

Making Sense of Medicare's Drug Benefit: Information and Resources to Help Beneficiaries

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ED HOWARD: Good afternoon. Let's try to get started. I think there are some folks still making their way through the lunch line, but we want to make sure we give you as much opportunity to hear about today's topic and asking questions as we possibly can.

I'm Ed Howard with the Alliance for Health Reform. Our Board of Directors sends its welcome to you, headed by Jay Rockefeller, our chairman and Bill Frist, our vice chairman.

This program, as I hope you know, is designed to inform all of us better on the basics of the new prescription drug benefit in Medicare, the so-called "Part D" benefit. We not only welcome those of you who are here, but also via live webcast over kaisernetwork.org—a welcome to those congressional staff in state and district offices who are tuning in to learn more about what their constituents are confronting. Our partner in today's program is, in fact, the Kaiser Family Foundation; and we're happy to have Diane Rowland, the executive vice president of the foundation, with us. We'll hear from her in a moment.

The goal of this program is not necessarily to debate the still multitudeness and prickly policy issues that people have with this prescription drug benefit, but to give you a better grasp of what to expect once beneficiaries start to sign up next week. And the actual benefits begin in January.

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Let me just make a couple of logistical notes. In your packets—those of you who are here and, actually, you should have also, in congressional offices, gotten a mail packet—you're going to find a lot of background information. There is other background information that was collected after those packets were put together. You'll find either text or links to those materials, which I commend to you on both the Alliance website, allhealth.org, and kaisernetwork.org, associated with the webcast.

You'll also find speaker biographical information much more extensive than we're going to be able to verbalize today. You'll find Tricia Neuman's slides. We don't have Julie Goon's slides in the packets or on the website yet, but they'll be there later today.

In a few days, you're going to be able to view a transcript of this event in case you want to double-check something that one of our speakers said and copies of those materials both at the Kaiser website and at ours. I want to encourage you at the appropriate time to either fill out that green question card—for those of you who are here in the room—or go to one of the microphones that you'll find on the floor. Or for those of you who are watching via the webcast, if you want to submit a question, you can do that by either emailing [frontdesk—that's all one word—@allhealth.org](mailto:frontdesk@allhealth.org), or calling the Alliance phone number at 202-789-2300; and we'll get the

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question and try to get you an answer.

Well, as I noted, we have with us today Diane Rowland of the Kaiser Family Foundation who is not only the co-host but, also, the executive vice president of the foundation and one of the most respected and sought-out health policy analysts in the country, and we're very pleased to have her with us. Diane?

DIANE ROWLAND, SC.D.: Thank you, Ed. I'm pleased to be here, and I'm very pleased that we're able to co-sponsor this session today. We spend a lot of our Alliance briefings talking about issues that are, hopefully, going to be changed through legislation, but this is one where we actually had the briefings. We got through the Medicare Drug Benefit, and it's time now to make it real and to have people sign up and actually be able to get the benefits that were legislated for them.

I think that all of us are here today, in part because we know not only as analysts do we want to see how this benefit works and get it implemented and have it work properly. But we're all getting lots of calls from friends and family who expect us to know everything about this benefit. And so I think this is a learning experience for all of us, and we're anxious to hear the speakers and to really begin to understand about the choices people are about to make for themselves and their family members around how to best match the drug benefits

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being offered by the different plans to the personal needs of our senior citizens and our people with disabilities who have so long waited for a Medicare drug benefit.

We are also pleased that this is a briefing that we can do with a webcast so that it can reach out to the district offices because we thought that one of the places where people would be getting a lot of phone calls and need some assistance on how to answer them was in the district offices. We keep getting comments from friends and family about, "We don't understand this," and we know understanding is going to be critical to the successful implementation of this benefit.

And I just wanted to give you a FYI heads-up that on Thursday of this week from 9:30 to 10:30 at the Kaiser Family Foundation, we'll be releasing our latest public opinion survey on "What do seniors think about the new Medicare Drug Benefit?" And I think that briefing will demonstrate how important sessions like today are to help further the understanding that the seniors and disability population have about the benefit they're about to receive.

So that—let's get on with hearing about the way in which this benefit is going to operate and the plans that are going to be there to provide the services. But let's also really get to your questions because I think many of us know that the answers to the questions are probably as important as the presentations we're about to hear. So thank you and thank

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you for being here.

ED HOWARD: Thank you, Diane. And as I said, I apologize to our speakers for not giving you the introductions that you deserve, but in the interest of brevity, let me just do the "Cliff Notes" version, if you will.

Our first speaker is Tricia Neuman. She's vice president of the Kaiser Family Foundation and director of its Medicare Policy Project. She publishes articles in peer review journals like *Health Affairs* and goes on the "Today Show" to explain these issues in terms that even I can understand. So we're very pleased to have her in that latter capacity backed by the knowledge of the former capacity.

