. And I do believe that its lessons can be applied more broadly to the rest of Medicare and that the application really needs to be done soon. Thank you.

MR. KUTTNER: Mary Grealy.

MARY GREALY: Well, similar to Doug, I'm going to take a bit of a walk down memory lane. I think it is very fair to say that the Medicare Part D program was something of an underdog when it first started out, for a number of reasons that I'll comment on in just a moment.

But I would say it's not fair to call it "The Little Engine that Could," because I don't think you could describe a program that covers tens of millions of beneficiaries as little; but also because it would probably be more accurate to describe the Medicare Part D program in those early days as the engine that had every possibility of derailing, overturning, and bursting into flames, much as I think was Doug's concern.

So I think it's important to take a moment to explore how we did avoid that fiery crash. I remem-

ber the launch of Medicare Part D very vividly. The organization I represent, the Healthcare Leadership Council, had long supported putting a Medicare prescription drug benefit into the program. The HLC felt we really needed to modernize that program, and I thought it was appropriate to call it the Medicare Modernization Act.

As that was being debated, we ran television ads with a coalition we were heading, and some of you may remember the ads: a crotchety old man looking into the camera and saying to Congress, “When are you going to get it done?” I’m not going to claim total credit for us getting this vote and getting it passed, but I really like to think that some people probably voted for it just to get that guy off the air.

After passage, I don’t think it took a psychic to realize that there were going to be some serious hurdles to this new program, to getting it widely accepted by seniors. And as you remember, we had something like an 18-month to two-year period before seniors were actually going to have this benefit in hand.

First, we had to deal with the projections. Many of them we now know were widely off base, and many were just flat-out contradictory. You would pick up the newspaper and, as Doug said, you’d read that no plans were going to participate with this new product. I remember one person saying, Well, it’s like insuring haircuts. You know, everyone is going to want that haircut. Who is going to insure just that product? We weren’t going to have plans entering the marketplace for Part D. Then we began to hear, Wait a minute; there are going to be too many plans participating and it’s going to be too confusing for the Medicare beneficiaries to choose among them. And I must say, I’m one of those people who don’t believe you turn stupid when you turn 65, but that’s a whole other story.

Then you would see predictions that Medicare Part D would bankrupt the entire Medicare program and would leave taxpayers with cost overruns. There was that drumbeat as well. It just seemed that every day there was a new negative pro-

jection about the program; it was quite a challenge.

We also had as a backdrop the intense political conflict surrounding the passage of the legislation, and that did not go away for quite a while. I think it’s natural that we were going to have some lingering hard feelings, given how close that vote was. As you remember, it was a very, very close vote, particularly in the House of Representatives.

We were dealing with that environment. We were out there trying to convince seniors that this is a good program while they’re still hearing from politicians in Washington that it’s a disastrous one. I happened to pull out an op-ed that was written for a seniors publication by a member of Congress just a few years ago. At the time when we should have been trying to educate older Americans about the new program, helping them seek out a plan that would work for them, that particular op-ed was describing the program as “deeply flawed,” one that “overwhelmingly fails the American people,” and again, “too confusing,” “too costly”; and of course, it was “just going to be a total failure.” That is mild compared to some of the stuff that I think was being put out immediately after passage of the Medicare Prescription Drug, Improvement and Modernization Act.

Of course we now know that Medicare Part D is not a failure, and it’s not a failure in the eyes of the Medicare beneficiaries. We made the commitment to members of Congress whom we asked to support this legislation: We will be there for you; we know that for some of you this was a tough vote, but we are going to work to educate seniors, educate the public, and educate the media as to why we think this is a good program.

One of the things we’ve been doing since passage has been to conduct annual polls measuring seniors’ satisfaction with the prescription drug program. The lowest figure we’ve seen—and that was in the first year, when it was hardly up and running—was a 78 percent approval rating. The highest we’ve hit is 90 percent, and just this past year, the survey showed 84 percent satisfaction. I’m not sure we can

find another government program that would have that high a satisfaction rate from its beneficiaries. I think it's better than most programs out there.

But we know that at the outset there was no way we could be certain that the program was ever going to be that popular, because of mistaken projections and the ongoing political battle. But I think also because the program was just so new and different that beneficiaries probably were going to be a little skeptical about enrolling in it.

The question for us was how do you overcome those doubts and encourage seniors to enroll in this new benefit? One of the things we did—and I would certainly commend this to those who are trying to implement the Affordable Care Act and who have to figure out how are we going to get people to enroll in insurance—was research the best vehicles to transmit the information and message about the new benefit. We knew that the federal government was going to be doing mailings to seniors, as well as some TV spots and public service ads. The question was, Is that going to be enough to penetrate the wall of doubt we know is out there? We engaged the Shapiro research firm to do some polling and also to do some simulation exercises on which methods of communication would be effective in getting seniors not just to know about the program but to actually enroll in it.

