Obama Backs off Assault on Medicare Part D

Benjamin Domenech

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On Monday, the Obama administration announced a rare surrender on an anti-market line of attack – this time, an attempt to warp the Medicare Part D prescription drug program into a more government-directed entity. The details of the move are here:

The Obama administration said Monday that it would scrap much of a proposed plan to limit the types of antidepressants and other drugs that seniors can get through Medicare after a backlash from lawmakers and the health industry.

In January, the Centers for Medicare and Medicaid Services proposed broad changes to the Medicare Part D prescription-drug program that covers medicines for about 39 million beneficiaries. Among the most contentious proposals was one to end the practice of covering essentially any type of antidepressant, antipsychotic or immunosuppressant prescription drug for consumers in the program. Medicare had said the plan was meant to save taxpayers money and simplify the program for seniors.

In a letter sent to congressional lawmakers Monday, Marilyn Tavenner, the Medicare agency administrator, said the drug-coverage provision and some other proposed changes to pharmacy networks and drug plans would be shelved for now. Ms. Tavenner said the agency would "engage in further stakeholder input before advancing some or all of the changes in future years."

She added that the agency planned to proceed with other proposals in its January document related to consumer protections and antifraud provisions that have bipartisan support. The House is scheduled to vote on a bill Tuesday by Rep. Renee Ellmers (R., N.C.) that directs Medicare to stop work on the proposed rule.

At a House hearing on the proposal last month, both Republicans and Democrats urged Medicare officials to rethink the changes to the drug plan. Then, a group of 20 senators, led by Senate Finance Chairman Ron Wyden (D., Ore.) and ranking member Orrin Hatch (R., Utah), also urged Medicare to back off. In a letter to Ms. Tavenner last month, the lawmakers said they had "strong" objections to the Medicare Part D drug proposals and were concerned they would "disrupt care" and "unnecessarily interfere with a successful program."

Here's the letter CMS sent to Capitol Hill announcing their retreat. The politics of this issue had cut across traditional lines, with Democratic Senators concerned about how these changes would impact them politically in the midterm elections, and with K Street opposed to the measures, which would've had broad impacts:

The Centers for Medicare and Medicaid Services (CMS) floated a long list of changes in addition to lifting "protected status" for three types of drugs.

One provision would have limited the number of Part D drug plans that insurance companies could offer in a specific region of the country. Another would have relaxed the rules that govern plans' preferred pharmacy networks, allowing all pharmacies to participate.

The regulations would have also permitted federal health officials to participate in negotiations between insurers and pharmacies in Part D for the first time. Each change quickly triggered its own fight among industry groups.

The administration's surrender on this ground doesn't end the battle over the prescription drug entitlement, which is often cited as the test-case for Paul Ryan's premium support plan to reform the entirety of Medicare. Heartland's site on Part D, SaveMedicarePartD.com, has more on the successes of the program.

-- Benjamin Domenech

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MCKINSEY: ONLY 14 PERCENT OF OBAMACARE SIGNUPS WERE UNINSURED

The Obama administration has, for months now, been peddling nice-sounding numbers as to how many people are gaining health coverage due to Obamacare. But their numbers have been inflated on two fronts. First, not everyone who has "selected a marketplace plan" under

Obamacare has actually paid the required premiums, payment being required to actually gain coverage. Second, only a fraction of people on the exchanges were previously uninsured. A new survey from McKinsey gives us a better view into the real numbers. Of the 3.3 million people that the White House has touted as Obamacare exchange "sign-ups," less than 500,000 are actual uninsured people who have actually gained health coverage.

McKinsey, the leading management consulting firm, has been conducting monthly surveys of the exchange-eligible population under the auspices of its Center for U.S. Health System Reform. McKinsey's most recent survey, conducted in February with 2,096 eligible respondents, found that only 48 percent had thus far signed up for a 2014 health plan. Within that 48 percent, three-fifths were previously insured people who liked their old plans and were able to keep them. The remaining two-fifths were the ones who signed up for coverage on the Obamacare exchanges.

Of the Obamacare sign-ups, only 27 percent had been previously uninsured in 2013. And of the 27 percent, nearly half had yet to pay a premium. (By contrast, among the 73 percent who had been previously insured, 86 percent had paid.)

Put all those percentages together, and you get two key stats. Only 19 percent of those who have paid a premium were previously uninsured. Among those that the administration is touting as sign-ups, only 14 percent are previously uninsured enrollees: approximately 472,000 people as of February 1.

SOURCE: Forbes

VIRGINIA GRIDLOCKED OVER MEDICAID

Gov. Terry McAuliffe called for a special session to begin March 24, and will use the two-week break to continue his public campaign for using federal Medicaid expansion funds to expand health coverage to hundreds of thousands of low-income, uninsured Virginians.

