Medicare Part D Drug Benefit: Five Years Later—Is it Working?

Featuring a Keynote Address from Secretary Michael Leavitt

with
Tevi Troy
Hanns Kuttner
Doug Badger
James Capretta
Mary Grealy
Jack Hoadley

September 15, 2011
Hudson Institute

Medicare Part D Drug Benefit: Five Years Later – Is It Working?

Welcome:
Tevi Troy,
Senior Fellow,
Hudson Institute

Keynote Address:
Michael Leavitt,
Former Secretary of Health and Human Services

Location: Washington, D.C.

Time: 12:00 p.m. EDT
Date: Thursday, September 15, 2011
TEVI TROY: Hello, and welcome to the Hudson Institute. My name is Tevi Troy. I am a senior fellow here at Hudson and I appreciate all of you coming out to our conference called “Medicare Part D Drug Benefit: Five Years Later – Is It Working?” And we’re going to have some 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 having worked with Secretary Leavitt at HHS, and I have the privilege and honor of being able to introduce my former boss, Secretary Leavitt, here today.

You know, there are many things that we know about Secretary Leavitt from reading his bio. And his bio and all of the panelists’ bios are there on your chair. We know that he is smart and he is talented. He is a three-term governor of Utah, 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 had the privilege of doing when I was deputy secretary at HHS for three years.

And I saw up close just how hardworking 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 and things that you don’t really know, again, unless you see somebody up. It doesn’t come across on a piece of paper.

So just to tell one quick story about that, when I began at HHS, right after I started I was told that I was going to go on a trip with Secretary Leavitt to talk about food safety. There were some concerns about some products that had been tainted and some people had gotten sick, unfortunately.

And we were going to do a nationwide tour on food safety, to promote the safety of our food system but also talk about all of our efforts to make sure that the system was safe and how we were examining the system, and we were in the midst of doing a major report on it and revising FDA regulations and the like. So we were going to go on this tour and it was a 48-hour tour.

We had a very small window to do this tour – only two days. And 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.
While we were there—and each one of these places, separate events, big kind of—you needed a full advance team at each one to set up the entire event and to have all of the people there.

But at each one 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 but also at the same time about all the efforts that we were undertaking to make sure that the system was safe. And 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 he said on the way over there: “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 Secretary Leavitt. And I went and I must say I was a little nervous because I hadn’t done that much of it. I had just been confirmed. But I not only did the event but I learned a great deal about doing it. Secretary Leavitt understood that sometimes the best kind of training is the on-the-job variety. And 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 do that kind of personal interaction with a large crowd. So I really appreciated his efforts and those two skills and I also saw that he took those skills and applied them to the implementation of Part D.

But in terms of those two skills, Secretary Leavitt applied them both to the Part D implementation in the following ways. Not long after the bill passed, we had an implementation period and 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. And in this particular case, there were skeptics on the left and on the right who were saying the bill would cost too much—the new program would cost too much, that seniors wouldn’t sign up, that seniors wouldn’t make choices. Secretary Leavitt knew that these were not true, that these were not accurate.

But he also knew that he could play a role in minimizing the extent to which those would be problems. And so he kind of rolled his sleeves up and he got to work. He worked very hard in terms of going over to CMS to work on the rules and the regulations and on the marketing materials that would go to seniors to make sure that the seniors were aware of what their options were. 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 and recognizing that they had choices, that it wasn’t a one-size-fits-all government benefit but that they had choices and they could pick the plan that was best for them.

And that was the whole point behind the design of the program. And then even afterwards, after the successful implementation, he continued to work on Part D and make sure that seniors were doing what they needed to do in terms of signing up and making choices. We would have an annual trip every year when it was time for the Part D open enrollment period.
And Secretary Leavitt would insist that all of the top senior staff at HHS would go around the country. We’d deploy around the country to senior centers to encourage seniors to sign up for the benefit and to take choices and to look at the options and to make the choice that was best for them.

