A Report Of The Republican Staff

Of the House Oversight and Government Reform Committee

Part D Gets an A

Private Medicare Drug Plans Are Serving Customers, Saving Money

EXECUTIVE SUMMARY

To be fair to our friends in the Majority, it was assigned a nearly impossible task – to find credible reasons to criticize a federal program that has a near-90 percent approval rating and has come in a third under budget.

After some early hiccups, Part D, the Medicare prescription-drug benefit, has emerged as perhaps the best rollout of a federal program ever. It is delivering more drugs to more seniors than ever before in American history. It's satisfaction rate bottoms out at 80 percent and rises incrementally according to how dependent seniors are on its benefits. In other words, those who need it most use it most and like it best.

The Majority did half the job. It found reasons to criticize Part D. It did not find credible reasons. It says administrative costs are too high for Part D because they are higher than for other parts of Medicare where government controls the payouts. Administrative costs are higher, but that's because the private plans that operate Part D actually attempt to administer the program in a professional way. They set up formularies, design products to meet the individual needs of patients, negotiate price rebates and other discounts and, of course, have to market their products. It's significantly cheaper – from an administrative standpoint – to simply write checks, as other agencies do.

The Majority criticizes Part D providers for how they handle the rebates they negotiate. Instead of lowering the price of Drug X because they negotiated a rebate for Drug X, providers spread out the savings so *all* participants benefit from them. It's hard to argue with the pricing and rebate policies of a program whose private providers will rebate to

the government $4 billion this year and still price their products at 40 percent below government projections. As we said, the Majority had a tough task here.

The real target of the Majority was the notion that private firms could deliver this service more effectively and efficiently than government. This attack probably proved least effective. The program works. Seniors love it. The 10-year cost projections to the government have dropped more than 30 percent in less than two years. And, unlike the government formularies for the Veterans Administration, the best and newest drugs are available to America's seniors.

It was a tough task. All we can say to our friends on the other side is "Nice try."

Preface

Not all the numbers are final yet, but those already in regarding Medicare Part D, the prescription-drug benefit for seniors, paint a definitive picture of success. More seniors have access to more drugs at more affordable prices than ever before in American history. They save, on average, $1,200 per year off their pre-Part D spending on drugs. Nine in 10 say they are pleased with the program – and those percentages have done nothing but rise since registrations began in 2006.

Already, the 10-year estimates of the cost of the program have been cut by a third, and this year, drug companies will refund the government nearly $4 billion because the program has been so much more successful than analysts on all sides predicted. It is no exaggeration to call this the most successful rollout of a federal program in history. And all this, despite the program having taken on the toughest patients in America – seniors use six times the drugs of the general population – and the toughest of the tough since seniors with the worst health and highest use of prescription drugs have been the most likely to sign up for Part D[1].

[1] "Most Seniors now have drug coverage, University of Michigan study Shows" Aug. 9, 2007.

None of this news seems to have reached the Majority Staff of the House Oversight and Government Reform Committee ("Majority"). It recently issued a report that criticizes what it claims are unduly high administrative costs and questions the type and size of savings Part D insurers have negotiated with pharmaceutical companies. The Minority staff appreciates the time and effort that went in to constructing the document and the responsible way the Majority handled sensitive information provided by the Part D plans. Nonetheless, the Majority has distorted the facts to find problems where few exist.

Organization of this Document

This Minority Report responds section-by-section to the Majority Report in an effort to point out logical fallacies, misstatements, and material omissions.

Introduction

In this section, the Majority cites the Department of Health and Human Services, *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds* and reports that the Medicare Part D coverage is estimated to cost $925 billion over the next 10 years. It doesn't mention that this figure is more than 30 percent less than the Congressional Budget Office originally estimated.[2] Peter Orzag, director of CBO, said the agency reduced the cost estimate to reflect significantly lower-than-expected bids submitted by prescription drug plans to provide coverage for seniors.[3] According to the CMS Office of the Actuary, the 2008 national average monthly bid amount for Part D plans will be $80.52, an increase of only nine cents from the 2007 amount of $80.43.[4] Other CMS studies indicate that almost all the savings result from the clause in the Medical Modernization Act of 2004 that prohibits government interference in drug-price negotiations.

The Structure of the Medicare Part D Program

[2] *See* "Fact Sheet for CBO's March 2007 Baseline: Medicare" and "Fact Sheet for CBO's March 2006 Baseline: Medicare" available at www.cbo.gov.
[3] Washington Post, January 26, 2007.
[4] See CMS Office of the Actuary memo, "Release of the 2008 Part D National Average Monthly Bid Amount," August 13, 2007, found at www.cms.hhs.gov.

