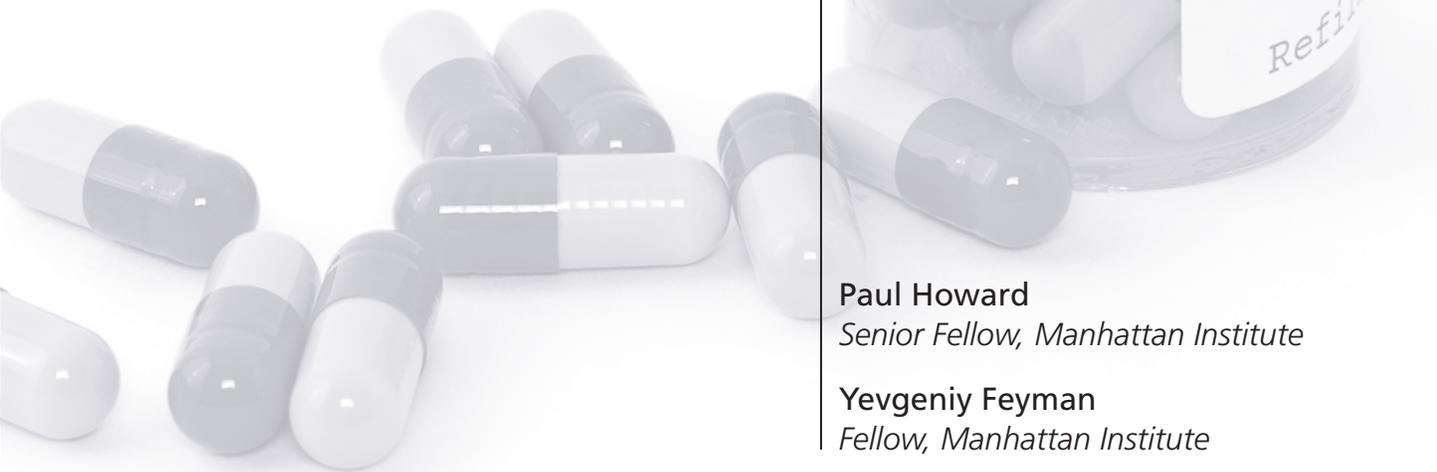


A DECADE OF SUCCESS: How Competition Drives Savings in Medicare Part D



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On December 8, 2003, then-president George W. Bush signed into law the Medicare Modernization Act (MMA). Without a doubt, the law created the most significant overhaul of Medicare in the program's history. As part of the MMA, a new, voluntary prescription drug program called "Medicare Part D" was enacted. Beginning in 2006, Medicare enrollees would also be able to sign up for outpatient prescription drug coverage through private insurance companies, with premiums subsidized by Medicare. To date, seniors have expressed high levels of satisfaction with the program, and Part D expenditures have been more than 40 percent lower than initial government estimates—a rarity for a government health-care program.

However, the program was controversial at the time of its launch in 2006 (and at the time of its passage). Indeed, soon after the bill became law, a plurality of seniors—some 47 percent—disapproved of the law.¹ Nevertheless, Part D is now often touted as a rare entitlement success story, with praise from both sides of the political aisle. In 2011, then-CMS administrator Donald Berwick said that Part D was a "competitive market and we're seeing effects of good competition among Part D plans," as he explained to reporters why Part D premiums had actually declined that year.² Former Senate majority leader Bill Frist pointed out that "[s]eniors, taxpayers and private industry all found a way to make [Part D] work,"³ and Karen Ignagni, CEO of America's Health Insurance Plans, noted that Part D is one of the few successful public-private partnerships operating at a national level.⁴

The root cause of Part D's success remains hotly disputed. Part D proponents attribute the law's success to competition driven by the use of private plans, competition, and private-sector cost-saving innovations.

Critics attribute Part D's lower-than-expected costs to external factors unrelated to the program's design. They argue that lower-than-predicted overall costs are a result of lower-than-predicted enrollment as well as a general slowdown in national drug spending, primarily due to a wave of patent expirations and other national trends unrelated to plan designs.

In this report, we review data from the Centers for Medicare and Medicaid Services, the Congressional Budget Office, and other sources, to examine which factors—market competition, patent expirations, or other national trends (including private-sector innovations such as tiered formularies and preferred networks)—explain overestimates for Part D costs.