Well, at one of these planning sessions, I just—being the curious kind of guy that I am—happened to notice that in the dead of winter on these trips, Secretary Leavitt was going to places like Miami, Dallas, Los Angeles, and my itinerary included places like Wichita, Providence and Albany—fine cities all—but less pleasant in February than any of the cities Secretary Leavitt was going to. And I asked 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.” And he was right. I mean, he understood the importance of deploying resources as appropriate. And so that was another one of his good and useful skills.

Now, here we are five years later and Part D, I would argue, is successful, although we will have a conversation about it today. And it is successful, I would argue, because, A, of its market-based design but also, B, because of the hard work that this man, Secretary Leavitt, put into it.

Now, you’re going to hear a lot of statistics today and I’m not going to bore you with them because you’ll have plenty of opportunity to hear from the people on the panel and Secretary Leavitt. But 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.

MICHAEL LEAVITT: 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 you for that. And I want to greet a number of other friends that I see here today and thank you for the time that you’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 we could take—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 should we be or 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 at the federal level or in regulation at the federal level or in the implementation of it at the state level, that it 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 it is not one necessarily to diminish or cast less importance but 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 their involvement, not only would Greece economically tumble but also it could have a profound effect on them. 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 at a political election – or rather 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 in the past that might have seemed important but necessarily didn’t occur because we always had the capacity to add it to a debt structure that no longer or at least is rapidly coming to a close in terms of our capacity to do it.

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 then would be to move to Medicare Part D. I’ve 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, that most people are not just willing but that they are capable of making thoughtful, smart and self-interested decisions as a health consumer.

Now, you will recall that when we rolled out Part D, there were serious question about whether or not people could make those decisions or would make those decisions. And it wasn’t something that was automatic. It was in many cases a learned behavior.

People realized that they could, and what we now have in my judgment is a generation of not just informed but 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, and that is that it is essential that there is extra help available to a certain part of that population who may not have family, may not have part of a faith community or a local pharmacist or someone else who can help them, but that 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 goes on I believe as a very important part of the innovation of Part D. So the second, just to be clear, is it is essential to have additional help for some subpart of the population.

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

Now, I think that’s evident because part of the reason – the evidence that 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 that that could be explained, 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 actually—having a function of operating the system to one that organized the system—a fundamental difference.

And it 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: Those savings are scorable. Actual and scorable savings based on this program.

Number four, 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 both 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 it. 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 it.

But we used a sensitivity to the capacity of people to pay. That was a progressive policy but we maintained in the course of it the capacity for us to have a limitation on how much was spent; again, a very important scorable feature on 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. And obviously from what I just said, the volume of people who made a selection of 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. Now, I think this is important because part of the magic of the invisible hand—was at play here in that instead of having one benefit, we had many different organizations doing consumer research to figure out what consumers wanted and needed.

And when those 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 when you reward it.

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. One, we found out that given good options and clear information, people can be good consumers.

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, that competitive plans turned out to be a very good way to organize a market in a meaningful way and that 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.

So let me move now to the third module I introduced, which is: so what do we do with these lessons? Could I suggest that Congress today with the committee of 12 have come to the conclusion that global economic dispassion will require the Congress to act. They 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 is 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’s the two things that 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 a Medicare Part D plan also had a requirement to pick a Medicare Part A and B plan that represented an integrated system of care.

Now, could I point out that many people—I think it is bordering on most in the future—will in fact be entering Medicare having come 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.
So what if we said at some point—pick an age, say age 55—if anyone younger than 55 when they age into Medicare makes a selection for not only their Part D plan but also their Part A and B plan. 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 an integrated care with a risk-based payment. So if you expanded that to A and B, you would now 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 you have to change, though I think it would be a viable thing to invite them to if they wanted to because they would likely get a better system of care. Let’s apply the same lessons from Medicare Part D and try to project, would it work? Well, first of all, we again know now 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 which is fee-for-service medicine. We now know that there is a need for 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? Absolutely, a lesson of Part D. Would it be valuable to have multiplan competition? We know it would, because it would drive savings and it would drive 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 be able to transition from a defined benefit to a defined contribution? Absolutely, unchallengeable, 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 consumers 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 for the future, and my advocacy would be for the committee of 12 to take a hard look at implementing changes in Medicare that will in fact drive change in the system.

