

Assessing Medicare Part D Ten Years After Enactment

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Good afternoon, Mr. Chairman and Members of the Committee. My name is Jack Hoadley, and I am a Research Professor at Georgetown University's Health Policy Institute. As a long-time analyst of prescription drug issues, I have studied Medicare Part D since before it was created by the Congress. And I have published a wide variety of papers relating to this program. I appreciate the opportunity to speak to the Committee on the tenth anniversary of its creation.

History of Medicare Part D

The Medicare Part D prescription drug benefit today is in its eighth year of operation. As this hearing highlights, Part D became law ten years ago as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Enacted in a contentious, partisan environment with close votes in both the House and Senate, the MMA was signed into law by President George W. Bush on December 8, 2003.

The history of outpatient drug coverage in Medicare is far longer. By one account, such coverage was omitted from the original Medicare program in 1965 “on the grounds of unpredictable and potentially high costs.”¹ Other opportunities to address outpatient drug coverage came and went until Congress added an outpatient drug benefit to Medicare as part of the Medicare Catastrophic Coverage Act of 1988. This benefit, which would have provided coverage after an initial \$600 deductible, never went into effect because the underlying legislation was repealed in 1989. President Bill Clinton included Medicare drug coverage in his unsuccessful effort to enact broader health reform legislation. Then in 1999, President Clinton proposed a Part D drug benefit. This proposal did not become law, but included many but not all of the elements that were part of the program that passed in 2003.²

As enacted in 2003, Medicare Part D marked several firsts. Not only was it the first program to offer outpatient prescription drug benefits to Medicare beneficiaries, but it was the first part of Medicare to be made available solely through competing private health plans, rather than being

¹ Theodore R. Marmor, *The Politics of Medicare*, 2nd ed. New York: Aldine de Gruyter, 2000.

² For more information on the history of Medicare drug coverage, see Thomas R. Oliver, Philip R. Lee, and Helene L. Lipton, “A Political History of Medicare and Prescription Drug Coverage,” *Milbank Quarterly* 82(2): 283–354, June 2004.

offered as part of traditional, fee-for-service Medicare. Part D also marked the first time that assistance for low-income beneficiaries was offered directly through Medicare, not through supplemental coverage provided through Medicaid. Although everyone is eligible for the Part D benefit without any type of means test, those at lower income levels are eligible for more highly subsidized coverage. As a result of later changes in law, those at higher income levels pay a premium surcharge.

The standard Part D benefit includes a deductible and beneficiary cost sharing. But it also includes the unusual feature of a coverage gap or “doughnut hole,” in which beneficiaries are required to pay the entire cost of their drugs. Those who make it through the gap become eligible for catastrophic coverage with more modest cost sharing. As a result of the Affordable Care Act, the coverage gap is currently being phased out and will no longer exist as of 2020. Plans offering Part D have the flexibility to modify the benefit design, within specified limits. Many plans eliminate the standard deductible, most plans substitute tiered cost sharing with flat copayments for the 25-percent coinsurance in the standard benefit, and most also include a specialty tier for selected high-cost drugs. In addition, some plans offer enhanced benefits, for example, to provide coverage for some drugs in the coverage gap or to reduce overall cost-sharing levels.³

The Successes of Medicare Part D

In several key respects, Part D can be considered a success, although several ongoing problems limit our ability to call the program an unqualified success. In the remainder of my testimony, I will outline the program’s successes and the ongoing issues. At the end, I will identify a few lessons that the Part D experience offers to the implementation of the health insurance exchanges (marketplaces) under the Affordable Care Act.

Success: the cost of Part D has been lower than expectations. A key element of the debate over the creation of Part D was the potential cost of the program. At the time of passage, the Congressional Budget Office (CBO) estimated the ten-year budget impact of the drug benefit as \$407 billion for fiscal years 2004 to 2013, while the Bush Administration’s estimates were 25 percent higher. Estimating these costs was challenging, since there was no precedent for the program’s stand-alone private drug plans. Trends in drug spending were also a concern, with annual growth at the time standing at around 12 percent – a combination of both price increases and higher utilization.⁴

The reality is that Part D spending has been considerably lower.⁵ Based on spending numbers from the 2012 Medicare Trustees Report, total spending on Part D benefits and administration was about 74 percent of projected levels in the program’s first year (2006) and average 68 percent of

³ Jack Hoadley et al., *Analysis of Medicare Prescription Drug Plans in 2012 and Key Trends since 2006*, Issue Brief, Kaiser Family Foundation, September 2012; Jack Hoadley et al., *Medicare Part D: A First Look at Part D Plan Offerings in 2013*, Data Spotlight, November 2012.