In our analysis, we find strong evidence that:

- **National trends are not a sufficient explanation for Part D's success.** While patent expirations are part of the story—national drug spending as a whole slowed during the period we examine—they are far from the full explanation for large overestimates in Part D spending (indeed, patent expirations were likely captured in the original projections). Instead, the available evidence indicates that private-sector firm-level innovations, including preferred pharmacy networks and aggressive negotiations with drug manufacturers, have played a significant role in keeping the program's costs below projections. We find that broader market trends (e.g., patent expirations and other changes) account for only about half (56 percent) of the program's performance. The remainder—44 percent—of Part D's lower-than-estimated cost savings is attributable to factors not captured in national prescription drug trends, which should include competition between Prescription Drug Plans (PDPs). This is strong evidence indicating that consumer-driven competition in Part D has been critical to the program's financial success.
- **Consumer-driven competition is a relatively new tool in the government's effort to control health-care costs.** In hindsight, government overestimates of Part D's cost are not surprising, since the program utilizes a

model of consumer choice (robust competition among dozens of regional drug plans and Medicare Advantage plans) that has no perfect analogue in other government health plans, such as Medicaid.

- **Part D is an excellent model for future health-care and entitlement reforms.** Arguably, Part D and Medicare Advantage plans represent the first national health-care exchange (the Federal Employees' Health Benefits Program [FEHBP] is a close cousin). While the Affordable Care Act (ACA) operates a similar exchange concept, there are important differences. First, Part D plans compete in large regional areas, not states (this creates much bigger risk pools because even large states are incorporated into larger regions), as the ACA exchanges do. Even the federal exchange is layered on top of a state-regulated insurance market. This potentially limits the ability of plans to create economies of scale to bargain with providers and to utilize innovative tools to arbitrage cost and quality differences across state markets (preferred pharmacy and mail-order networks in Part D; telemedicine and medical tourism to "centers of excellence" for health-insurance plans). Notably, while Part D includes higher subsidies for sicker seniors (typically, the low-income subsidy population), it does not penalize healthier seniors through higher premiums, as the ACA's community rating provisions do. Arguably, a better approach would be to rely more on backdoor (non-cross-subsidized) risk adjustment of plans and larger subsidies for sicker or older patients, while allowing plans to charge actuarially fair premiums to younger enrollees. The cross-subsidies in the Part D approach are more transparent in that sense, since they come from tax revenues rather than from private premiums.

Finally, we also suggest additional reforms for Part D, including a "shared savings" program for participating plans that would encourage them to focus on chronic disease management and prevention, reducing Medicare spending in other parts of the program.

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In 2013, Feyman, with colleagues Avik Roy and Paul Howard, released the *Obamacare Impact Map*, a state-by-state look at the effects of the ACA. Republican strategist Karl Rove called the map an "indispensable tool" in understanding the law's effects on Americans.

Feyman has written for various publications including *National Review Online*, *FoxNews.com*, *The Washington Examiner*, *Health Affairs*, and *Politico*. He has spoken on radio shows around the country and has appeared on *Al Jazeera America* to discuss the effects of the ACA.

Feyman holds a degree in economics and political science from Hunter College.

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CONTENTS

- 1 Introduction: Background on Medicare and Part D
- 2 Part D Performance: Satisfaction, Coverage, Choice
- 4 Part D Success: Market Competition or Patent Expiration
- 4 Competition in Part D
 - Patent Expirations
 - Benefit Design
 - Remaining Concerns
- 8 Lessons for Entitlement Reform
- 8 Conclusion
- 10 Endnotes

A DECADE OF SUCCESS: HOW COMPETITION DRIVES SAVINGS IN MEDICARE PART D

Paul Howard & Yevgeniy Feyman

INTRODUCTION: BACKGROUND ON MEDICARE AND PART D

Since 1966, Medicare has been the United States' federally funded health-insurance program for the elderly and disabled. When the program was first instituted, there were two main components: Hospital Insurance (HI) and Medical Insurance (MI), more commonly known as Part A and Part B, respectively. Part A covers inpatient hospital expenses that are incurred when a beneficiary is hospitalized, and Part B covers outpatient expenses that might be incurred due to routine doctor visits.⁵

Benefits for these two components are standardized, with premiums, deductibles, and coinsurance rates that change year to year.⁶ However, since 2003 (with the passage of the MMA), new and current Medicare beneficiaries have had the option of enrolling in insurance plans run by private companies—under the Medicare Advantage (or “Part C”) program, or (beginning in 2006) Part D (Parts C and D both offer prescription drug coverage).