I’d like to just end by telling you the most important thing I learned in four years as secretary of health about health care reform. 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—the fastest way to do it is to use the lessons of Part D and to begin moving forward—we’ll have scorable savings, higher quality, better value, and the committee of 12 can in fact make serious progress.

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

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

SEC. LEAVITT: It’s not. Let’s just acknowledge that. But it might not be as easy for the committee of 12 to agree upon it if you said, look, let’s just have everybody have Medicare Advantage.

I mean, if we had to invent something even slightly different, the principle is, let’s start managing A and B the way we now do D. Medicare Advantage, frankly, is the perfect vehicle for that because, look, if you break a, quote, “ACO” down, and what it is, an ACO – Medicare Advantage is an ACO. It is integrated care with someone running it who has a financial interest in making certain it turns out in the best possible way and in which value is 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 question the data. 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 point is the real question is does government have a role in this at all. You know, it didn’t really have a role in medical care until, what, 50, 60 years ago. And no one talked about a health care crisis.

I know you’re on the inside. You’re a government insider looking at this. But I think that those of us who haven’t been in government, there’s a real question. And then your notion—again, it was a fundamental premise—that it’s all been based on compassion.

SEC. 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; the food system is a really valuable insight. I would argue we have an integrated version of—I mean, 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 and 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 in the context of this.

Now, 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, many of these things given the circumstances will require government. And I would argue that much of this is about the discussion of what government’s role could be.

Look at food. In food, we have a system where we have 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, they 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 then lastly, we have Meals on Wheels if you can’t afford it. Now, you can argue with parts of that. But what we’ve used is 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’d 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 to owning it. And I think the incumbent 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. Now, you didn’t ask 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 some examples of where that’s been tried or suggestions you may have for it?

SEC. 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, 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 and 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. Now, we don’t call it managed care. But we are doing 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, quote, “managed care” earlier is that people hated insurance companies telling them what they could have and they couldn’t have.

And I think we may have learned from that because in the future, instead of having an insurer tell us, we’re now 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."

And 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 the physician is now far more involved in how that’s going to work.

Q: Could you comment on what I see as sort of the Democratic Party’s approach to these issues, which is sort of—you know, the comparative effectiveness research which I might think of as sort of managed care from a panel of experts.

SEC. LEAVITT: Your question is a good one and it prompts me to basically make the observation that if you were to take this entire debate—I indicated I think it’s moved from health reform to economic reform—I think there are two fundamental questions that it boils down to 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 say, “How much can we afford to spend?” and “What’s the role of government in making that decision.” I would argue that the world economic marketplace is now beginning to say there’s a limit on the amount that you can spend and still remain viable.

And so that that big question may be answered more in a dispassionate way than people exercising that – they’re going to be exercising their financial best interest in a way that’s right down from the country all the way to ordinary consumers is clearly coming down on the side of there’s a limit.

And the second piece is what’s the best way for government to be involved. In the same way that I believe that creating and organizing an effective marketplace we’ll find the efficiencies far more quickly in Medicare and as it has in Part D, I think the same is true in the area of, quote, “comparative effectiveness.”
Now, I just need to give 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 that are 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."

So what I want to suggest is—I don’t think government does that as well as markets. But I don’t think the markets have yet created a structure around which we can begin to judge this and I think that 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 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.
Hudson Institute

Panel Discussion:
Medicare Part D Drug Benefit:
Five Years Later – Is It Working?

Moderator:
Hanns Kuttner,
Visiting Fellow,
Hudson Institute

Speakers:
Doug Badger,
Partner,
The Nickles Group

Mary Grealy,
President,
Healthcare Leadership Council

James Capretta,
Fellow,
Ethics and Public Policy Center

Jack Hoadley,
Research Professor,
Georgetown University Health Policy Institute

Location: Washington, D.C.

