

MEDICARE PART D

Editor's note: Medicare Part D, designed to provide enhanced prescription-drug coverage for seniors, went into effect in January 2006. Here we present two opposing viewpoints on how successful the implementation of Medicare Part D has been to date and whether it is fulfilling its stated objective.

The First Months of the Prescription-Drug Benefit — A CMS Update

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January 1, 2006, marked the beginning of prescription-drug coverage under Medicare.¹ The new benefit is provided by competing “stand-alone” private drug plans that work with the traditional fee-for-service Medicare benefit and by plans that are part of private Medicare Advantage programs. After the initial start-up challenges, the drug benefit is being widely used.

Because the average beneficiary had many options, choosing a plan was often daunting, but enrollment assistance has been available through Medicare and other organizations. Of the 42 million beneficiaries eligible for drug coverage, more than 31 million were enrolled in a plan by early May 2006, including 6.2 million people who previously had prescription-drug coverage through state Medicaid programs (referred to as full-benefit “dual-eligibles”); another 5.8 million Medicare beneficiaries had drug coverage from sources such as the Department of Veterans Affairs or a current employer. Many more joined close to the May 15 deadline. Of the 5 million beneficiaries who are not enrolled or otherwise covered, roughly 3 million have limited incomes and are eligible for additional assistance.

At the beginning of 2006, there were some substantial problems. Certain beneficiaries, particularly certain dual-eligibles who switched plans late in December, did not have full coverage information readily available when they went

to pharmacies. We at the Centers for Medicare and Medicaid Services (CMS) make no excuses for these problems, and we have been working hard to fix them.

We are cognizant that we will probably never again face such an enormous transition, and we are attempting to improve all aspects of the program. As of April 1, reports of problems at pharmacies had decreased by 95 percent, and the waiting time for beneficiaries who call our 1-800-MEDICARE telephone number is now routinely less than two minutes.

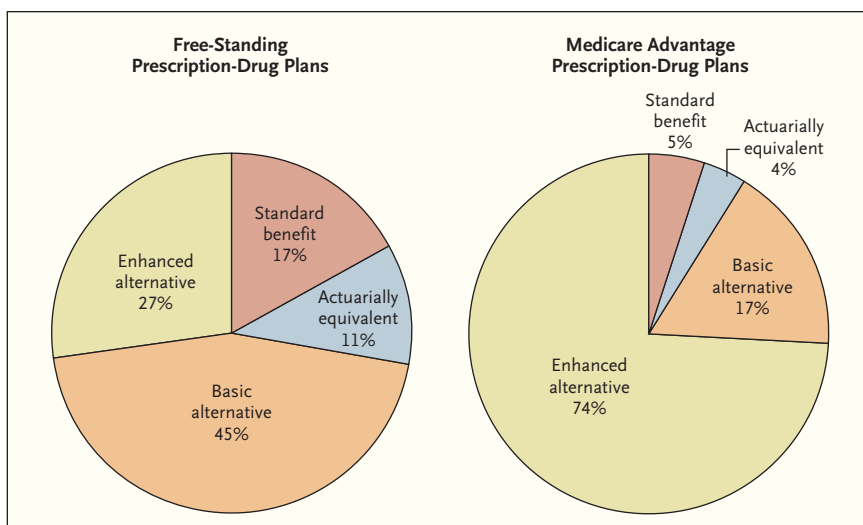
We are also taking steps to help beneficiaries as soon as they enroll. Although Medicare prescription-drug coverage is generally effective on the first day of the month after enrollment, we are encouraging beneficiaries to allow at least two weeks between a new enrollment or enrollment change and their first use of coverage, if at all possible. Beneficiaries who have difficulty obtaining prescriptions after they enroll may contact their selected plan or Medicare for assistance. As we move past the initial implementation of the benefit, we have three broad goals: ensuring that competition promotes simplicity as well as better benefits, minimizing drug prices while providing access to needed drugs, and intensifying outreach to lower-income beneficiaries who do not yet have comprehensive drug coverage.