⁴ Jack Hoadley, *Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition*, Kaiser Family Foundation, Issue Brief, May 2012. Similar conclusions have been noted elsewhere. Edwin Park, “Misleading Claim About Medicare Part D Relies on Faulty Arithmetic,” Blog posting, Center on Budget and Policy Priorities, June 12, 2012. Doug Elmendorf, “The Accuracy of CBO’s Budget Projections,” CBO Blog, March 23, 2013.

⁵ Jack Hoadley, *Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition*.

projections over the first six years. In 2011, actual program spending was \$60 billion dollars, compared to the projected level of \$95 billion. Several factors have contributed to lower total costs.

- Initial program enrollment was significantly below projected levels in 2006. Enrollment growth from year to year, however, has been at projected levels.
- The growth of drug spending across all payers (public and private) has been considerably slower than projected. CBO had projected 12 percent growth per capita between the law's passage and the 2006 start of the benefit and 9 percent per capita thereafter. In fact, the actual trend has been 10 percent and 4 percent, respectively.
- The start of Part D coincided with patent expirations for many of the most commonly prescribed drugs – sometimes referred to as the “patent cliff” – and the relatively slow pipeline for new drugs. The share of generic drugs for Part D enrollees rose from 60 percent in 2006 to 75 percent in 2010, and is higher today. Because the cost of the average generic drug is about 25 percent of the chemically equivalent brand-name drug, higher generic use translates into lower drug spending.
- Based on available evidence, claims that spending is lower because of the program's use of competing private plans seem overstated. Plans' management of the Part D benefit may have helped to encourage greater use of generic and other lower-cost drugs, but broader trends across the health system have been more important.

Success: Part D has reduced costs and increased access for enrollees. Without drug coverage, people are more likely to skip some necessary drugs and to take others less frequently than prescribed.⁶ The acquisition of drug coverage through Part D has meant that use of drugs grew considerably for those without a prior source of coverage.⁷ It has also reduced the amounts that enrollees pay out of pocket to obtain needed drugs. Although more research is needed, there is some evidence that increased use and adherence to medications by Part D enrollees is saving money elsewhere in Medicare as a result of fewer hospitalizations and less use of other services.⁸

⁶ Patricia Neuman et al., “Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors,” *Health Affairs* 26(5): w630-w643, August 21, 2007; Stephen B. Soumerai et al., “Cost-Related Medication Nonadherence among Elderly and Disabled Medicare Beneficiaries: A National Survey One Year before the Medicare Drug Benefit,” *Archives of Internal Medicine* 166(17): 1829-1835, September 25, 2006.

⁷ Jennifer M. Polinski et al., “Changes in Drug Use and Out-of-Pocket Costs Associated with Medicare Part D: A Systematic Review,” *Journal of the American Geriatrics Society* 58(9): 1764-1779, September 2010; Jennifer M. Polinski et al., “Medicare Part D's Effect on the Under- and Overuse of Medications: A Systematic Review,” *Journal of the American Geriatrics Society* 59(10): 1922-1933, October 2011; Sebastian Schneeweiss et al., “The Effect of Medicare Part D Coverage on Drug Use and Cost Sharing among Seniors without Prior Drug Benefits,” *Health Affairs* 28(2): w305-w316, February 3, 2009; Wesley Yin et al., “The Effect of the Medicare Part D Prescription Benefit on Drug Utilization and Expenditures,” *Annals of Internal Medicine* 148(3): 169–177, February 5, 2008; Jeanne M. Madden et al., “Cost-Related Medication Nonadherence and Spending on Basic Needs Following Implementation of Medicare Part D,” *JAMA* 299(16):1922-1928, April 23/30, 2008; Jeanne M. Madden et al., “Cost-Related Medication Nonadherence After Implementation of Medicare Part D, 2006-2007,” *JAMA* 302(16):1755-1756, October 28, 2009; Dana G. Safran et al., “Prescription Coverage, Use and Spending Before and After Part D Implementation: A National Longitudinal Panel Study,” *Journal of General Internal Medicine* 25(1): 10-17, January 2010.

⁸ J. Michael McWilliams et al., “Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage,” *JAMA* 306(4): 402-409, July 27, 2011; Christopher C. Afendulis et al., “The Impact of Medicare Part D on Hospitalization Rates,” *Health Services Research* 46(4): 1022-1038, August 2011; Congressional Budget Office, *Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services*, November 2012.