Time: 12:00 p.m. EDT
Date: Thursday, September 15, 2011
HANNS KUTTNER: Thank you, Secretary Leavitt, both for taking this as an opportunity to address the narrow topic of Part D, but also to give us a way to think about this as a way to think about Medicare going forward in a very thought-provoking way.

I’m Hanns Kuttner. I have the difficult task of moderating this crowd.

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? And I would be interested in hearing how you think about this question about what is it that we—how is that we answer the question, is it working? Why does it need to be working or not, which itself is a good way to start.

DOUG BADGER: Thank you. I’m going to offer that from the perspective of someone who was involved in the implementation of the law as well as in its drafting. And I want to go back and consider about a president signing into law a measure that he calls historic. And 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 both what is probably occurring right now in 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. So 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.

And I can talk about four areas in particular, things that we worried about. And 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, and suddenly we were going to, through the creation of this program that the secretary has very well described—suddenly they were going to materialize.

There were all sorts of reasons why they wouldn’t, and precisely, they go to the question of the extent to which people’s risks are actually predictable and were these – was drug coverage 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 will be the cheapest plan for you, not just in terms of premium but premium and cost-sharing, with a little map 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 plan 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 this 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 busses and they went not to the major media markets, they went 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, you dominated the 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, I have colleagues on this panel who are serious researchers, unlike me, and I apologize to you in advance. Clearly—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.

But I think as the fact sheet points out here, the churn from year to year is about 6 percent, which looks a lot like the Federal Employees Health Benefits Program. Most people 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 to sign up for most people.

MR. Kuttner: I’m in it.

MR. BADGER: Everybody does. Everybody does, and just renews in that plan rather than taking advantage of the fact that year over year they can select plans that make more economic sense. But people tend to be—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. In the Administration and the Senate, we 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, and causes 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? And 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 that we would have 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 they 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: Well, 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 has been a success.

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

And I think really what this gets down to is, is a question of political economy, and how do – what we need in American health care—and we need it in the drug benefit and we need it in 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, then 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 where it actually does deliver more for less over time? And it’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 go to try to make that happen more readily going forward?

And there are sort of 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, you know, there I think 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, that 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.

But I think you have to then ask, well, wait a second, how would [you] introduce that into the political process we have in the United States, and what would happen when you do so? And I think it’s pretty predictable what would happen.

Let’s assume that the government said, well, we’re going to mandate certain levels of generic substitution, which is really what has happened a lot in Part D. I mean, Part D, a lot of what’s happened is that seniors have been incented in huge numbers to take up effective generics when they’re available to substitute for a branded drug. And it’s happened throughout the marketplace, but it’s happened even in a 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 we did it alternatively where the government was running everything, and you tried to mandate generic substitution.
You know, you might have gotten some provision halfway into law in doing so, but it would have been with lots of caveats. I’m sure the branded pharmaceutical industry representatives wouldn’t be all that keen on having the government mandate generic substitution for all their products. And so, 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 or this case or that case. Furthermore, you’d have huge fights about the level of reimbursement for the generic substitutes. And so, looking at that going forward, it’s not at all clear that that 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.

Now, why do I bring this up? Because it’s relevant to the rest of Medicare as well, that 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, and 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 as a result. 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, you have to be in generics, that may have been one thing. But if it can save them 10 bucks a month on a premium by a Part D plan organizing a system of formulary and coverage such that they’re pretty strongly incented to use generics instead of branded drugs, and they were going to save 10 bucks a month in premiums by doing so, yeah, they signed up in droves for that, OK?

So the kind of delivery system change, so to speak—and this is only in the pharmaceutical context—the kind of delivery system change we want throughout the health system—more efficiency, higher productivity, more for less—was brought about in Part D without the government requiring it. And if the government every required it, it largely probably would have backfired.

And if you look at the rest of the Medicare program, it does backfire. It happens all the time. There’s all these efforts underway in the larger Medicare program to sort of 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 through that. They end up cutting costs by just paying everybody less. They just sort of do an across-the-board payment rate reduction. And that doesn’t bring about any kind of productivity improvement.