This section is only technically accurate in that it relies on prospective payment data. Although CMS is required to pay plan sponsors prospectively based on their bids in the beginning of a fiscal year, only after the end of the calendar year, when the actual costs are known, can CMS complete a final reconciliation. When all the claims data becomes available, prospective payments are compared to actual costs and CMS adjusts payments.

Because 2006 costs came in so much lower than expected, CMS announced on Oct. 5 the Treasury would recoup $4 billion from Part D Plans for that year.[5]

One must understand the reconciliation process to truly evaluate the program's cost. The Majority seems to have based its criticisms of the costs of Part D plans on the bids submitted to CMS in early 2006 and 2007, *not the actual costs*. The costs for 2007 can't even be known yet. And any analysis must take into account the $4 billion plans are expected to remit for the 2006 plan year.

The Debate over the Reliance on Private Insurers

The Majority, which has devoted significant time in the last year to attacks on privatization in all forms, frames the debate over Part D as an ideological one:

> *"On one side, President Bush, other senior administration officials, Republican leaders in Congress, and the insurance and pharmaceutical industries argue that competition among many private insurers is the most effective way to keep prices low for seniors and taxpayers…*
>
> *On the other side of the debate, public health groups, some independent health experts, and Democratic members of Congress have raised questions about the cost and effectiveness of the private Part D insurers."*

[5] CMS Press Release, "Medicare Expects to Recover $4 Billion from Part D Plans Following 2006 Plan Reconciliation."

This characterization of the debate leaves out the opinion of the most important group – the seniors who now receive drug coverage under Part D. They are signing up in increasing numbers as the program matures and early hiccups are resolved.[6]

More importantly, they report high satisfaction with the benefit. Numerous studies, including independent ones, have been done on satisfaction with Part D by the Kaiser Family foundation, the Amundsen Group, and many others. All report the same results – that Part D is enormously popular and effective.[7] Kaiser's study says 81 percent are very or somewhat satisfied with Part D, and 76 percent say their experience with the program was positive or somewhat positive.

Objective and Methodology

As previously mentioned, the Majority failed to note its analysis of 2006 and 2007 costs was based on plan bids, not actual costs, and that costs for 2006 came in $4 billion lower than estimated.

Findings

We find especially troubling the sections that deal with administrative costs, which is the cornerstone of the Majority's case against Part D. Methodologies are inconsistent. Apples are compared to oranges. And the Majority doesn't even attempt to explain important differences between Part D and Medicaid that justify higher administrative expenses.

The Majority says administrative costs – sales costs, profits and "other administrative costs[8]" – total 9.8 percent of the cost of Part D in 2007, or $4.6 billion.[9] These numbers are based on bids and estimates, not actual costs. The definition of "other administrative

[6] "Medicare Rx Education network Encouraged by Increased Medicare part D Enrollment Numbers" available at http://www.medicalnewstoday.com/articles/61979.php.
[7] J.D. Power and Associates; "2006 Medicare Part D Beneficiary Satisfaction Study," September 18, 2006, and The Medicare Rx Education Network, January 2007, http://medicarerxeducation.org/survey.htm.
[8] The majority does not attempt to define what activities are actually included in "other administrative costs."
[9] Note: these are estimated and not actual costs.

costs" is never supplied. Compliance costs are not measured. And the costs incurred almost certainly result from actually administering a program rather than merely issuing checks as Medicare does are neither measured nor acknowledged. By using a percentage of the total cost measure, the Majority ignores the dramatic differences in the medical services which make up total costs under Medicare Part A, B, and D.

So, we are left to ask: What is an administrative cost? Activities considered "administrative" in a bid by a Part D plan include the performance of drug utilization reviews to assure safe drug interaction; assembling networks of retail pharmacies; negotiating prices with pharmaceutical manufacturers, and developing formularies. By contrast, traditional Medicare essentially functions as a claims payer. We're never told, for instance, whether the low administrative costs attributed to traditional Medicare includes the administrative expenses incurred by medical contractors or practice expenses for doctors. We're never told whether the administrative expenses incurred by Part D plans might not save taxpayers money in the long run. And we're certainly never told whether government could administer the program at lower cost.

Second, we question the validity of comparing administrative costs as a percentage of total costs. In Part A, total costs include those for hospital care, skilled nursing facilities and some home-health and hospice care. In Part B, the total cost of "outpatient" care includes more-expensive office visits to medical specialists, visits by physicians during hospitalization, ambulance transportation and diagnostic tests performed on an outpatient basis. Of course, administrative costs are going to be low as a percentage of total costs for these higher-value services compared to Part D, where the only costs are for drugs and administration.

But according to the Majority's own numbers, the administration of Part D costs $4.6 billion and the administration of Part A and Part B costs $6 billion. The Majority doesn't compare these costs directly, even though it is at least as valid a measurement.