Success: A big design flaw in Part D – the coverage gap – is being fixed. In the Affordable Care Act, Congress addressed one of the least-liked features of Part D and one that is unique to this program. The coverage gap is not well understood by enrollees, but one in five Part D enrollees typically reaches the gap in any one year and experiences higher out-of-pocket costs. Many enrollees in this situation respond by stopping some of their prescribed drugs or by taking them less often.⁹ It is harder to know whether this reduction in use has health consequences.¹⁰ The Affordable Care Act's reduction of the gap started in 2011 with lower beneficiary costs for brand-name drugs. By 2020, enrollees will face the same cost sharing at the spending levels now associated with the gap as they do at lower spending levels.

Success: The program's launch, despite initial concerns, went relatively smoothly. On the eve of the program's first open enrollment period, there was considerable wariness and skepticism that the program launch would occur as designed. Would drug plans be offered, or would fallback plans, part of the original law, be necessary?¹¹ Would the Centers for Medicare & Medicaid Services (CMS) and its partners succeed in educating potential enrollees about the new benefit? Would information systems needed for enrollment and subsidy eligibility operate effectively? Would people sign up for the new benefit? When the initial open enrollment period ended on May 15, 2006, 22.5 million Medicare beneficiaries had enrolled in Part D plans, and another 7 million remained in employer-sponsored retiree coverage with a federal subsidy. While about 9 million beneficiaries retained coverage from another source (for example, through the Veterans' Administration), about 4.5 million, or about 10 percent of all beneficiaries, remained with no source of coverage.

The program's launch was not without glitches that included errors in the online Plan Finder, unanswered calls to Medicare and plan call centers, confusion on the part of potential enrollees, and problems getting needed drugs at the right price at the pharmacy counter. In many cases where problems were found, federal and state officials responded quickly to correct mistakes, add staff at call centers, provide counseling, and ensure that temporary supplies of drugs were dispensed.¹²

Outstanding Issues for Medicare Part D

Notwithstanding these successes, however, issues remain. Congress and CMS have made adjustments to lessen some of the outstanding concerns, but there is still room for improvement.

Issue: Part D remains complex and confusing to many beneficiaries. Many beneficiaries still think there are too many plans to choose from in Part D. CMS has taken some important steps to eliminate plans with low enrollment and to require that multiple plans offered by the same plan sponsor are meaningfully different from each other. But on average, each Medicare beneficiary still has a choice of 31 stand-alone drug plans – even more in areas where there are many Medicare

⁹ Jack Hoadley et al., *Understanding The Effects of The Medicare Part D Coverage Gap in 2008 and 2009*, Kaiser Family Foundation, August 2011.

¹⁰ Geoffrey F. Joyce et al., "Digesting the Doughnut Hole," *Journal of Health Economics*, accepted manuscript, 2013.

¹¹ To address the possibility that no private plan sponsors would enter the market to offer stand-alone drug plans for beneficiaries enrolled in traditional Medicare, the law provided for a fallback option offered directly through the government in any region failing to meet the threshold of two plans being available.

¹² Mark McClellan, CMS, "Implementation of the New Medicare Prescription Drug Benefit, testimony to the Senate Committee on Finance, February 8, 2006

Advantage plans.¹³ In selecting a plan, beneficiaries must consider benefit and formulary differences, cost levels, and plan reputations. In recent years, the increased use of preferred pharmacy networks has introduced an additional element to be considered in selecting plans. Several studies have shown that enrollees fail to select a plan that would keep their costs as low as possible.¹⁴ Furthermore, the program's complexity encourages many enrollees to stick with their current plans even when a switch could save considerable money.

Issue: Not every beneficiary has drug coverage. According to the best available counts, 10 percent of Medicare beneficiaries remain without drug coverage in Part D or some other source of equivalent or better coverage. We lack good information on why these people have no coverage. While some in this group likely are making rational decisions to forgo coverage, it is important to reach out to all beneficiaries and determine whether others are unaware of the help they could receive from Part D.

Issue: Some beneficiaries who are eligible for the Low-Income Subsidy (LIS) are not signed up. The Low-Income Subsidy in Part D is helping about 11 million Medicare beneficiaries obtain assistance with the cost of drug coverage. Many get this extra help automatically as a result of receiving benefits from Medicaid (dual eligible), Medicare Savings Programs (MSP), or Supplemental Security Income (SSI). But only 40 percent of eligible low-income beneficiaries who are not automatically enrolled by CMS enrolled for the LIS in 2009 (the most recent estimate available).¹⁵ In addition, about 1.6 million beneficiaries with the LIS unnecessarily pay a premium for the Part D coverage because they have not selected one of the qualifying benchmark plans.¹⁶ Many of them pay at least \$10 per month, and some pay much more. This is in addition to about 900,000 beneficiaries who were reassigned by CMS during the most recent open enrollment season to avoid following into this situation. The advantage of a reassignment or voluntary plan switch is that it avoids the situation of paying a monthly premium for drug coverage; the drawback is that it means a disruption of one's current coverage. A new plan usually means new formularies and new coverage rules, new procedures, and a different pharmacy network. The Congress and CMS have taken steps to increase the number of benchmark plans that are available, but other changes are needed. Although the LIS has been an enormous help to many low-income Medicare beneficiaries, critical design improvements could make this program even more effective.