So, you know, I think it’s quite clear from all the evidence we’ve already talked about and that Secretary Leavitt laid out and others have mentioned 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 really needs to do so 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,” one, because I don’t think you could describe a program that covers tens of millions of beneficiaries as little, but also I think it would be more accurate to describe the Medicare Part D program in those early days probably as the engine that had every possibility of derailing, overturning and bursting into flames, I think much like Doug was worried about.

So I think it’s important to maybe take a moment to explore how we did avoid that fiery crash. I remember 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, that we really needed to modernize that program, and I thought it was appropriate to call it the Medicare Modernization Act.

Now, as it was being debated, we ran television ads with a coalition we were heading, and some of you may remember it was this crotchety old man looking into the camera and saying to Congress, “When are you going to get it done?” So 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.

But 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, and getting it to be widely accepted and as a success with 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.

So, first we had to deal with the projections. Many of them we now know were widely off base, and many of them were just flat-out contradictory. You would pick up the newspaper and, as Doug said, you’d read there are going to be no plans that are going to participate with this new product, that is like—and 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? So 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 that are participating and it’s going to be too confusing for the Medicare beneficiaries to choose among all these plans. And I must say, I’m one of those people that 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 over-runs. And there was that drumbeat as well. So it just seemed that every day there was a new negative projection about the program. So it was quite a challenge.

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

So we were dealing with that environment. We’re 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 program.

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. Now, 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, here were some of the words and phrases in that particular op-ed, describing the program as “deeply flawed,” one that “overwhelmingly fails the American people,” again, “too confusing,” “too costly,” and of course, “it’s 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 MMA.

Well, 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. What we’ve been doing – and, believe me, we made the commitment to members of Congress that we asked to support this legislation. We made the commitment: We will be there for you. We know 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.

So one of the things we’ve been doing since passage was having PRC Research do 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 this survey showed that there was 84 percent satisfaction.

And I’m not sure we can find another government program that would have that high of a satisfaction rate from its beneficiaries. So I think it’s better than most programs that are out there.

But, at the outset we know there was no way we were certain that the program was ever going to be that popular, and, again, 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 this.

So 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 that are trying to implement the Affordable Care Act and how are we going to get people to enroll in insurance—the most important thing we did was to do research on what were the best vehicles to transmit information and the message about this new benefit. We knew that the federal government was going to be doing mailings to seniors—they would be getting something in the mail—and that they also would be doing some TV spots, public ads as well. So the question was, is that going to be enough to sort of penetrate this wall of doubt that we knew was out there? So we engaged the Shapiro research firm to do some polling, but also to do some
simulation exercises on what methods of communication will be effective in getting seniors not just to know about the program but to actually get them to take that action to enroll in the program in Medicare Part D. And I found it very interesting what the results were.

First, 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 about the program. They also wanted that information from someone that they considered an expert. It could be a government official or it could just be someone knowledgeable about health care and knowledgeable about the program. And that could be in a town hall setting, or it could be a radio program 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 may not ask a question at that town hall, but they said, I’d like to hear what other people are asking and maybe that’s the information I need.

So, armed with that kind of information, we formed a coalition of over 400 national and local groups called Medicare Today, including groups like AARP, local pharmacies, as many groups—a lot of church groups as well, really doing that outreach, and then finding 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, they understood this was an important benefit for their beneficiaries and constituents. And so they would ask us to come and work with them at the local level to help educate and help enroll their constituents that would benefit from this.

So we directly enrolled about 6 million Medicare beneficiaries just from 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 are Medicare beneficiaries going to save under this program.

And 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 this much. And 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 this “the wheel”—where beneficiaries, you know, what are you spending on drugs today?
What’s your age? What kind of coverage do you have? And they could manipulate this and just get an idea of why they should enroll, because this is how much they were going to save.