Under Part C, private plans bid to provide the same coverage that Parts A and B offer, with the opportunity to alter benefit structures and offer supplemental benefits. Medicare pays plans based on the risk-adjusted cost of plans' enrollees relative to regional benchmarks that are determined by the Centers for Medicare and Medicaid

Services (CMS). Part C plans have been successful along several different metrics, including overall and specific disease-related mortality, according to recent research.⁷

Under the Part D program, insurers submit prospective bids representing expected benefit payments and administrative costs. These bids are then adjusted for actual health status of enrollees, case mix, and other factors, including low-income status. (There are also reinsurance subsidies for the highest-cost enrollees, as well as risk corridors that limit plans losses.) CMS then uses these bids to calculate a national weighted average bid. Medicare pays 74.5 percent of this average bid, with enrollees responsible for the remainder. In 2013, enrollees are responsible for a base plan premium of \$31.17 per month, plus any difference between the national average and the plan's bid. Plans that cover more branded drugs, more extensive pharmacy networks, or other benefits, may charge somewhat higher premiums, but supplemental benefits are not subsidized by Medicare. Some "zero-dollar" plans are also available in certain markets—meaning that their bid came in under the national average bid and are effectively free for seniors; low-income subsidy beneficiaries also receive zero-dollar premium plans. Because Medicare's share of the national average bid

is set by law, Medicare consumers retain a significant incentive to shop for plans and to balance preferences for generosity with premium costs. When plans bid lower than the national bid, enrollees pay less. When plans bid above, enrollees pay the difference.⁸

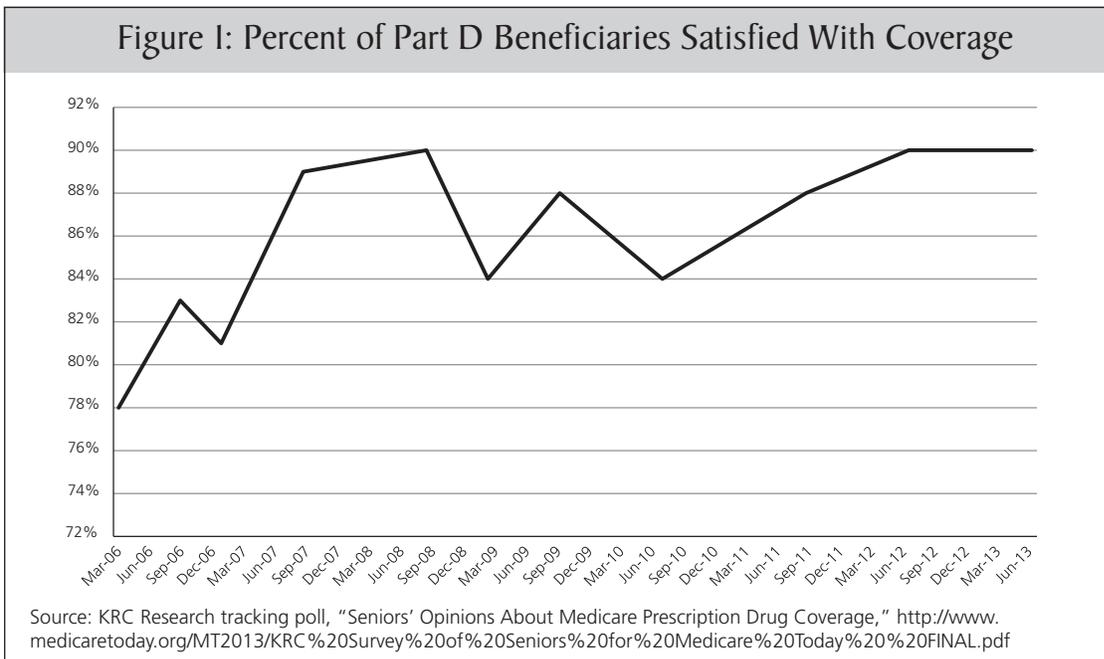
PART D PERFORMANCE: SATISFACTION, COVERAGE, CHOICE

One concern initially voiced about Part D was that private plans would not participate, leading policymakers to insert a federal fallback plan option if at least two Part D plans were not available in every region.

That fear proved unwarranted. In the Medicare Payment Advisory Commission (MedPac) report to Congress in 2013, MedPac found that Medicare beneficiaries have significant choices of plans—between 23 and 38 prescription drug plans, depending on where they live. Moreover, the Part D program has helped expand the share of Medicare beneficiaries with prescription drug coverage from 75 percent prior to Part D to 90 percent in 2013.⁹

Overall, about 64 percent of seniors receive prescription drug coverage through Medicare Part D, including 24 percent through Medicare Advantage Prescrip-