"I think it's important for everybody to go home to their constituents and hear the issues that I've been hearing as I've been traveling around the commonwealth," McAuliffe said Friday after meeting with House leaders in his office.

But, just two months into his term, the Democratic governor has his work cut out for him if he expects to change minds in the Republican-controlled House of Delegates.

Most Republican lawmakers, including House GOP leaders, remain adamantly opposed to Medicaid expansion and want the issue severed from budget negotiations. House Republican leaders have cast a Senate proposal to extend health coverage to the uninsured as a risky expansion of "Obamacare," and want the state to make additional reforms to a Medicaid program that consumes about one-fifth of Virginia's general fund budget.

“Something this complicated takes time,” said Del. Charles Poindexter, R-Franklin County, a member of the House Appropriations Committee. He said the ultimate decision on Medicaid expansion “will impact Virginia for decades.”

“We don’t have but one chance to get it right,” said Poindexter.

McAuliffe and Democratic lawmakers insist that expanding health coverage is a moral and economic imperative and that federal Medicaid expansion funds will free up state dollars for other critical priorities.

The Senate’s “Marketplace Virginia” plan, crafted with the support of three GOP senators, would use federal Medicaid expansion funds to help an estimated 250,000 adults purchase private insurance. The plan would allow the state to recoup $1.7 billion in taxes that Virginia residents and businesses are paying under the Affordable Care Act and mitigate cuts that hospitals will absorb under other provisions of the health care law, supporters have said.

The infusion of federal money would free up more than $200 million annually in state funds, including $137 million that Virginia spends to subsidize indigent care at hospitals, Senate leaders contend.

SOURCE: Roanoke Times

MISSOURI’S MEDICAID ENROLLMENT FALLS

The consensus among health care experts was that regardless of whether they expanded their programs under the law, all of the states would see their Medicaid enrollment rise markedly as part of the Medicaid expansion push.

So far, that uptick in enrollment hasn’t actually happened in Missouri, and as of February enrollment in the state’s program had actually declined by about 14,000 people since last October. Of course, it doesn’t help that HealthCare.gov is sending Missouri bad data:

Missouri’s Medicaid program expected to see an uptick in enrollment with the rollout of HealthCare.gov because outreach efforts would attract more people -- particularly children -- who were already eligible.

Indeed, the federally run marketplace has turned over to the Missouri Department of Social Services more than 25,000 applications from people who seemed to meet the state’s income criteria.

But the state hasn’t added any of them to the Medicaid rolls….

The state says application data forwarded by the online exchange is fraught with errors and duplication. “We’re in the process of sorting it out,” said Brian Kinkade, acting director of the social services department.

There’s no telling at this point how many of those 25,000 entries are duplicates, are real, or if they’re real, if they’re even eligible for Missouri’s Medicaid program. To make matters worse, reports suggest that the federal government sent the new enrollees to Missouri as a “flat file” -- basically an Excel spreadsheet.

In other words, an error-laden Excel spreadsheet is the sort of high tech health care solution we purchased for $600 million+ with the HealthCare.gov website. You’re welcome, America.

SOURCE: Forbes

INSURERS WORRY ABOUT OBAMACARE EXCHANGES

With the Department of Health and Human Services announcing that plans that were supposed to be cancelled this year can now be renewed for another two years, “the health insurance plans participating in Obamacare are a very worried group right now,” according to health insurance industry consultant Robert Laszewski.

Because he’s in close touch with insurance industry executives, Laszewski became a widely-cited figure during the botched rollout of President Obama’s health care law, and now he says insurers who agreed to take part in the law are coming up against a key concern: “The fundamental problem here is that the administration is just not signing up enough people to make anyone confident this program is sustainable.”

Though the department has reported that 4 million have signed up for health care plans through one of the program’s new insurance exchanges, that number drops to 3 million when individuals who haven’t kept up with paying premiums are included (about 20 percent never paid the first month’s premiums, and an additional 2 to 5 percent haven’t paid the second month’s premium, Laszewski writes, citing insurance carriers).

That isn’t enough to create a sustainable risk pool with a critical mass of young and healthy enrollees to offset the cost of covering older and sicker individuals who are now guaranteed an offer of coverage.

The enrollment problem is exacerbated by Obama’s attempt to reduce the number of headlines this fall about plans getting cancelled as a result of the law ahead of midterm elections in which Obamacare is already putting Democrats on the defensive.