This saved me. It was right before the election. I’m in West Fort Lauderdale, and I grew up in that area, a Democratic stronghold, and it was a very tough audience. You know, this was not too long after passage. Once they saw this tool and what they were going to save, you know, it changed the whole tenor and tone of the meeting.

So our goal was to give people factual information and really help them see why this was something that was going to help 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, but, you know, really trying to break through a lot of the rhetoric that was out there. And I think having HHS and CMS as a great partner, working with this coalition, really helped us have the information that we needed.

So I think we’ve heard, you know, 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 it may even be decreasing. Again, can you tell me anywhere else that might be happening in health care? I don’t think so.

And that just leaves me to say, as Secretary Leavitt said—I think, Jim, what you’re saying—we really see this as a model for the entire Medicare program, and that it is a much better alternative than us going through this exercise of continuously cutting fee-for-service payments, and thinking that cutting payments to providers, pharmaceutical companies, medical device manufacturers, and thinking that that’s not going to affect Medicare beneficiaries.

It is, and it’s going to affect them directly in terms of access and in terms of their access not just to services but to new innovations in medical care. So we would really like to see—and the Healthcare Leadership Council has put this forward to the super committee—we think there’s scorable savings here and we think by doing this type of approach it will be a better program for Medicare beneficiaries as well. Thank you.

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

JACK HOADLEY: OK, thank you.

So I spent a lot of my time analyzing the numbers on the Part D program, and I’ve done that since day one of the program—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. But—

MR. KUTTNER: And?

MR. HOADLEY: Well, I’ll give you a few hints as I go through. And most of those numbers I didn’t have time in an hour to do, so—but I do have a few things.
And so, as I look at the numbers over the years, it’s going to lead me to be a little bit of a contrarian at this party. My overall view is that—and, 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 of this program over the six years that it’s been in existence. And I want to talk quickly about six dimensions.

First is coverage. So, overall, the coverage news is pretty good. We do now cover -90 percent of all Medicare beneficiaries have 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.

So we’ve reduced the number of people without drug coverage by half—that’s good news—but we’ve still got half of that group, 10 percent of the overall Medicare population, that we haven’t managed to reach.

Now, some of them may be people with low needs who are just making a rational decision, I don’t need these plans. And we don’t really know, and that’s part of the problem where 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 just failed to reach.

Dimension two is program design. I think the bad news here is that I would differ with some of what people have said. I think this program is still more complicated and more confusing than it needs to be. When we talk to seniors in focus groups, yes, they like the program a lot. That’s absolutely true. They also tell us that the program is really confusing and hard to understand. And that’s one of the reasons—and I’ll come back to this point in a minute—why once they get in a plan, they kind of stay there whether it’s treating them well or not. And, you know, that has consequences.

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. So that’s come down gradually. Some of that is just consolidations and mergers in the marketplace, but some of that has been steps that CMS has taken to try to make sure that some of the duplicative coverage that’s out there and some of the plans that just haven’t attracted much business are encouraged to leave the program.

Up to that point, they were just kind of staying in, and it was more clutter that a beneficiary trying to do research had to sort through. And 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. So, for example, a couple of years ago, there were plans that offered supposedly an enhanced benefit that actually had higher cost sharing than the same company’s plans with a basic benefit.
And I’ve never yet been able to understand what was enhanced about the benefit that that 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. And so people that choose an enhanced plan know that they’re getting something extra. They’re getting extra value for the dollar. It will come at a higher price tag, and that’s a choice that they make.

Dimension three, volatility in a low-income market. So 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 problematic is that there’s been a lot of volatility in the plans available to low-income beneficiaries.

There are about 10 million or so beneficiaries who take advantage of those low-income subsidies, and each year something like 2 million of them typically 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.