Figure 1: Percent of Part D Beneficiaries Satisfied With Coverage



Covering the Drugs Seniors Need Most

Medicare regulations specify that Part D plans must cover at least two drugs per therapeutic class and all medicines in protected drug classes, including antidepressants, antipsychotics, and antiretrovirals.¹¹ Initial concerns that seniors would lose out on access to needed medicines have not proved founded. In a 2012 report, the Department of Health and Human Services (HHS), Office of Inspector General (OIG), noted that on average, 96 percent of the 200 most commonly used drugs by dual-eligible beneficiaries (191 drugs in total) are covered by Part D plans. Out of

the remaining nine drugs, five are excluded from Part D coverage because they are benzodiazepines (psychoactive drugs that have sedative, hypnotic, antianxiety, and anticonvulsant properties; prior to 2013, these drugs were not covered under Part D); one is an inexpensive supplement (folic acid); two are nonprescription drugs (available over the counter); and one is no longer available for sale in the U.S. All the excluded drugs are available as inexpensive generics.¹² It is important to note that as of 2013, Part D began covering benzodiazepines as well.

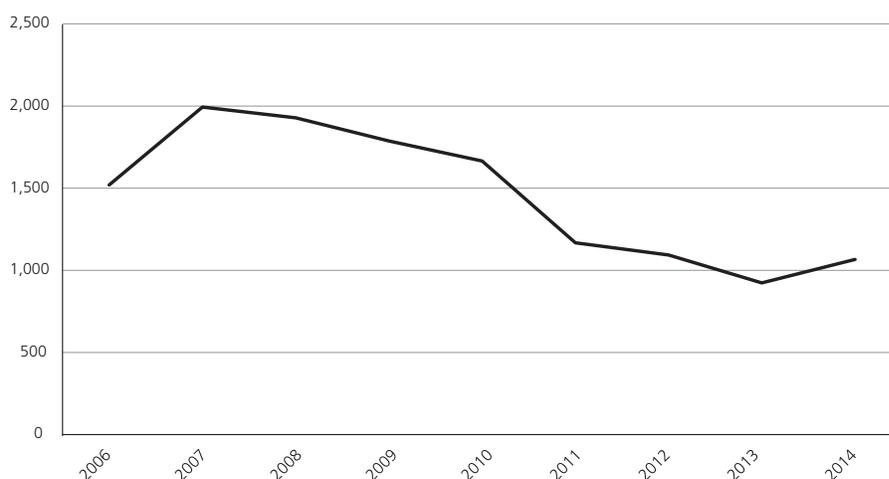
tion Drug Plans (MA-PD) and 40 percent through stand-alone Prescription Drug Plans (PDPs).¹⁰ Part D beneficiaries (including those with MA-PD plans) have generally been very satisfied with the program. A nationally representative poll by KRC Research, an opinion research firm, shows that since the program was first implemented, seniors have become very satisfied with the coverage provided.

According to the most recent data, collected in August 2013, a full 90 percent of beneficiaries say that they are satisfied with the coverage provided under Part D. Moreover, the same survey indicates that

racial minorities—African-American and Hispanic beneficiaries—as well as dual-eligible beneficiaries (low-income seniors with both Medicaid and Medicare, who are likely to have a significant number of comorbidities) are the most satisfied with Part D.

Interestingly, there has been some attrition in the number of Part D plans over time. While beneficiaries now have access to fewer plans than were initially available—1,520 were available nationally in 2006, and 1,066 are available nationally for 2014—beneficiaries still have significant choices among plans. The drop in plan offerings has slowed since 2011 and

Figure 2: Number of Part D Plans Available



Source: Authors' analysis of CMS's annual PDP landscape files. Numbers exclude special-needs plans, MA-PD plans, and sanctioned plans.

likely indicates that insurers are focusing on the most attractive plan designs to offer to consumers and are ending plans with less-than-optimal benefit packages.

That enrollees have become more satisfied with the program since its implementation indicates that the fewer total plans available each year are better meeting beneficiaries' needs.

Given Part D's high satisfaction rate and its success at covering important medications, it would be difficult to dispute that Medicare Part D is a successful program—and it continues to enjoy strong bipartisan support.