I found the results very interesting. We *knew* that direct mail would have a positive effect, because it would make people familiar with the program. We *learned* that TV commercials would really convert very few people into taking action and enrolling. So what would move people to act?

We found that seniors wanted to have very detailed information and that they would be offended if the message was too simplistic. So they really wanted in-depth knowledge and detailed information. They also wanted that information from someone whom they considered an expert. It could be a government official or it could just be someone knowledgeable about health care and about the

program. That could be imparted in a town hall setting or on a radio or TV program, but they wanted something about 30 minutes long. And I remember Secretary Leavitt and others doing some of those types of programs, again to educate. Maybe it's a population that's just a little more patient than younger people, but they wanted the information, they wanted to go to town halls. They might not ask a question at that town hall, but they wanted to hear what other people are asking, because maybe that would be the information they needed.

Armed with that kind of information, we formed a coalition of over 400 national and local groups called Medicare Today. They included groups like AARP, local pharmacies, and a lot of church groups, which were really doing outreach. Then we found expert spokespersons to go and meet with those groups. We trained over 175,000 people to be those expert spokespersons and to really get out there and help enroll these beneficiaries. This coalition conducted about 3,500 education and enrollment events, and over 500 of them were with members of Congress.

And I must say, even as some Democrats were criticizing the program at the *federal* level, that they understood this was an important benefit for their beneficiaries and constituents. They would ask us to come and work with them at the *local* level to help educate and help enroll their constituents who would benefit from the program.

We directly enrolled about six million Medicare beneficiaries just through our initiative, and I think helped educate many, many more. We also commissioned PricewaterhouseCoopers to do a state-by-state study to give us factual information on how much Medicare beneficiaries would be saving under this program.

That really helped when we were doing these local radio station call-ins where we could say, OK, beneficiaries living in this state are, right now, spending on average this much, and under this program they're going to save that much. That was

very effective. We worked with local newspapers, local radio, local TV as well.

PricewaterhouseCoopers also helped us create some very useful tools. One of them we called “the wheel.” Beneficiaries answered such questions as, What are you spending on drugs today? What’s your age? What kind of coverage do you have? And they could manipulate this tool and get an idea of why they should enroll, because the tool showed how much they were going to save.

It saved me, right before the 2004 election, not too long after passage. I was in West Fort Lauderdale. I grew up in that area, a Democratic stronghold, and I was appearing before a very tough audience. But once those people saw this tool and what they were going to save, it changed the whole tenor and tone of the meeting.

So our goal was to give people factual information and help them see why this was something that was going to work for them. I must say this turned out to be what I would call a door-to-door sale. It was a retail initiative and really involved a lot of people, really trying to break through a lot of the rhetoric that was out there. And I think having HHS and CMS as great partners, working with this coalition, helped us acquire the information we needed.

I think we’ve heard that the program has come in way under the projected cost, and I think that’s fantastic. The average premium costs remain at a relatively low level. In fact, this year, the average premium is either not going to increase or may even be *decreasing*. Can you tell me anywhere else that might be happening in health care? I don’t think so.

That just leaves me to say, as Secretary Leavitt and I think Jim were saying, that we really see this as a model for the entire Medicare program. It is a much better alternative than one that has us going through this exercise of continuously cutting fee-for-service payments, thinking that cutting payments to providers, pharmaceutical companies, medical device manufacturers is not going to affect Medicare beneficiaries.

It is, and it’s going to affect them directly in terms of access—not just to services but to new innovations in medical care. We think there are scorable savings here, and we think that this type of approach will produce a better program for Medicare beneficiaries as well. Thank you.

MR. KUTTNER: And Jack Hoadley, our last panelist.

JACK HOADLEY: Thank you. I spent a lot of my time analyzing the numbers in the Part D program, and I’ve done that since day one—in fact, well before day one of the program. And if I weren’t here talking to you this morning, I would actually be back on my computer, because the plan listings for 2012 were released this morning at 10:00, and I spent an hour before I came here starting to take a look at those. Most of those numbers I didn’t have time to look at in an hour to do, but I do have a few things.

As I look at the numbers over the years, they lead me to be a little bit of a contrarian at this party. My overall view is that, no, this program is not a failure, but I think it’s a mixed success. There’s good news and bad news in the track record over the six years that it’s been in existence. And I want to talk quickly about six dimensions.

First is coverage. Overall, the coverage news is pretty good. We do now have 90 percent of all Medicare beneficiaries with drug coverage. But the less positive way to look at that is that of the people who didn’t have coverage prior to the existence of Part D, we’ve only picked up half of that group. We’ve reduced the number of people without drug coverage by half—that’s good news—but we haven’t managed to reach the other half, 10 percent of the overall Medicare population.

Some of them may be people with low needs who are just making a rational decision that “I don’t need these plans.” We don’t really know, and with that part of the problem, we need to dig deeper. But we

worry that a lot of the people in that group are the ones who all these campaigns have failed to reach.