Issue: Higher spending trends could increase future cost pressures. Although Part D costs to date have been considerably lower than the original projections, lower costs have resulted in great part from the patent cliff and the substitution of low-cost generic drugs for brand-name alternatives. We will soon reach the point where most commonly used drugs are available as generics or at least

¹³ Jack Hoadley et al., *Medicare Part D: A First Look at Part D Plan Offerings in 2013*, Data Spotlight, November 2012.

¹⁴ Yaniv Hanoach et al., "Choosing the Right Medicare Prescription Drug Plan: The Effect of Age, Strategy Selection, and Choice Set Size," *Health Psychology* 30(6):719-727, November 2011; Jason Abaluck and Jonathan Gruber, "Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program," *American Economic Review* 101(4): 1180-1210, June 2011.

¹⁵ Laura Summer, Jack Hoadley, and Elizabeth Hargrave, *The Medicare Part D Low-Income Subsidy Program: Experience to Date and Policy Issues for Consideration*, Kaiser Family Foundation, September 2010.

¹⁶ Benchmark plans are drug plans that are available for no monthly premium to LIS enrollees, defined as below a regional average premium. Jack Hoadley et al., *Analysis of Medicare Prescription Drug Plans in 2012 and Key Trends since 2006*, Issue Brief, Kaiser Family Foundation, September 2012.

have a generic alternative in the same drug class. As forecast by both CBO and CMS, drug cost growth is likely to be higher in the coming years, although not as high as in the 1990s. The larger role played by biologics and other specialty drugs – typically with prices far higher than conventional drugs – will likely contribute to this higher growth. These new drugs may offer important treatments, especially for some health conditions lacking effective medications today. But managing this cost growth will be critical to keeping the program affordable for both plan enrollees and taxpayers. The regulatory approval of follow-on biologics (a process starting with the new approach that became law in the Affordable Care Act) offers one route to controlling the cost of these drugs. But ensuring that newly approved follow-on biologics will be accepted and used by patients and their physicians will require further steps. The proposal introduced recently by several members of Congress, including the Chairman of this Committee, for a new federal Part D rebate for drugs purchased by LIS beneficiaries offers another means of addressing the cost of expensive drugs. Development of more robust medication therapy management (MTM) programs by Part D plans could also help to ensure appropriate use of high-cost medications. At the same time, it is vital that high cost sharing for specialty drugs does not create an impediment for the appropriate and timely use of these drugs and prevent the health benefits of their use.

The Bottom Line for Part D and Lessons for Insurance Exchanges

In the ten years after the Medicare Part D program was created by the Congress, we can point to some clear successes. More Medicare beneficiaries are able to take prescription drugs that may be improving their health and extending their lives. They are spending less out of pocket, meaning they are not forced to make difficult choices between medications and other needs. Many low-income beneficiaries receive extra help beyond the basic help available to all beneficiaries. Thanks to a lower growth rate for drug spending, we have accomplished these results at a cost lower than originally projected.

But it is critical that we not rest on this record of success. Steps should be taken to ensure that new cost pressures, such as those posed by expensive specialty drugs, do not challenge the program's affordability in the future. Steps should also be taken to ensure that every Medicare beneficiary who is eligible for both Part D and its Low-Income Subsidy has a real opportunity to participate. Recent actions by the Congress and the Administration have helped to improve the benefit by phasing out the coverage gap and simplifying the program, but further changes can help make sure that Part D enrollees get access to needed drugs without paying unnecessary costs out of pocket.

Finally, let me observe that the successful launch of Medicare Part D offers lessons to the launch of insurance exchanges later this year. In 2005, there was considerable concern wariness and skepticism that the government could get Part D started in time for the program's first day on January 1, 2006. Indeed numerous issues did arise during the initial enrollment period and when beneficiaries visited pharmacies for the first time to use the new benefit. But in many cases, officials at CMS and in the states as well as other stakeholders found ways to address problems with short-term fixes. And as described in my testimony, both the Congress and CMS have made further improvements since that time. We should be mindful of the Part D experience as implementation of insurance exchanges moves forward this year.