PART D SUCCESS: MARKET COMPETITION OR PATENT EXPIRATION

As noted, since the program first took effect in 2006, it has consistently required less in federal appropriations than initially projected. Indeed, in 2005, Medicare's trustees projected that the program would cost \$760.7 billion over the seven-year period from 2006 to 2012.¹³ However, as of the most recent report, the program has spent a significantly lower \$400.3 billion over that period (47.4 percent lower), a difference of about \$360 billion.¹⁴

Predictably, this has led to a dispute between those who believe that Part D's underlying competitive structure

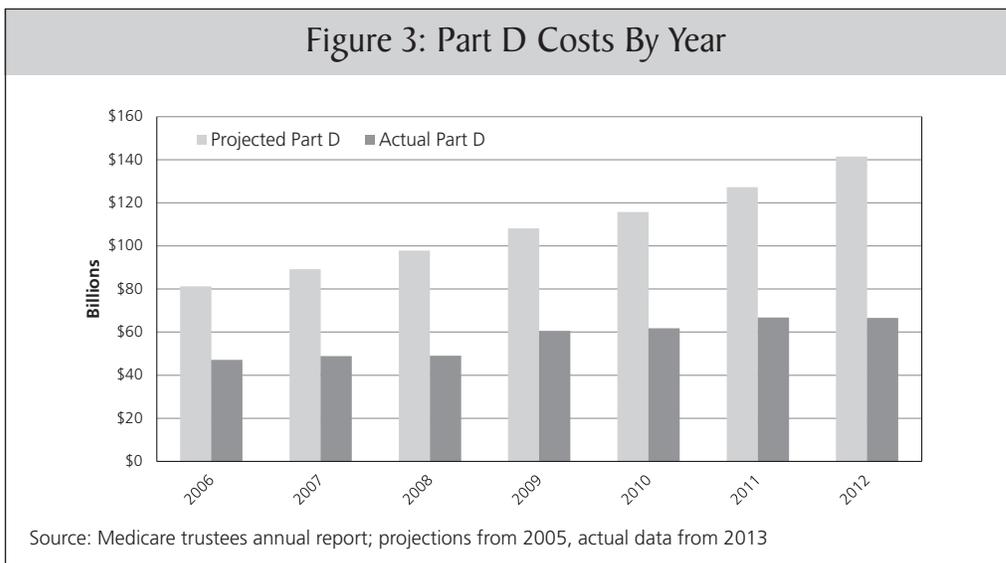
is responsible for the savings, and those who attribute the deviation from projections to patent expirations, lower-than-expected enrollment, and Part D piggybacking on favorable national trends. In the next section, we evaluate whether Part D's competitive structure has led to lower-than-projected spending.

COMPETITION IN PART D

As noted earlier, advocates of the "competition" argument tend to highlight the important incentives in Part D that encourage competition in the program.¹⁵ For instance, as opposed to Medicare Advantage, the benchmark rate in Part D is determined based on actual Part D bids rather than administrative benchmarks tied to fee-for-service Medicare. Because reimbursement to plans is tied to actual bids, plans have an incentive to ensure that their bids to offer coverage are at or below the national benchmark, or that they offer valuable supplemental benefits above the benchmark that will be even more attractive to seniors.

Skeptics argue that patent expirations, along with favorable national trends (such as tiered formularies and preferred pharmacy networks) during Part D's existence, better explain the divergence from initial estimates. A 2012 report from the nonpartisan Kaiser Family Foundation finds that "the claim that Part D spending is lower than originally projected due to competing private plans seems overstated," pointing

Figure 3: Part D Costs By Year



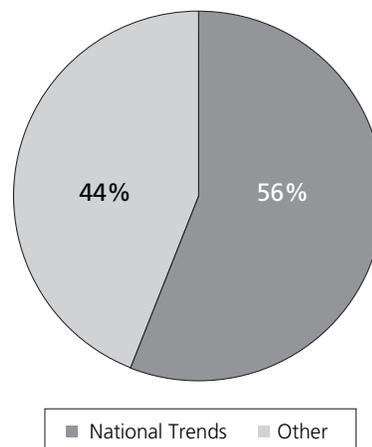
out that national trends—including substitution to generic drugs, patent expirations, and fewer-than-expected drug approvals—along with lower-than-projected enrollment in Part D, better explain the deviation from projections.¹⁶

A report from the Center on Budget Policies and Priorities argues more definitively that fully half of the lower-than-projected spending on Part D is due to lower enrollment (based on our calculations, even if enrollment would have been as high as projected, total costs would still have been \$262.2 billion lower—actual enrollment was, on average, about 19 percent lower than expected); lower per-beneficiary costs, they argue, reflect “a system-wide slowdown in prescription drug costs, driven mainly by expiring patents on major drugs, fewer new blockbuster drugs, and greater utilization of generic drugs.”¹⁷ The report claims that because Part D plans are banned from using Medicaid’s price controls (automatic rebates) in determining reimbursements, the cost of the Part D program is higher than it should be.