Several different types of coverage are available to beneficiaries. Our beneficiaries are socioeco-

nomically and medically diverse and their needs vary widely, so we believe that these options are a positive feature of the program. Others have argued that a uniform (perhaps mandatory) benefit would be superior. The data on plan choices are relevant to this argument (see pie charts).

The “standard benefit” defined in the statute entails a \$250 annual deductible, followed by 75 percent coverage for the next \$2,000 in drug costs, then by a “doughnut hole” in which patients pay the next \$2,850 in drug costs, and finally by catastrophic coverage for 95 percent of any further prescription-drug costs in a given year. Only 17 percent of beneficiaries electing a free-standing prescription-drug plan and 5 percent of those electing a Medicare Advantage plan selected the standard benefit. By contrast, 78 percent of all beneficiaries who enrolled chose plans with no deductible, and 18 percent elected a plan that offered some coverage in the doughnut hole.

In making choices among plans, beneficiaries have highlighted the features that are most important to them. As we assist other beneficiaries in making their choices, we will therefore emphasize these distinctions: whether plans carry a \$250 deductible or none, whether they require flat copayments or coinsurance, whether they offer coverage in the doughnut hole, the breadth of their formulary, and the scope of any prior authorization required



Enrollment in Medicare Part D Prescription-Drug Plans and Medicare Advantage Plans through April 27, 2006, According to Type of Plan, for Enrollees Choosing a Plan.

Medicare Part D prescription-drug plans are free-standing, drug-only plans. Medicare Advantage plans are comprehensive plans that include drug coverage. The “standard benefit” is a plan with the statutorily defined coverage of deductibles, doughnut hole, and cost sharing. An “actuarially equivalent” plan is one that adheres to the statutorily defined coverage with respect to deductibles and doughnut hole but has different cost sharing (such as reduced copayments for preferred drugs and generic drugs). A “basic alternative” plan is actuarially equivalent to the statutorily defined benefit, but both the deductible and cost sharing can be altered. (Most of these plans have no deductible.) An “enhanced alternative” plan exceeds the defined standard coverage — for example, by offering coverage in the doughnut hole.

for formulary medications. For 2007, Medicare expects to approve only two plan options from each plan sponsor, unless there is a compelling reason for a third.

Competition is providing better coverage options and is leading to lower costs than expected for beneficiaries and taxpayers. As of April 2006, the average monthly premiums for beneficiaries were 32 percent lower than was originally forecast. (The average premium is \$25 per month, as compared with a projected \$37 per month.) The overall cost to taxpayers for 2006 has dropped by about 20 percent from the mid-session estimates from last year, according to the CMS Office of the Actuary. Some beneficiaries are achieving larger savings than the average suggests, because they are electing plans that offer their medications or generic equiva-

lents at low prices. (Specific drug prices can be searched at www.medicare.gov.) We believe that these savings are a product of the plans’ three sources of negotiating leverage: market leverage, inclusion of “preferred” drugs available in many classes with lower copayments, and the availability of tailored information on how much a beneficiary can save by switching to a generic or preferred brand-name drug.

Some have suggested that Medicare should negotiate directly with drug manufacturers to achieve lower prices for beneficiaries, rather than allow the plans to negotiate individually. The data on plan costs are germane to this debate. The Congressional Budget Office and the Office of the Actuary at CMS both concluded that Medicare itself could not obtain the same level of discounts unless it

imposed severe formulary restrictions that would limit therapeutic options for beneficiaries.²⁻⁴ The plans have achieved their low prices without such restrictions because of their other sources of pricing leverage. Today, the average plan includes 91 of the 100 most commonly taken drugs (coverage that compares favorably with most Medicaid preferred-drug lists and the Veterans Affairs plan), and some plans offer “open” formularies that provide access to essentially all drugs.