The good news is that we've done some things in the program, especially in the last couple of years, to try to reduce the degree to which the program is confusing. The typical beneficiary, just looking at stand-alone drug plans in 2007, the second year of the program, faced about 50 choices. As of today, for next year's offerings, that's down to about 30 choices.

It's come down gradually, partly through consolidations and mergers in the marketplace, partly because of steps that CMS has taken to try to eliminate some of the duplicative coverage that's out there and partly by encouraging some of the plans that hadn't attract much business to leave the program. Up to that point, they were just kind of staying in, producing more clutter that a beneficiary trying to do research had to sort through. So the number of plans has diminished. It's still, I think, more than it should be in order to make it easier for people to sort through these options.

They've also taken steps to create some greater standardization of what's out there, not to say one size fits all but to say we're going to label these plans in ways that are understandable. For example, a couple of years ago, there were plans that offered a supposedly enhanced benefit that actually had higher cost sharing than the same company's plans with a basic benefit. I've never yet been able to understand what was enhanced about the benefit that the particular kind of plan was offering. Well, the rules don't allow that anymore. If you're going to offer an enhanced benefit plan, it has to be visibly enhanced, so people who choose that plan know that they're getting something extra. It will come at a higher price tag, and that's a choice that they make.

Dimension three, volatility in the low-income market. We've heard some discussion about the fact that this is a program that has extra subsidies for low-income beneficiaries, and that's a good thing. We all, I think, agree on that. What's been problem-

atic is that there has been a lot of volatility in the plans available to low-income beneficiaries.

There are about ten million or so beneficiaries who take advantage of those low-income subsidies, and each year something like two million of them face the fact that their plan is no longer eligible to be available to them at no premium. It's no longer what we call a benchmark plan. People either have to switch on their own or, if they meet certain sets of criteria, be reassigned by CMS to a new plan without a premium. But a lot of these people have

“There has been a lot of volatility in the plans available to low-income beneficiaries.”

seen themselves switching plans multiple times over the years simply to try to stay in a zero-premium plan, a privilege to which they're entitled by the fact of the subsidy.

Again, there have been some improvements. There's more stability. We actually see this year that the number of plans that are eligible as zero premium for the low-income benchmark is basically the same. So because of some things done in the Affordable Care Act (ACA) and some things done administratively by CMS, they've taken some significant steps to cut back on that volatility.

Unfortunately, we still know that in 2011, there are a million low-income beneficiaries who are paying premiums that they shouldn't have to be paying because they're now in plans that don't qualify as benchmark plans, and half a million of those people are paying at least \$10 a month in premiums. All they have to do is switch to another plan. We're either not getting out the word to them or they

think that they can afford it and want to stay where they are—a lot of them because it *is* where they are.

Dimension four is making smart choices. This is where I really want to talk about plan switching. It was cited earlier that 6 percent of people switch plans every year. We actually don't know really what that 6 percent means. The last time a number was published on the amount of switching was from 2007 to 2008. We haven't seen numbers on how much has occurred since then, and we don't know how much of it is switching among plans under the same sponsorship versus people who are actually going out and doing research and deciding that they want to move into a different plan.

We also, of course, don't know how many people do the research, decide that where they are is perfectly good and how many people simply decide not to do the research. We're going to try to look into this subject further. It's kind of tough to do the way the data are structured, but we really would like to understand better why people switch and why, more importantly, they don't.

While the premiums overall have not gone up as rapidly as some expected, there are some plans in the market whose premiums have doubled and tripled since the program began, and people stay in those plans when we know that there can be better deals for them out there.

Again, some steps have been taken to disseminate more information to make it easier for people to switch, but we really don't know whether we've seen any improvement in people's willingness to shop. So I tend to say, thinking about what the Secretary said earlier, yes, people learn to make decisions but not necessarily good ones, and they haven't necessarily learned to shop repeatedly to make sure they're still in the best plan for them.

The fifth dimension is completeness of coverage. The biggest hole in that was the famous donut hole, or coverage gap. The good news there is we're phasing that out. We're now in the second year of a phase-out—really, in a sense, the third year of that

as we go into next year. By 2020, that gap will under the provisions of the ACA, if it's not repealed, go away. That will provide a more complete benefit to people. But it's still also true that the average beneficiary is facing about 25 percent co-insurance, which is higher than typical private-sector commercial coverage. So cost sharing, copays for drugs, tend to be higher in Medicare Part D than elsewhere, and I think that's still something to be concerned about.

And last, program costs. Again, the good news is that the costs have come in well under projections. You can always ask, Was that a problem with the projections versus simply the track record of the program? I think it was probably some of both. My sense is that what's happened in Part D is that, for the most part, the plans have ridden the wave of so many more generic drugs being available.