Certainly, national-level trends are important in determining spending patterns in a government-funded but privately administered program. For instance, expiring patents on brand-name drugs can increase generic utilization; however, this does not happen in a vacuum. Encouraging enrollees to make the switch to generics from brand-name drugs, or adopting differential co-pays for branded medicines, is heavily dependent on a plan’s benefit design and bargaining with manufacturers. In fact, a 2012 study from the Robert Wood Johnson Foundation found that Part D plans with generic co-pays and no utilization management requirements had a lower rate of generic drug utilization compared with plans with better utilization management schemes and no co-pays for generics.¹⁸

The reality is more complex. Because pharmacy benefit managers operate in both the Part D market and in national markets (managing formularies for self-insured companies, for instance), lessons learned from competitive markets outside Part D can quickly be applied to the program. In this sense, allowing private management of Part D plans ensures that the

Figure 4: National Trends Explain 56% of Part D Per-Capita Savings



Source: Authors’ analysis of Part D and national prescription drug spending data; methodology in nn. 19 and 22 below

latest innovations in prescription drug management can be incorporated into the program in a timely way. Far from being a mark against the program, Part D’s mirroring of broader, cost-saving market trends is a sign that it is working effectively to control costs.¹⁹

To evaluate the extent to which national competitive trends have affected Part D spending, we first quantify how much of the deviation in Part D spending can be explained by such trends.²⁰ Importantly, to control for changes in Part D spending due to enrollment, we focus on per-capita costs. Our results in Figure 4 indicate that 56 percent of Part D’s deviation from projected per-capita costs is explained by national trends—that is, changes in prescription drug spending for the country as a whole.

Controlling for national-level trends in this way helps to account for patent expirations, drug utilization trends, tiered formularies, and just about any other factor that would be captured in the national health expenditures data. What is striking about this analysis is that it reveals that about 44 percent of Part D’s deviation from per-capita projections is left unexplained by national trends. Part D also diverges from national trends in other ways: for instance, from 2006 through the end of 2010, drug prices in Part

D (taking into account generic substitution) grew only 2 percent in total (an average of 0.4 percent per year)²¹ while the cost of drugs in the commercial market (including generics, branded, specialty, and nonspecialty drugs) grew by 24.6 percent over the same period²² (an average of 4.92 percent per year).²³

While this does not explicitly identify competition or the use of private plans as causal factors for the divergence between national trends and Part D, the results clearly contradict claims that national trends account for nearly all the deviation. Again, critics forget that the learning occurs across competitive markets and that tools developed by insurers outside Part D will find their way into the program, insofar as they are popular and effective.

The penetration of preferred pharmacy networks, the slower cost growth in part D, and evidence that links regions with a greater number of plans to lower premiums²⁴ are good reasons to believe that much of the remaining 44 percent can be explained by the participation of private drug plans.

Patent Expirations

The claim that patent expiration on brand-name drugs led to overestimates of Part D's costs is *prima facie* faulty. Identifying the year of patent expiration is generally a simple task, unless a drug's patent gets extended for new indications; the standard patent life is simply 20 years. Therefore, it isn't the fact that drugs lost patent per se that would lead to overestimates; rather, government projections would underestimate the increased utilization of generic drugs *because of* patent expirations.²⁵

Even giving the benefit of the doubt to those who use patent expirations as a major explanatory factor

in the overestimated Part D cost projections—that is, assuming that generic utilization is mainly a function of patent expirations rather than plan designs (we address this more directly in the following section)—the argument doesn't hold much water. Here's why.

As Figure 5 illustrates, of the 246 drug patent expirations that took place over Part D's lifetime, the majority have happened in the second half. This means that overestimates for Part D's costs—at least those during the first four years of the program—cannot be explained simply by expiring patents. Moreover, of the top 100 drugs purchased nationally in 2012 (by dollar amount), only 17 had lost patent from 2006 to 2012—altogether, this group made up less than 15 percent of national drug sales of the top 100 drugs in 2012.²⁶

Benefit Design

As noted earlier in this report, generic drug utilization is heavily influenced by plan design. And insurers seek to offer smart benefit packages to make their plans more attractive to the largest number of enrollees. Indeed, savings due to increased generic drug utilization could very well be attributed to the use of private insurers, which are better able to develop innovative, cost-saving solutions (such as preferred pharmacy networks) that may not be captured by previous forecasting models.