Finally, when the Majority compares the administrative costs of Part D with the administrative costs of private plans, it does so in a disingenuous fashion. Instead of relying on the same methodology used to compare government programs, the Majority compares administrative costs on a per-prescription basis. By that measure, Part D doesn't stack up too well. The Majority says administrative expenses account for $5.08 per prescription for Part D participants but just $2.48 for those in other private plans. Looked at on a percentage basis, administrative costs for Part D account for 9.8 percent of the expense, and those for other private plans 8.9 percent.[10] Again, the higher actual costs may be attributable to the fact that medications prescribed for the conditions of Part D patients are more expensive, on average, than medications prescribed for other patients.

Why the multiple methods for determining costs? Why no attempt to define what these costs included? How can one claim government can administer the program for less when all the objective evidence says otherwise and only these figures – at best meaningless, at worst deliberately misleading – argue for it? Considering government's lousy record of managing waste, fraud and abuse, these claims are even more dubious.

Rebates from Manufacturers

The Majority staff claims drug spending could be reduced by $15.6 billion if the Part D program received rebates as large as Medicaid. But this ignores reality as well as basic economic principles.

Medicaid and the Veterans Administration do not negotiate drug prices with pharmaceutical manufacturers. The prices they pay are set in statute.[11] For brand-name drugs, Medicaid requires: (1) a rebate that is the greater of 15.1 percent of the average

[10] Merrill Matthews, Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector, January 10, 2006 (p.2).

[11] The Omnibus Budget Reconciliation Act of 1990 requires drug manufacturers that wish to have their drugs available for Medicaid enrollees to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under the agreements, pharmaceutical manufacturers must provide state Medicaid programs with rebates on drugs paid for Medicaid beneficiaries. The formulas used to compute the rebates are intended to ensure that Medicaid pays the lowest price that the manufacturers offer for the drugs.

manufacturer's price (AMP) per unit or the difference between the AMP and the manufacturer's "best price" per unit, and (2) and an additional rebate for any price increase for a product that exceeds the increase in the Consumer Price Index (CPI-U) for all items.

The prices of drugs acquired by the Veteran's Administration must be at least 24 percent below the average price paid by wholesalers for drugs distributed to non-federal purchasers. If this price is not offered to the VA for any of the manufacturer's drugs, then all of the manufacturer's drugs are excluded from Medicaid, Medicare Part B, and other Federal programs.

Clearly, any comparison between negotiated rebates obtained by Part D providers and other government run programs is not a comparison between like programs. Moreover, CBO has consistently predicted that the government would not be able to negotiate prices across the broad range of Part D drugs that are more favorable than those obtained by PDPs today.[12]

The Majority does not even mention the independent CBO analysis that found government would **not** be able to negotiate lower prices with the pharmaceutical industry than Part D providers currently do.

We're compelled to ask then: How can it conclude Medicare Part D could save $15.6 billion if a best-price provision were included in the law? For one thing, Part D serves a vastly different public. The Veterans Administration cares for 3.5 million patients and accounts for about 1 percent of total U.S. prescription purchases. Discounts can be made available to that relatively small group that simply can't be made to the Part D market – which serves 14 percent of the population and accounts for 40 percent of all drug sales. As Yale economist Fiona Scott Morton says:

[12] Letter from Donald Marron, Acting Director of the CBO to Congressman John Dingell, January 10, 2007.

> *"Medicare [Part D] is too large to pay a below- average price; it is the average… with close to half of all spending [on prescription drugs] being generated by those seniors, whatever price they pay will tend to be the average market price."*[13]

In other words, if everybody gets a discount, it's not a discount. And that's what would happen if the VA model were imposed on Part D. And since the Majority's predicted savings fail to account for these effects, the projected savings is not a reliable number.

The Majority acknowledges discounts received by VA can't be compared to rebates received by Part D insurers. It also must realize that about 1 million veterans enrolled in the VA system also have enrolled in Part D, and another 400,000 receive drug coverage from an employer who receives a Part D subsidy.[14] This tells us even veterans know better than to rely on the VA benefit for all their drug needs. So why the comparisons to the VA plan?

Drug Manufacturer Windfalls

Another section criticizes how Part D handles the so-called "dual eligibles" – those old enough to be in Medicare and poor enough to be eligible for Medicaid. It alleges Part D providers use this group to make windfall profits. Under the Medicare Modernization Act of 2004, all seniors receive the same benefit -- just as they do elsewhere in Medicare. Those with incomes of less than 150 percent of the poverty level -- $15,315 for singles or $20,535 for couples in 2007 – also were eligible for the Low Income Subsidy (LIS).