And so people either have to switch on their own or some people, if they meet certain sets of criteria, can be reassigned by CMS to a new plan that will qualify without a premium. But a lot of these people have seen themselves switching plans multiple times over the years simply to try to stay in a zero-premium plan, the 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, although the number of plans has gone down overall in the program, there’s actually an increase of about 20 in the number of plans that are eligible as zero premium for the low-income benchmark. So because of some things done in the 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 people who are 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. And, again, all they have to do is switch to another plan, and we’re either not getting out the word to them—again, some of them may make a choice that they can afford it and they want to stay where they are on purpose, but our thought is—and the best we can tell from the research is a lot of these people are just staying where they are because it’s where they are.

Dimension four is making smart choices. So this is where I really want to talk about the sort of 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 that a number has been published on the amount of switching was from 2007 to 2008, and we haven’t seen numbers on how much switching has occurred since then, and we don’t know how much of that switching 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; how many people simply decide not to do the research. We’re going to try to do some more research on this subject. 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 switch.

We watch people who are in plans—you know, while the premiums overall have not gone up as rapidly as some expected, there are some plans in the market where 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, there’s been some steps to try to get 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, you know, 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 over time to make sure they’re still in the best plan for them.

Fifth dimension is completeness of coverage. Well, 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 a phase-out of that as we go into next year. And that gap will, by 2020, under the provisions of the ACA, if it’s not repealed, go away.

And so 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 what typical private sector commercial coverage is. And so, cost sharing, copays for drugs tends to be higher in Medicare Part D than it is 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. Now, you can always ask, was that a problem with the projections versus simply the track record of the program, and I think it’s probably some of both. You know, my sense is that what’s happened in Part D is, for the most part, the plans have ridden the wave of so many more generic drugs being available.

If you’ll look at the flat premiums for 2012 and you just think about Lipitor and four or five other top drugs that go generic between now and just the middle of next year, and if you simply assume that 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, that would account for essentially the absence of a premium increase for this year.

So, I think 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 do that. 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.
We also, I think on costs, have some issues to raise into the future, which is the expense of the growing part of the program are the high-cost beneficiaries, and I think that 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 mechanisms and risk-sharing mechanisms.

Once people get up into that vein of catastrophic coverage – and the problem is going to be not the sort of health care costs for the average person, but the health care costs for that segment of the population that’s up in catastrophic costs. 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 that off the top.

MR. KUTTNER: Let me sort of take the moderator’s privilege here and show you this graph, which is on the handout. And I want to ask people about, so what were the surprises of where we are now with Part D relative to where we started out?

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, and that seems to be sort of—because things that weren’t understood well then in the analytical community, particularly generic substitution.

So let me ask the panel—and whoever wants to be the first to answer—what has been, to you, most surprising about what’s happened over these last five years.

There were no surprises.

MS. GREALY: Well –

MR. KUTTNER: No, no.

MS. GREALY: Yeah. No, I think the projections, because I can’t think of any other time that a benefit has been added to the Medicare program that the cost reductions didn’t underestimate where—I mean, you know, usually—

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

MS. GREALY: Exactly.

MR. KUTTNER: Yes. I got it, yes.

MS. GREALY: And so I think this is a first. It’s a stunning first.

MR. KUTTNER: Are there things that were surprises relative to what your priors were, going into all that? Jack?
MR. Hoadley: I guess I just want to comment a little more on this graph that you put up and the trend. I mean, I think in the trustees’ reports the actuaries have said explicitly every single year – I just went through and reviewed the six statements, the six rounds of trustees’ reports.

Every single year they’ve commented, obviously, on why are projections lower than they were. And one of the primary reasons—usually the primary reason they cite is more generic conversions and in fact—and, importantly, fewer new, important drug products than expected.

And I think, you know, their projections really assumed that, like in the 80s and 90s when drugs like Lipitor and the new round of antidepressants and the new rounds of antipsychotic drugs and the new rounds of diabetes drugs were coming out on a regular basis, that we’d see some pattern of continuing of that, whether it was for Alzheimer’s or just further treatments for blood pressure or cholesterol or depression or whatever.

We have not seen those products. And so, the typical drugs—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. And certainly some of the—

MR. Kuttner: Does Rick Foster owe Tom Scully an apology?