Along with benefit designs, Part D insurers make use of network management to help keep down costs. It is very likely that without the competition imposed by the design of the Part D program, insurers would not compete as much along tight networks. (Tight networks—known as preferred pharmacy networks—restrict the pharmacies at which beneficiaries can shop, in exchange for lower prices for drugs at

Figure 5: Drug Patent Expirations over Part D's Lifetime

Years	Total Number	Share of Total
2006–09	32	13%
2010–12	214	87%

Source: <http://www.q1medicare.com/PartD-BrandNameDrugPatentExpirationsRX.php>. There is some overcounting because different formulations of drugs are counted multiple times (e.g., there are four variations of the Advair Diskus; Seroquel and Seroquel XR are counted separately).

those pharmacies.) Since 2011, preferred pharmacy networks have grown significantly in the Part D program. Adam Fein of Pembroke Consulting found that in 2014, over 70 percent of regional PDPs will have preferred pharmacy networks. This is up from almost none in previous years.²⁷

Payers that offer these preferred networks negotiate special rates with pharmacies in exchange for referring their plan beneficiaries there. This leads to lower premiums for enrollees and lower costs for the government. A recent analysis by actuarial consultancy Milliman of the effects of greater penetration of preferred pharmacy networks in Part D found savings of about \$870 million for 2014. The authors find that over ten years, these savings accumulate to about \$9.3 billion.²⁸ A 2013 study by CMS also confirmed that on average, preferred pharmacies in Part D tend to have lower costs than non-preferred pharmacies.²⁹ Independent analysis of the CMS study further clarified that overall prescription costs for Part D tend to be 6.1 percent lower at preferred pharmacies, and generics are 11 percent less expensive.³⁰

Despite the promise of tighter pharmacy networks for cost savings, preferred pharmacy networks are still new to Medicare Part D. And because preferred networks became a major element of Part D plans only around 2011, it is not accurate to pin any savings prior to 2011 on preferred networks. Nevertheless, future savings in Part D will—at least partly—be driven by this innovation.

Remaining Concerns

As noted, although there is a wealth of evidence suggesting that competition among private plans for enrollees drives Part D's savings, this is not to say that further improvements cannot be made to the program.

Perhaps the biggest concern³¹ is that Part D enrollees may not be optimizing their plan-buying decisions. For instance, a report from the Kaiser Family Foundation notes that from 2006 to 2010, a relatively small portion of Part D enrollees—an average of 13 percent—changed plans, even though about 46

percent of enrollees who switched saw their premiums fall by at least 5 percent.³² The authors note that relatively few Part D enrollees are enrolled in the least expensive plan for them, given their particular drug regimens. This is potentially problematic, given that in a competitive market, participants should be optimizing their purchasing decisions based on all available information. Yet the fact that Part D enrollees are incurring greater than necessary health-care expenditures indicates that the Part D market may not be optimally competitive. This is probably because Part D enrollees are not making the most of available resources to help guide their purchasing decisions. A full 60 percent of beneficiaries do not use the Internet, while only 10 percent of the total Part D population has used Medicare.gov's Part D Plan Finder. Most beneficiaries are unaware of Medicare counselors who can assist seniors in comparing Medicare plans, and most are also unaware of Part D's quality-rating system.³³

Overall, the problems in the program are minor and eminently manageable. Beneficiaries' relatively low levels of plan switching may have to do with low levels of Internet use by beneficiaries. If that is the case, it is likely attributable to the generational gap rather than problems in Part D itself. As new generations age into Medicare, they will be more tech-savvy and able to make better use of available plan-comparison tools.

First, it is important to remember that Part D legislation is only entering its ninth year. Markets take time to become truly competitive—especially markets that are delivering new products to a population that has little or no familiarity with them or the technology used to deliver them. One would expect that it would take time for seniors to become comfortable and proficient at accessing all the relevant information.

Second, research from the Congressional Budget Office (CBO) offers a slightly rosier picture of consumer choice in Part D: 20–25 percent of beneficiaries change plans each year, according to CBO's analysts.³⁴ In addition, CBO's research shows that 60 percent of beneficiaries are within six dollars of the lowest premium plan available to them—a relatively small margin at which it may not be optimal for seniors

to invest additional time in seeking the lowest-cost plan.³⁵ Perhaps more important, CBO finds that regions with more plan sponsors tend also to have lower bids.

Moreover, targeted outreach by CMS to inform beneficiaries about plan availability and the availability of plan-comparison tools (online and through counselors) would likely improve beneficiaries' decisions. For the most part, however, none of the concerns, when it comes to Part D, are significant criticisms of the program as a whole, nor are they indictments against its competitive nature. They amount largely to critiques at the margins that can likely be worked out fairly simply.

LESSONS FOR ENTITLEMENT REFORM

Perhaps the most important lesson from the Part D program is that public-private partnerships can work to save taxpayers money and offer smart, effective programs for their beneficiaries.

Indeed, would-be entitlement reformers should see Part D's experience as a teaching moment. Clear and predictable rules with flexibility for private-sector innovation are at the root of the program's success. The program also teaches us that elderly—and even poor—consumers can still be relied on to make smart, cost-conscious decisions.