Look at the flat premiums for 2012, and think about Lipitor and four or five other top drugs that go generic between now and just the middle of next year. Also think about people whose switches will be made automatically at the pharmacy from brand Lipitor to generic Lipitor, with no intervention of their own; if that simply brought the price of those drugs down by half, it would account for essentially the absence of a premium increase for this year. When you talk about the track record of the program and the costs, you have to think a lot about generics. Some of that is what the plans do to help to encourage people to use generics. A lot of it is just the automatic switching that occurs. You're on Lipitor; Lipitor is suddenly available generically. By state law, the pharmacist will switch you to the generic version.

Regarding costs, we also have some issues to raise in the future. One is the expense to high-cost beneficiaries. Part of the design of this program is that plans have very little incentive to address those high-cost people. Plans have only 15 percent exposure because of reinsurance and risk-sharing mechanisms. The problem is going to be not the sort of

health care costs for the average person but the costs for that segment of the population that's up in catastrophic zone. An analysis by MedPAC has suggested that's the area we need to look at in the future, and I do worry that the structure of the benefit doesn't put enough incentive on the part of the plans to really manage for the population with the top expenditure levels.

MR. KUTTNER: I want to ask people, What were the surprises of where we are now with Part D relative to where we started out?

Let me take the moderator's privilege here and show you this graph (Figure 2 in the introductory essay, page 7). Certainly if you're Rick Foster, the Medicare actuary, how much it would end up costing is a surprise for you. It's wound up costing a lot less than it at first was expected. That seems to be because of things that weren't understood well then in the analytical community and by the cost-estimators, particularly generic substitution.

Let me ask the panel what has been, to you, most surprising about what's happened over these last five years.

MS. GREALY: I think the projections, because I can't think of any other time that a benefit has been added to the Medicare program when the cost reductions didn't underestimate the cost.

MR. KUTTNER: So it violates the law of gravity, in a way.

MS. GREALY: Exactly. I think this is a first. It's a stunning first.

MR. KUTTNER: Are there things that were surprises relative to what your prior beliefs were, going into all that? Jack?

MR. HOADLEY: I want to comment a little more on this graph that you put up and the trend. I just

reviewed the six rounds of actuaries' reports. Every single year they've commented, obviously, on why are projections lower than they were before. And two of the primary reasons—usually *the* primary reasons—they cite are more generic conversions and, more importantly, fewer new, important drug products than expected. Their projections really assumed that—as in the 80s and 90s when drugs like Lipitor and the new round of antidepressants, antipsychotic drugs, and diabetes drugs were coming out on a regular basis—we'd see some pattern of continuation, whether for Alzheimer's, treatments for blood pressure or cholesterol or depression, or whatever.

We have not seen those products. Of the top 100 brand drugs that were being sold at the beginning of this program, a quarter of them are already off-patent, and most of the second-quarter of those will be off-patent within the next three years or so.

MR. BADGER: I'll be a little less charitable to the actuaries. I think they blew it. Certainly generic substitution, to some extent, should have been in their projections because they knew when these various drugs were going to come off-patent. They should have foreseen that.

In addition, when we looked at the outset, it was estimated, I think, that the average monthly premium for this would be \$35. And as you know, the premium is set as a percentage of overall spending. When the first actuarial projection came out, they estimated the average premium at \$37.50. The Secretary gave a press conference today, and they're looking at an average premium in year seven of the program at \$30. Isn't it interesting that during mark-up on the original legislation, the Senate Finance Committee actually voted on an amendment to lock the premium in at \$35? It was defeated. But had they done that, the program would be much more costly to beneficiaries than it is today.

So I agree with you. Generic substitution has a lot to do with it. You're much more conversant with the numbers, obviously, than I am. I don't think

generic substitution was entirely unforeseeable. I do think that they made other assumptions that proved to be false about both the competitiveness of the marketplace—it is a very competitive market—and the ability of seniors to navigate that market.

I'd also note that when you look at national health expenditures, we haven't seen a real decline in pharmaceutical spending as a percentage of those expenditures. That's held fairly constant at 10 or 11 percent. There's growth in drug spending, but somehow or other the Part D program is managing to come in dramatically below what it was estimated to cost.

MR. HOADLEY: The overall national health accounts for drug spending is also dramatically down. And to some degree it's a riding-the-wave issue.

The other thing I would point out about the actual premiums that beneficiaries pay—because the base premium that we tended to hear about is the value of the base benefit—is that people of course pick higher cost plans; they pick enhanced plans with additional benefits. The base premium has gone up 48 percent over a six-year period. So people are paying more to pick up their benefits. Some of that comes from their unwillingness or inability to make a switch from a plan with rising premiums back to one that's less expensive, not from a failure of the market.

MR. KUTTNER: Jim?

MR. CAPRETTA: I think a couple of things. One is that it's true that the national accounts estimates have come down—look at they were as of 2004—but not as much as Part D. That has come down dramatically more. And the numbers that are often cited for the drop in the national accounts include Part D. So the first thing you've got to do is pull out the senior population and see what happened to everybody else, and then you'll see it's down but not nearly as much as it is in the senior population.