As a result of placing these dual eligibles under Part D – of moving them from a government-controlled system such as the Majority suggests to the privately run system it criticizes – the per-day costs to seniors of supplying their prescription drugs has fallen from $2.17 to 67 cents. Given these savings, it is hard to take seriously the Majority's

[13] Testimony of Fiona M. Scott Morton before the Senate Finance Committee, Jan. 11, 2007.
[14] HHS Press Release; June 14, 2006, "Over 38 Million People with Medicare Now Receiving Prescription Drug Coverage" found at http://www.hhs.gov/news/press/2006pres/20060614).

claims that moving these seniors back to a government system would somehow afford them similar access to the drugs they need at costs less than 67 cents per day.

And even if they could, it's doubtful those seniors would want to go back. Formularies for the two Part D plans with the highest enrollment both contained 97 percent of the branded drugs seniors use most often. [15] And 89 percent of the dual eligibles tell surveyors they are happy with the program.

Drug Rebates in Coverage Gap

The Majority faults Part D Plans for not using rebates to reduce drug prices at the pharmacy (i.e. point-of-sale). They claim this decision forces beneficiaries in the "doughnut hole" – the statutorily imposed gap in coverage – to pay the full costs of the drugs out of pocket. And then, the Majority asserts, "*a portion of this purchase price – 8.1% on average – then flows back to the insurer in the form of a rebate. In effect, beneficiaries in coverage gaps pay inflated drug prices to fund rebates paid to the Part D insurers*."

Only, most Part D participants never reach the gap – which begins at $2,250 per year. And many of those who do pay a little extra for plans that cover the gap. And those premiums – in fact, all Part D premiums – are lowered to reflect the savings gained through rebates, as required by law. Moreover, according to a recent study, passing on the savings through lower premiums does more to lower total plan costs than reducing point-of-sale prices.[16]

And about those premiums: The average premium will "go up" this year to $25. This owes more to the government refining how it defines "average" for such a large, varied pool than to actual price increases by Part D providers. Moreover, the "higher" price is still far lower than CMS projected two years ago of $41 per month. And it even lower than the $35 premium Democrats wanted to statutorily mandate for 2008 back when the

[15] Some disadvantages of Medicaid include restricted access to drugs, script limits, prior authorization, and inadequate pharmacy networks.
[16] Steven Lieberman, "Prescription Drug Plan Rebates in Medicare Part D," Feb. 26, 2007.

program began[17]. In fact, if Democrats would have had their way, *the average senior would have paid $132 more in premium costs in 2006 and $156 more in 2007.* This is why the Majority's sole focus on the price of prescription drugs fails to capture all the ways Part D providers work to lower the overall cost of providing prescription drugs to America's seniors.

PART D BENEFICIARY PREMIUMS

	2006	2007	2008
CMS Estimates	$37.00	$40.00	$41.00
CMS Predicted based on bids	$32.00	$24.00	$25.00
Actual based on beneficiary selection	$24.00	$22.00	?
Democrat Amendment	$35.00	35.00 + inflation	?

Increase in Drug Manufacturers List Prices

The Majority also criticized the practice of Part D insurers of incorporating the average wholesale price into the price offered to Part D beneficiaries. It claims this leaves seniors vulnerable to price increases by manufacturers. This may be true. But it's still better than the alternative – government-mandated price controls.

Participants in Part D – which now includes more than 90 percent of those eligible – are mostly insulated from such fluctuations. They need only meet their deductible and co-payments. Uninsured seniors face the full risk of such fluctuations.

That said, according to a recent *New York Times* article, "annual inflation in drug costs are at the lowest rate in the three decades since the Labor Department began using its current method of tracking prescription prices. The rate over the last 12 months is 1

[17] On June 16, 2003 Representative Waxman supported the Strickland Amendment to H.R. 2473, the Medicare Prescription Drug and Modernization Act of 2003 as introduced by Chairman Thomas, which would have fixed the initial premium at $35. (see addendum)

percent."[18] This deceleration in the growth of drug prices is widely attributed to the success of Part D plans in negotiating real savings for their customers.[19]

Conclusion

In short, there is not much to criticize about Part D as it has unfolded so far. After some early hiccups – to be expected with the biggest entitlement rollout in 30 years – the program operates smoothly and at significantly less cost than expected. As such, the concerns expressed by the Majority are relatively minor in scope and not supported by accurate and meaningful analysis. But then, it didn't have all that much to work with.

[18] Saul, Stephanie, Generics: An Inflation Therapy, The New York Times, Sept. 21, 2007.
[19] Christopher Lee, Medicare Benefit Appears to Slow Spending Growth on Drugs, The Washington Post, Feb. 21, 2007.