Past Is Prologue

The last rollout of a major government insurance program was a disaster. This time could be even worse. By Margot Sanger-Katz

When Medicare's Part D, a prescription-drug benefit, launched in January 2006, the early reports were bad. A front-page *New York Times* story predicted beneficiaries would "experience delays and frustration." In Allentown, Pa., *The Morning Call*'s headline declared the program "an absolute nightmare." Another from the South Florida *Sun-Sentinel* said the plan "fails many." Premium-calculation errors left some seniors with no Social Security checks. Low computer literacy meant many couldn't choose from the litany of drug plans. Often, poor seniors went to pharmacies to fill prescriptions, only to find no record of their insurance. Toll-free help numbers were overrun, and seniors couldn't figure out what drugs their plans covered. Larry Kocut, then a senior adviser to the administrator at the Centers for Medicare and Medicaid Services, remembers a rain of fury. "I got so many letters from pharmacists," says Kocut, now deputy director at the Brookings Institution's Engelberg Center for Health Care Reform. "One guy said I ruined his life."

But less than a year later, enrollment was high, plans were working, and a J.D. Power survey determined the new benefit to be the most popular health insurance program it had ever examined. Now, Part D is embraced across the political spectrum and has consistently performed under budget. "The Part D experience did not go perfectly," says Ron Pollack, the president of the liberal health care advocacy group Families USA. "They did get ironed out, but there were glitches."

Government officials and consumer advocates who rolled out Part D say their experience should serve as both warning and consolation to people engaged in the marathon task of implementing the Affordable Care Act. Creating programs, building enrollment systems, and educating the public about how to use health insurance are complex, confusing, and inevitably buggy tasks. Anyone expecting a smooth start for the new health care law is fooling themselves, they say. "Any time the federal government tries to do something for tens of millions of people, you've got to anticipate that there are going to be some initial bumps," says Keith Hennessey, who served on President George W. Bush's National Economic Council and is now a lecturer at Stanford University. Hennessey opposes the health care law but says it would be unfair to judge the program based on the unavoidable implementation hiccups.

In some ways, the Affordable Care Act can benefit from the Part D experience. Many of the basic tasks are the same, and many of the career staffers still work at CMS, the agency behind both programs. Charlene Frizzera, a former 30-year CMS employee who was chief operating officer at the time, says Part D prompted an overhaul of the center's organization and mission—changing it from a slow-moving regulatory body to one that could design and market consumer products on tight deadlines.

Bush administration officials said they worked quickly to troubleshoot problems and develop work-arounds. Close communication between CMS and the White House allowed them to make quick adjustments, such as establishing a default health plan for seniors whose information didn't pop up at the pharmacy, and agreeing to resolve the details later. They also learned how important one-on-one communication was in helping people sign up for health plans. So Obama administration officials are collaborating with private groups, states, and health plans to make sure people have many places to go for information about how to use the new system and pick the best plan for them.

Drugged: Seniors *eventually* got what they needed.

But implementation of the health care law may be even bumpier than the Part D rollout. For starters, its ambitions are much broader—it hopes to overhaul existing insurance markets, change the way doctors and hospitals deliver medicine, and expand state Medicaid programs—in addition to establishing the online insurance marketplaces for the uninsured. That makes CMS's mission more complex in kind *and* in degree. The agency's digital systems will need to communicate with many more organizations than the Part D networks did, increasing the odds of failures and crashes. Comprehensive health insurance products are also necessarily more complicated and expensive than a standalone drug benefit. (A typical Part D premium is $30; health insurance premiums will run into the thousands of dollars a year for higher-income Americans.) It "is going to dwarf what we saw with Medicare Part D by an amount of degrees that I can't even calculate," says Nora Eisenhower, who was Pennsylvania's secretary of aging in 2006 and is now at the National Council on Aging.

The Obama administration also faces much greater challenges in enrolling beneficiaries. Signing up seniors for Part D was difficult at first, but at least the federal government knew all the people it was trying to reach—they were already enrolled in Medicare's other health benefits. The feds also mostly knew where they lived, where they received health care, and how much money they earned. Frizzera remembers that CMS could track every beneficiary by ZIP code and measure how many times they had communicated with outreach workers. And seniors largely wanted (and needed) drug coverage, so they were motivated to persist through difficulties.

Finding people with no health insurance, fewer acute health needs, and less experience enrolling in government programs is going to be much tougher—accompanied, in all likelihood, by a period of bad headlines. ■

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