The second thing is that competition works in a number of dimensions. Take the plans that are par-

ticipating in Part D—and there's a concentration of beneficiaries among a certain number of them. Those plans know that, yeah, there's a certain stickiness to enrollment, but if they move too much away from their competitors or they lose a little bit of an advantage, there's the possibility they're going to lose enrollment, and this has happened with some of them. You don't have to have a huge amount of slipping for competition to also still be working.

Finally, I think you have to ask what would work better. What's the alternative to this? And the alternative is essentially price controls. We can have a long argument about that, but I think it gets back to Mary's point that that policy will be more arbitrary, the pricing more politicized; and it will be more subject to lobbying and not some kind of determination in the marketplace as it is today; and it also probably will end up stifling innovation over time.

Is there always room for improvement in Part D? I agree. I believe there is. But it's far better than the alternative.

MR. KUTTNER: Back to Secretary Leavitt's remarks about Greek bonds. It's a different world now, the world we're in now versus when Part D became law. But I haven't seen anybody saying, I want to constrain the cost of government and get rid of Part D. Has Part D now sort of achieved this institutional, iconic status where its basic legitimacy is not to be questioned?

MR. CAPRETTA: You know it is when an Obama administration official goes to the Hill and argues against changing Part D because competition is working, which happened about a month ago. You know things have sort of settled down when you reach that point. There was a hearing at the Special Committee on Aging about a month or so ago where Jonathan Blum was testifying for CMS, and there were a lot of questions about shouldn't we change Part D in this way; shouldn't we change Part D in that way. Given administration policy, he had to fol-

low the line, and the line was that it's working fine, let's just leave it alone, which is pretty interesting.

AUDIENCE QUESTION: My comment to you, Jack, is just that Secretary Leavitt began by talking about seniors making smart choices, and you talked about the data that you're looking at and whether or not it can be proven that seniors are making smart choices.

I think it really goes to the heart of the discussion between the Affordable Care Act and Part D. I was someone who spent a lot of time with seniors, walking through their choices in the department on Plan Finder. Ultimately, while I would agree that I may not think their choice was the smartest one, there were reasons why they made those choices. It may be that they were at a pharmacy they wanted to be near or that they wanted a particular drug. But at the end of the day, it has to do with consumers making choices that make sense for them and not necessarily the government telling them that they're making the smartest choice. And we could sit there and tell them that the lowest plan is the smartest choice, but ultimately it's leaving them with the power to make the decision that works best for them.

MR. HOADLEY: I totally agree with you that there are lots of dimensions involved in a smart choice. In addition, there have been a couple of studies that have tried to look very simplistically at the numbers, and are people always in the cheapest plan for them under the circumstances, and that's not really the whole story. Like you say, there are choices of pharmacies, there is comfort with the brand name—not of the drug but of the plan. People like to be in an AARP plan or a Humana plan or a Blue Cross plan because they've had experience with it, or whatever.

My concern is when circumstances change—either in their own drug use or in premiums being offered by plans. When we talk to them in our focus

groups, pretty consistently they're telling us that they're not interested in trying to take a look because it's too hard to do. It's too hard to make the switch and too hard to research the options. And as other people have said, even if they do like to research in some detail, they're looking at 30 and 50 different plans, not even counting the Medicare Advantage options; and that was the number we had a few years ago. The book *Nudge*, that's been popular over the last few years, kind of speaks a lot to this point.¹² When decision-making is too complicated, people shut down and decide not to decide.

My point is that we need to continue to make this program an easier one to navigate, through a combination of better tools and fewer overlapping, indistinct choices so that they really can pick between the plan that gives them a big discount to use the Wal-Mart pharmacy and a plan that gives them a broader array of pharmacies perhaps at a higher price, or whatever the choice might be.

MR. KUTTNER: We're going to close out with Tevi Troy, who kicked us off.

MR. TROY: I want to thank all the panelists and the moderator for doing a great job. You really brought out a lot of questions.

I do want to close with a question for Doug Badger. It's a political question, which is why I'm pointing directly to you, Doug. On one hand, congressional Democrats don't seem to love Part D, because it seems like some kind of Bush plan that was helpful to the pharmaceutical companies. Republican presidential candidates don't seem to love it; there was a question in the presidential debate the other night about getting rid of it, and I guess Rick Santorum was the only one who was really willing to defend it, to the extent he did, and that was because he had voted for it when he was in the Senate. Some people did that up on stage, but Santorum wasn't one of them.

But then Secretary Leavitt gets up here today and

makes a statement that Part D is working and we should use it as a model to apply it to the rest of health care reform. What do you think of the prospects, given the dislike on both side of the aisle for some type of broader Part D-type reform?

MR. BADGER: I would totally agree with you, and I think it goes to the fundamental conflicts in health care policy in terms of how you design these plans.

On one side, there's an argument that you should standardize the coverage—the way Medicare has traditionally worked in the fee-for-service program, with slight deviations in recent years for some means testing. The notion is that everybody pays the same, everybody gets the same. That's the ideal. And there are arguments to be made for that as to why it's good and the best way to structure a social insurance program.