MR. Badger: And certainly generic substitution, to some extent, is simply—it should have been in their projections because they know when these various drugs were going to come off-patent. So I’m not sure that was unforeseeable to them, and they should have foreseen that.

But, you know, in addition to that, when we looked at the outset, it was estimated, I think, that the average monthly premium for this to 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 average premium at $37.50. The secretary did a press conference today, that you alluded to, you know, with the release of the new data, and they’re looking at an average premium in year seven of the program at $30.

Isn’t it interesting; 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 about the ability of seniors to navigate that market.
And I’d finally note that when you look at national health expenditures, we haven’t seen a real decline in pharmaceutical spending as a percentage of national health expenditures. That’s held fairly constant at 10 percent or 11 percent. So clearly there’s a 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 accounts for drug spend is also dramatically down. And again, you know, to some degree it’s a riding-the-wave issue.

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

MR. KUTTNER: Jim?

MR. CAPRETTA: Well, I just think a couple of things. One is that it’s true that the national accounts estimates have come down—to go back to what they were as of 2004 and look—they have come down, but they haven’t come down as much as Part D. Part D has come down quite a bit dramatically more. And the numbers that are often cited for the drop in the national account 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—I kind of come back to Doug’s point that, you know, there’s a lot of noise around this, you know, but the competition works on a number of dimensions, that the plans that are participating in Part D—and there’s a concentration of beneficiaries among a certain number of plans—and they 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 in some plans. And so you don’t have to have a huge amount of slipping for competition to also still be working.

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

And so for all those reasons, yes, is it—you know, 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: Any questions?

Q: Back to Secretary Leavitt’s remarks about Greek bonds. You know, it’s a different world now, different set of things that he reminded us—the world we’re in now versus then. But yet I haven’t seen anybody out there sort of saying I want to constrain the cost to government and I want to get rid of Part D. Has Part D now sort of achieved this institutional, iconic status so—where it’s—on a going-forward basis it’s 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. So you know things have sort of settled down when you reach that point. There was a hearing at the aging committee about a month or so ago where Jonathan Blum for CMS was testifying, and there was a lot of questions about shouldn’t we change Part D in this way; shouldn’t we change Part D in that way. And it was administration policy, and he had to follow it. You know, you’ve testified. You know sometimes you get the administration—you follow the line, and the line was essentially it’s working fine, let’s just leave it alone, which is pretty interesting.

Q: Yeah. My question—I don’t know if this is on yet. My question 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.

And I think it really goes to the heart of the discussion between the Affordable Care Act and Part D, which is—as Doug knows, I was someone who spent a lot of time with seniors, walking through their choices in the department on Plan Finder, and ultimately while I would agree that I may not think their choice was the smartest choice, there were reasons why they made the choices that they did. It may be that they were at a pharmacy that they wanted to be near. It may be 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 of what means a smart choice, and 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 you know, that’s not really the whole story. Like you say, there are—there’s choices of pharmacy, there are comfort with the brand name of the—not the brand name of the drug but the brand name 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, 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 it’s too hard to research the options. And as other people have said, they do like to research in some detail, but when they’re looking at 30 and 50—a few years ago—different plans, not even to count the Medicare Advantage options. The book “Nudge” that’s been popular over the last few years kind of speaks a lot to this point. When decision-making is too complicated, people shut down and decide not to decide.

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

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

Q: I want to thank all the panelists and the moderator for doing a great job, and you really brought out a lot of questions.

I do want to close with a question for Doug Badger, which is a political question, which is why I’m pointing directly to you, Doug. And you see on the 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; it was one of the questions 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 there 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 its mutual dislike on both sides—apparent mutual dislike on both sides of the aisle for some type of Part D-type reform more broadly?

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

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

And there are others, as Secretary Leavitt well articulated, who believe that what we should have is not defined benefit but defined contribution, and try to provide people with multiple options and let them choose. And 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, they 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.

So the fact is, people—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, you know, is simply not the case. And in the end it comes down to, you know, which model do you think is the better way to go, and 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 dusting it up.