SOURCE: Washington Examiner

JOHN C. GOODMAN'S OBAMACARE REPLACEMENT

The proposal I suggest would achieve four remarkable things: It would be more progressive than Obamacare, because it would involve more distribution from higher- to lower-income households. It would provide genuine protection for people who have a preexisting condition, as opposed to the bait-and-switch promises of Obamacare. It would provide genuine access to care for everyone, as opposed to leaving 30 million uninsured, as Obamacare does. And it would work in practice, primarily because it would confine the role of government to setting a few simple rules of the game, leaving individual choice and the marketplace to do the heavy lifting.

I call this reform a "consensus reform" because it draws not just on such right-of-center think tanks as the Heritage Foundation, the Cato Institute, and the American Enterprise Institute but also on such left-of-center think tanks as the Brookings Institution and the Urban Institute, and various scholars including President Obama's former and current economic advisers, Peter Orszag and Jason Furman. It takes the best ideas these folks have offered and combines them with an important principle: No plan designed by those at the top can ever work unless people at the bottom have an economic incentive to make it work.

Further, the ideas presented here are consistent with the health-care plan John McCain endorsed when he ran for president and with health-care-reform legislation introduced by Senator Tom Coburn, Representative Paul Ryan (Wis.), and other Republican members of Congress. So it could easily be adopted as the Republican alternative to Obamacare.

Choice. People should be able to choose a health-care plan that fits their individual and family needs, rather than a plan designed by bureaucrats in Washington. This means no mandate. Men shouldn't have to buy maternity coverage; women shouldn't have to buy coverage for prostate-cancer tests; teetotalers shouldn't have to buy substance-abuse insurance; etc. And no one should have to buy coverage for preventive procedures that health researchers have known for years are not cost-effective.

It is commonly believed that, without a mandate, people will game the system -- waiting until they get sick to enroll. But we have found a way to handle this problem in Medicare Part B, Medicare Part C, and Medigap insurance without any mandate. In all three cases, the insurance is guaranteed-issue (no one can be turned down) and community-rated (no one can be charged a higher premium because of a health condition). But people are not permitted to game the system. If you don't enroll when you are first eligible, you will be charged a penalty, and, in the Medigap market, you may be charged a premium that does reflect your health status.

Had we accepted the principle of choice in designing a health-care reform, we would not face the prospect of up to 10 million individual policyholders' losing insurance they were promised they could keep. We would also not face the prospect of millions of additional people's fearing the loss of their employer plans.

SOURCE: National Review

KILL THE FDA BEFORE IT KILLS AGAIN

Despite rare exceptions for "compassionate use" and "orphan drugs" secured in the wake of AIDS activism, the FDA's drug-approval process is still widely recognized as being ultra-conservative in weighing the risks versus the benefits of various pharmaceuticals. It is also increasingly facing challenges based less on cost-benefit analyses and more self-ownership principles. "Right to Try" legislation – which proceeds from the presumption that there "is a fundamental right to save your own life" – is currently under discussion in Arizona and other states.

A 2006 Government Accountability Office (GAO) study found that the number of new drug applications submitted to the FDA between 1993 and 2004 increased by just 38 percent despite an increase in research and development of 147 percent. The mismatch, said GAO, was the result of many factors, ranging from basic issues with translating discoveries into usable drugs, patent law, and dubious business decisions by drug makers. But the problems also included "uncertainty regarding regulatory standards for determining whether a drug should be approved as safe and effective," a reality that almost certainly made pharmaceutical companies more likely to tweak old drugs rather than go all in on new medicines.

In fact, the FDA's often arbitrary but always time-intensive requirements have created a system in which new drugs take somewhere around 10 to 15 years to come to market, at a typical cost of $800 million or more. As my Reason colleague Ronald Bailey has written, this means the FDA's caution "may be killing more people than it saves." How's that? "If it takes the FDA ten years to approve a drug that saves 20,000 lives per year that means that 200,000 people died in the meantime." Yet it's easy to understand why bureaucrats remain slow-moving. "Officials know they will be punished by the public and politicians more for underregulating – approving a harmful drug, say – than for tightening the approval process, even if so doing so delays a useful innovation," wrote Harvard's Regina Herzlinger in 2006.

That perverse calculus is made even worse given that we are at "the Dawn of Precision Molecular Medicine," in which cures and interventions can be tailored to the specific genetics of specific patients. As the Manhattan Institute's Peter Huber explains in *The Cure in the Code: How 20th Century Law is Undermining 21st Century Medicine*, we're fast arriving at – and are already there in certain cases – the point in which we can take "full advantage of modern pharmacology's power to develop a vast array of precisely targeted drugs." The early experiments in this sort action involved things such as "cocktails" of a variety of AIDS drugs mixed up for individual patients (some of this comes through in The Dallas Buyers Club).