There are others, as Secretary Leavitt well articulated, who believe that what we should have is not a defined benefit but a defined contribution, and try to provide people with multiple options and let them choose. There are advantages to that, and as Jack has pointed out, there are also disadvantages that come with choices. I would argue that if you

did the research among federal employees under 65 and looked at their choices in the Federal Employees Health Plan, the employees would probably look even less rational than seniors from an economic point of view, because they do what I did: you've got your little flyer, you put it on your desk, it migrated its way down to the bottom of the pile, and then you realized it was too late to change, and you were in Blue Cross again.

Whatever you say about people, you could present them with choices, but the notion that people are rational economic actors and do what they have to do to make what is the best choice for them, is simply not the case. In the end it comes down to which model you think offers the best way to go. We don't have agreement on that at a political level, and I'm not sure we will anytime soon, regardless of how well or how poorly people think the Part D program has worked.

MR. KUTTNER: Let's thank this panel, because they've done a great job.

[Applause.]

Photos by Philip Ross



MARY GREALY, JAMES CAPRETTA, DOUG BADGER, MICHAEL LEAVITT, TEVI TROY, HANNS KUTTNER, AND JACK HOADLEY

SPEAKER BIOGRAPHIES

Keynote Address

THE HONORABLE MICHAEL O. LEAVITT

He earned a bachelor's degree in business while working in the insurance industry. In 1984, he became chief executive of The Leavitt Group, a family business that is now the nation's second largest privately held insurance brokerage.

In 1993, Leavitt was elected governor of Utah. He served three terms (1993-2003). In 2003, he joined the cabinet of President George W. Bush, serving in two positions: first as leader of the Environmental Protection Agency (2003-05); and then as Secretary of Health and Human Services (2005-09). At HHS, Leavitt administered a \$750 billion budget—nearly 25 percent of the entire federal budget—and 67,000 employees.

He led the implementation of the Medicare Part D Prescription Drug Program. The task required the design, systematization, and implementation of a plan to provide 43 million seniors with a new prescription drug benefit. By the end of the first year, enrollments exceeded projections, prices were lower than projected, and seniors expressed high levels of satisfaction.

Leavitt is, at heart, an entrepreneur. As governor, he organized a group of his colleagues to form Western Governors University. At WGU, degrees are earned based on competency rather than credit hours. WGU now has more than 20,000 students who reside in each of the 50 states and several foreign countries. Enrollment is growing at 35 percent a year. In November 2008, *Time* magazine named WGU “the best relatively cheap university you’ve never heard of.”

Introducing Secretary Leavitt

THE HONORABLE TEVI TROY

Tevi Troy is a Senior Fellow at Hudson Institute, and a writer and consultant on health care and domestic policy.

On August 3, 2007, he was unanimously confirmed by the U.S. Senate as the Deputy Secretary of HHS. As Deputy Secretary, Dr. Troy was the chief operating officer of the largest civilian department in the federal government. In that position, he oversaw all operations, including Medicare, Medicaid, public health, medical research, food and drug safety, welfare, child and family services, disease prevention, and mental health services. He served as the regulatory Policy Officer for HHS, overseeing the development and approval of all departmental regulations. In addition, he led a number of initiatives at HHS, including implementing the President's Management Agenda, combating bio-terrorism, and contributing to public health emergency preparedness. He also sponsored a series of key conferences on improving HHS' role with respect to innovation in the pharmaceutical, biomedical, and medical device industries. Dr. Troy has led U.S. government delegations to Asia, the Middle East, Europe, North America, and Africa.

He has extensive White House experience, having served in multiple high-level positions over a five-year period, culminating in his service as Deputy Assistant and Acting Assistant to the President for Domestic Policy, where he ran the Domestic Policy Council and was the White House's lead adviser on

health care, labor, education, transportation, immigration, crime, veterans affairs, and welfare. At the White House, Dr. Troy specialized in crisis management, creating intra-governmental consensus, and all aspects of policy development, including strategy, outreach, and coalition building. He spearheaded the White House's American Competitiveness Initiative, featured in the 2007 State of the Union Address. He also served as Special Assistant to the President and Deputy Cabinet Secretary.

Before coming to the White House, Dr. Troy filled the post of the Deputy Assistant Secretary for Policy at the Department of Labor, where he was the Department's lead regulatory strategist. At Labor, Dr. Troy crafted the Department's new ergonomics policy, as well as plans for a compliance assistance strategy for the department's regulatory and enforcement arms.

Dr. Troy has held high-level positions on Capitol Hill as well. From 1998 to 2000, he served as the Policy Director to Senator John Ashcroft; from 1996 to 1998, as Senior Domestic Policy Adviser and later Domestic Policy Director for the House Policy Committee, chaired by Christopher Cox. He has also been a Research Fellow at the Hudson Institute and a researcher at the American Enterprise Institute.

Dr. Troy has a B.S. in Industrial and Labor Relations from Cornell University as well as an M.A and Ph.D. in American Civilization from the University of Texas at Austin.