The joint state-federal insurance program for the poor and disabled—Medicaid—is a prime example of where Part D-style reforms would help. With states already able to experiment with federal waivers, we have seen laboratories of innovation demonstrate both successful and failed programs. Indiana's "Healthy Indiana" program, for instance, gave its beneficiaries partly funded health savings accounts (HSAs)—tax-advantaged savings vehicles for out-of-pocket medical spending. While the program is still young and long-term results have not been evaluated, early evaluations showed strong enrollment and retention.³⁶

The idea of requiring some out-of-pocket spending from even poor enrollees is an important factor in Part D's success: even low-income subsidy benefi-

ciaries have some minimal co-pays for generic and branded drugs, to minimize moral hazard.

Part D also offers lessons for managing pharmacy benefits. A recent study³⁷ found that if Medicaid programs—both fee-for-service and managed care—were to better manage pharmacy benefits (through Pharmacy Benefit Managers [PBMs]), as Part D does, the states and the federal government would save over \$70 billion over ten years. Again, the lesson is allowing more private-sector involvement and innovation, within clearly established guidelines.

CONCLUSION

Medicare Part D represents the most successful public-private partnership in Medicare's history. The program offers clear and simple requirements for participating insurers as well as reasonable subsidies for seniors, and it allows flexibility for private-sector innovations in plan design. From reviewing the preponderance of available evidence, it becomes clear that consumer-driven competition is a significant factor in Part D's success, even taking into account learning from markets outside Part D.

Future enhancements to Medicare Part D should build on this program design. A growing body of economic evidence indicates that effective utilization of prescription drugs has substantial positive spillover effects into other parts of the Medicare program. For instance, CBO projects that for every 1 percent in Part D spending, Medicare saves 0.2 percent in other health-care spending.³⁸ Medicare could provide an additional incentive for optimizing seniors' utilization of, and adherence to, appropriate prescription drug treatments by allowing Part D plans to share in the savings cost reductions in other Medicare spending.

Medicare could begin to implement this system by sharing de-identified claims and outcomes data for Medicare Parts A, B, and dual-eligible with chronic ailments that are responsible for a significant share of Medicare spending (e.g., diabetes, heart disease, cancer, and dementia) with Part D plans. Plans could analyze these data to identify opportunities for more effective prevention or disease management strate-

gies that could improve outcomes and reduce costs across the Medicare program. This would have several beneficial outcomes.

First, plans would have an incentive to coordinate seniors' care with other health-care providers and invest in the electronic infrastructure to do so. Second, plans would have a significant incentive (plans' quality ratings are already partly determined by their ability to keep enrollees) to get and keep enrollees for longer periods of time, including seniors with serious health conditions. Having the same population, over time, would allow them to accrue the long-term savings from successful prevention and management strategies that might take years, or even decades, to fully capture. (If seniors switched plans after a period of time, the new plan might have to make a "reverse payment" to the original plan to take into account successful prevention strategies.) Finally, plans would be able to reduce outlays, giving them an incentive to lower premiums to attract and keep more seniors.

This approach might even be superior to the Accountable Care Organization (ACO) concept because savings are shared across many medical categories and over a longer period of time than is associated with episodic care management. Moreover, the limited open-enrollment period of Medicare ensures that enrollees cannot shift in and out of plans (beneficiaries face no penalty for going "out of network" under the ACO concept). This approach would also encourage drug manufacturers to develop and submit evidence on the pharmacoeconomic value of their products and to collect and analyze long-term safety and efficacy data so that their products remain frontline therapies in a shared savings environment. Although these recommendations will be the focus of future research initiatives, they represent fruitful avenues for policymakers to consider. The ultimate goal is to balance the importance of innovation with the cost savings available through market-based competition, enhancing the long-term viability of the Medicare program while fulfilling its function as a social safety net.

ENDNOTES

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- ²¹ “Report to the Congress: Medicare Payment Policy,” p. 356.
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- ²³ There is a slight methodological concern with comparing MedPac’s numbers with those of Express Scripts. The cited MedPac number is a chain-weighted Fisher price index (this takes into account generic substitution). Express Scripts does not develop a price index but rather looks at actual prescribed medicines (this should implicitly take into account any substitution that happens, since the approach does not assume a particular “basket” of medicines). Regardless, there is good reason to believe that Part D’s trend is lower than the commercial trend; the most recent Express Scripts Drug Trend Report (2012) shows a pure Medicare PDP Cost Trend of -2.8 percent while the commercial cost trend is 2.1 percent.
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