An estimated 3 million Americans who qualify for the limited-income subsidy in Part D have not signed up. For those who qualify, the benefit is available for either no premium or a substantially reduced premium, with copayments ranging from \$1 to \$5 or 15 percent coinsurance. The average value of the coverage is estimated at \$3,700 per year. Enrollment for these beneficiaries has been extended past the May 15 general-enrollment deadline and will not be subject to late-enrollment penalties. Many physicians are helping by handing their Medicare patients a Social Security Administration application for the limited-income subsidy along with their prescriptions; others are directing their patients to www.ssa.gov/prescriptionhelp or 1-800-772-1213. We believe that as physicians, we should try to ensure that the prescriptions we write do not go unfilled because of cost, particularly when help is so easily available. Limited-income assistance reduces the cost of prescription drugs by 95 percent on average. These savings will help elderly people obtain the medications they need.

Although the drug benefit is now up and running for more than 31 million beneficiaries, we still have our work cut out for us.

We must ensure that choices are available and easy to comprehend and that formularies provide a broad range of therapeutic options at a reasonable cost to patients. We must work with physicians and other providers to reach beneficiaries with limited incomes. These steps will ensure that elderly people and people with a disability continue to benefit.

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Medicare Part D — The Product of a Broken Process

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Most Americans agree that affordable drug coverage under Medicare has been needed for some time. But instead of a solution to a growing problem, Congress gave the country a prescription-drug plan that achieves few of its original goals. The current problems with Medicare Part D are largely the direct result of the undemocratic way in which the plan was authored and passed. The final legislation, heavily influenced by drug-company and health insurance lobbyists, focused mainly on the needs of those industries instead of those of the seniors it should serve.

The political process used to pass Part D was the worst abuse of the legislative process I have seen during my 20 years in Congress. In the months before its passage, a few powerful Republican leaders worked to undermine conscientious reform proposals. In early 2003, while the House bill was being drafted, Democrats and Republicans authored 59 sensible amendments to it. At the behest of the Republican leadership, however, the House Committee on Rules rejected all but one, preventing them from being debated by Congress. Many of those amendments — among them, one

requiring the administration to use beneficiaries' collective purchasing power to negotiate lower prices and one allowing Americans to import cheaper drugs from Canada — would have made the legislation far more effective and probably would have received bipartisan support, had they been allowed onto the floor.

Next, the conference process, whereby the House and Senate versions of legislation are reconciled, was fundamentally corrupted and kept almost entirely secret by senior Republicans. Democrats on the conference committee were excluded from deliberations, to the point of being physically barred from the conference room on one occasion. The pharmaceutical industry, however, was invited in.

Serious conflicts of interest on the part of the bill's primary authors were common. The chairman of the Commerce Committee, Representative Billy Tauzin (R-La.), coauthored the bill while negotiating a \$2-million-per-year job as a lobbyist for the Pharmaceutical Research and Manufacturers of America (PhRMA), the drug industry's trade organization. The top Republican aide on a subcommittee involved in writing the legislation also left his

position soon afterward to lobby for PhRMA. Thomas Scully, the administration's top Medicare official, deliberately understated the program's projected cost by \$134 billion, and when the chief actuary of the Centers for Medicare and Medicaid Services (CMS) objected, Scully reportedly threatened to fire him if he shared his true estimate with Congress. Soon after the legislation passed, Scully resumed his career as a health care-industry lobbyist.

When the conference report was brought to the House for a vote, members were given less than one day to read the 850-page bill, a violation of House rules. When the vote was called at almost 3 a.m., voting Democrats stood unanimously with 22 Republicans in opposing the legislation. Had the vote been gavelled down in the customary 15 minutes, the bill would not have passed. So the Republican leadership held the vote open for a record three hours while attempting to change the outcome — through intimidation and other tactics that, again, violated House rules. Finding itself with a narrow lead at 5:53 a.m., the Republican leadership immediately brought the vote to a close.