Panel Discussion

DOUG BADGER

Doug Badger is a Partner of The Nickles Group, LLC, providing clients expertise on a range of issues from health care and energy to taxes, financial services, telecommunications, and trade. Prior to joining The Nickles Group, Badger served as the Deputy Assistant to the President for Legislative Affairs, where he helped formulate the Bush Administration's policy

and legislative strategy. While at the White House, he was also the President's lead health-policy advisor, working on the Medicare Modernization Act as well as on Medicare's drug coverage, Medicare and Medicaid reimbursement issues, and the creation of health savings accounts

Badger has worked as a partner at Washington Counsel Ernst & Young, specializing in health care, intellectual property, and employee benefits. He served for a decade as a U.S. Senate aide, including stints as Chief of Staff to Assistant Majority Leader Don Nickles and Staff Director of the Senate Republican Policy Committee. He has held senior positions at HHS and the Social Security Administration

Badger holds a master's degree from Westminster Theological Seminary and a bachelor's degree from the University of Delaware.

JAMES C. CAPRETTA

James C. Capretta, a Fellow at the Ethics and Public Policy Center (EPPC), was an Associate Director at the White House Office of Management and Budget (OMB) from 2001 to 2004, where he had responsibility for health care, Social Security, education, and welfare programs.

At EPPC, Capretta studies and provides commentary on a wide range of public policy and economic issues, with a focus on health care and entitlement reform, U.S. fiscal policy, and global population aging. His essays and articles have appeared in numerous print and online publications, including *USA Today*, *Politico*, *Health Affairs*, *National Affairs*, *Kaiser Health News*, *The Weekly Standard*, and *Tax Notes*. He is the author of the blog *Diagnosis* and is a frequent contributor to *National Review Online*. Capretta has also testified before Congress and appeared as a commentator on BBC World News, PBS Newshour, Fox News, Fox Business News, CNBC, MSNBC, EWTN, and numerous national and local radio programs.

In addition to his work as a researcher and commentator on public policy issues, Capretta is a health policy and research consultant with Civic Enterprises, LLC, a Senior Advisor to Leavitt Partners, and an Adjunct Fellow at the Global Aging Initiative of the Center for Strategic and International Studies and Hudson Institute.

Earlier in his career, Capretta served for a decade in Congress as a senior analyst for healthcare issues and for three years as a budget examiner at OMB. He has an MA in Public Policy Studies from Duke University, and he graduated from the University of Notre Dame with a BA in Government.

MARY GREALY

Mary Grealy is president of the Healthcare Leadership Council, a coalition of chief executives of the nation's leading health care companies and organizations. The HLC advocates on consumer-centered health care reform, emphasizing the value of private-sector innovation. It is the only health policy advocacy group that represents all sectors of the health care industry. She was appointed to the position in August 1999.

Grealy has an extensive background in health care policy. She has led important initiatives on the uninsured, Medicare reform, improving patient safety and quality, protecting the privacy of patient medical information, and reforming the medical liability laws. She testifies frequently before Congress and federal regulatory agencies.

From 1995 until she began her tenure at HLC, she served as Chief Washington Counsel for the American Hospital Association, a national organization representing all types of hospitals, health systems, and health care networks. In her position, she was responsible for the organization's legal advocacy before Congress as well as executive and judicial branches of government.

From 1979 to 1995, Grealy was Chief Operating

Officer and Executive Counsel for the Federation of American Hospitals, a trade association representing 1,700 investor-owned and managed hospitals and health systems. She coordinated legislative and regulatory policies as well as lobbying activities for the federation.

She has a bachelor degree from Michigan State University and a law degree from Duquesne University. She is a member of the American Health Lawyers Association, and serves on the advisory boards of Duquesne University, Duke Health Sector Advisory Council, Women Business Leaders in Health, and the March of Dimes. She is a frequent public speaker on health issues and has been ranked by *Modern Healthcare* as one of the 100 Most Powerful People in Healthcare every year since 2003.

JACK HOADLEY

Jack Hoadley is a health policy analyst and political scientist with over 25 years experience in the health policy field. He joined Georgetown University's Health Policy Institute in January 2002; there he conducts research projects on health financing topics, including Medicare and Medicaid, with a particular focus on prescription drug issues. Prior to arriving at Georgetown, Hoadley held positions at the Department of Health and Human Services in the Office of the Assistant Secretary for Planning and Evaluation (ASPE); the Physician Payment Review Commission (PPRC) and its successor, the Medicare Payment Advisory Commission (MedPAC); the National Health Policy Forum at George Washington University; and in the office of U.S. Representative Barbara Kennelly.

While at Georgetown, Hoadley has undertaken projects for a variety of government and foundation clients, including MedPAC, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Kaiser Family Foundation, the Commonwealth Fund, the Jessie Ball duPont Fund, and

the Robert Wood Johnson Foundation. Recent projects have included the use of formularies in the Medicare drug benefit, a study of the potential for standardizing benefits in Medicare Advantage and the Medicare drug benefit, evaluations of recent or proposed changes to Medicaid programs in Connecticut and Florida, and an analysis of the use of evidence-based medicine to manage pharmacy costs in Medicaid. His series of reports on Medicare Part D formularies and the Part D coverage gap, published by the Kaiser Family Foundation, received considerable attention from both media and policy-makers. Hoadley is currently working on a new analysis of Part D claims data to assess the factors that influence decisions to use generic drugs.

During his time in ASPE, Hoadley played a key role in the development of legislative options for Medicare modernization, especially a prescription drug benefit. He headed a department team that released a report in April 2000, "Prescription Drug Coverage, Spending, Utilization, and Prices." During his time at PPRC and MedPAC, he was a lead contributor to the commission's annual reports, including analyses of trends and developments in Medicare managed care, risk adjustment, health system reform, and Medicaid managed care.

He received his Ph.D. in political science from the University of North Carolina at Chapel Hill in 1979. He taught political science at Duke University and at the State University of New York at Stony

Brook before coming to Washington as an American Political Science Association Congressional Fellow in 1983-84. He has published one book, *Origins of American Political Parties, 1789-1803*, and several articles in professional journals.

Moderator

HANNS KUTTNER

Hanns Kuttner is a Visiting Fellow at Hudson Institute. His career spans the policy and research world. During the presidency of George H.W. Bush, he was part of the White House domestic policy staff with responsibility for health and social service programs. Most recently, he was a research associate at the University of Michigan's Economic Research Initiative on the Uninsured. He has also worked for the federal agency which runs the Medicare and Medicaid programs and advised the state of Illinois on restructuring its human service programs.

He has written extensively about issues relating to Americans' health insurance status and the potential for improving the American health care system. With Gail Wilensky and Joseph Antos, he wrote, "The Obama Plan: More Regulation, Unsustainable Spending," published in *Health Affairs*, the policy journal of the health sphere, in September 2008. His current research projects investigate sources of growth in health care costs.

NOTES

1. National Bipartisan Commission on the Future of Medicare, “Building A Better Medicare for Today and Tomorrow,” March 16, 1999. <http://thomas.loc.gov/medicare/bbmtt31599.html>
2. The White House, “Fact Sheet: President Clinton and Vice President Gore: Working to Make Prescription Drugs Affordable for Seniors,” October 25, 1999.
3. The White House, “Fact Sheet: Framework to Modernize and Improve Medicare,” March 4, 2003. <http://georgewbushwhitehouse.archives.gov/news/releases/2003/03/20030304-1.html>
4. Dana P. Goldman and Geoffrey E. Joyce, “A Third—and Better—Way for Prescription Drug Coverage,” *Los Angeles Times*, November 5, 2000. <http://articles.latimes.com/2000/nov/05/opinion/op-47267>
5. Karen Davis, “Despite Medicare Bill’s Passage, Congress’s Work Unfinished,” The Commonwealth Fund, www.cmwf.org, November 26, 2003.
6. Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy. March 2008,” (Washington: MedPAC, 2008).
7. Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy. March 2011,” (Washington: MedPAC, 2011).
8. KRC Research, “Seniors’ Opinions About Medicare Rx: Sixth Year Update,” October 2011.
9. J. Michael McWilliams, Alan Zaslavsky, and Haiden Huskamp, “Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage,” *Journal of the American Medical Association*, 306 (4) (2011): 402-09.
10. The twelve-member Joint Committee on Deficit Reduction, also known as the Supercommittee, created by the Budget Control Act of 2011 and tasked with writing legislation to reduce the federal budget deficit by \$1.5 trillion over ten years. The statute creating the committee gave it authority without recent precedent to write legislation and see it put to an up-or-down vote.
11. Accountable Care Organization. Based on demonstration projects carried out during Secretary Leavitt’s tenure, the ACO provides a way for providers to enter into risk-sharing arrangements with Medicare.
12. Richard Thaler and Cass Sunstein, *Nudge: Improving Decisions about Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008).

Hudson Institute is a nonpartisan, independent policy research organization dedicated to innovative research and analysis that promotes global security, prosperity, and freedom.

Founded in 1961 by strategist Herman Kahn, Hudson Institute challenges conventional thinking and helps manage strategic transitions to the future through interdisciplinary studies in defense, international relations, economics, health care, technology, culture, and law.

With offices in Washington and New York, Hudson seeks to guide public policy makers and global leaders in government and business through a vigorous program of publications, conferences, and policy briefings and recommendations.

Hudson Institute is a 501(c)(3) organization financed by tax-deductible contributions from private individuals, corporations, foundations, and by government grants.

www.hudson.org



1015 15TH STREET, N.W., SIXTH FLOOR, WASHINGTON, D.C. 20005

HUDSON INSTITUTE

TELEPHONE 202-974-2400 WWW.HUDSON.ORG