TRICIA NEUMAN, SC.D.: Thank you, Ed. Well, this is a very exciting time both in health policy generally and in Medicare policy specifically with the beginning of the Medicare Drug Benefit. As you can see from this first exhibit, this has been a very busy time, mostly for the people who are at the centers for Medicare and Medicaid services who have been working feverishly, along with our colleagues at the Social Security Administration, to get ready for the drug benefit.

There were a lot of deadlines that were set forth for them in the law, and it's impressive that CMS and Social Security has done an incredible job at meeting those deadlines. But now we are eight days away from the November 15th open enrollment period and less than two months away from when

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seniors can begin to get—seniors and people with disabilities on Medicare—can begin to get their drug coverage under new Medicare plans. So this is—has been a phenomenal time in terms of what has happened and, yet, much will need to happen in the next few months and before May 15 when the enrollment period ends.

My task is to do the brief overview. So, many of you may know this, but I just wanted to be clear about the basics. Medicare will begin to be covering prescription drugs through private plans in order for people to get this coverage. They have some choices.

If they want to stay in traditional Medicare, they can sign up for drug-only plans or stand-alone policies that provide the prescription drug benefit. Or they can choose integrated plans that provide other Medicare benefits like hospital and physician services and the prescription drug benefit. These are plans like local HMOs, PPOs, which are Preferred Provider Organizations, and private fee-for-service plans, which are relatively new to Medicare.

The plans are allowed to provide or required to provide a standard benefit or something that is at least actuarially equivalent, which I'll go over in a minute. There are significant premium subsidies and cost-sharing subsidies for people with low incomes. There are various income and asset categories, but in general, if an individual has an income of

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less than \$15,000 or a couple has an income of less than \$20,000 and relatively modest assets then they can qualify this extra financial assistance.

A significant feature of this law is that Medicaid drug coverage and for the 6.5 million people who are dually eligible for Medicare and Medicaid—that happens the end of December, and their coverage begins under Medicare plans January 1. And that is the drug plan in a nutshell.

CMS and others are expecting 30 million people on Medicare to be enrolled in drug plans by 2006. So as you can see much needs to happen between now and May 15.

Now the private plans that are administering the drug benefit have considerable flexibility in establishing their benefit design. The law set forth a standard benefit which looks like the one that you see in Exhibit 3 here. People will pay a premium of the estimated average premium is for the—the average premium is \$32 per month, but the premiums vary significantly across plans. After an individual chooses a plan and pays their premium, they face a benefit design, which can vary somewhat.

But, as you can see, there's a standard which has a \$250 deductible. Then there's a co-insurance of 25 per cent [misspelled?] up to an initial benefit period. There is a "coverage gap" of \$2,850 until the person might qualify or would qualify for Catastrophic Coverage. And once they do,

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Medicare would pay 95 per cent and the individual pay generally 5 per cent [misspelled?] of total cost. To get the catastrophic benefit, they would have incurred \$3,600 out-of-pocket excluding the premium.

As you can see in this next slide, individuals on Medicare will face many opportunities to choose plans. And there will many, many prescription drug plans offered throughout the country. This map shows the number of prescription drug plans that will be offered in each state and, really, it is a conservative estimate of the number of plans in each state, because it is only the prescription drug plans, the stand alone plans. This does not include the PPOs and HMOs and private fee-for-services plans.

And Ed was just saying earlier, he was looking in Maryland and found more than 60 or so plans that were available where he was looking. So there are, indeed, a wide number of plans that will be available to individuals.

We looked at and did a comparison of four states just to see how much variation there is across states. And we are really just scratching the surface here. I think many analysts would like to look in greater detail at the plans and will be looking in greater detail.

But for now, what you can see is across the states, there's a similar number of organizations that are offering plans. Many are the national or nearly national organizations

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that have decided to enter into this program. There are, also, a similar number of Medicare prescription drug stand-alone plans.

Then we started to look at the number of plans that are available to low-income people. And that's when you do see some variety across the states. I should say in your folder, we have a state-by-state summary that Julieta Komansky [misspelled?] of the Foundation staff prepared, which will provide information about plans offered in each of the states. This is just a snapshot of four states.

You can see that the premiums in each state vary considerable from, for example, in Nebraska a low of \$1.87 per month to \$99.90 per month. So if people are concerned about premiums, that's one area where there will be quite a range. There's a range with respect to deductibles whether the plans them or not. There is also, by the way, some variety in terms of what's covered under the deductible, whether it's generic—what applies, whether it's generics or brands.

So that's something to look at. Most plans have a doughnut hole, but not all. So that's something to take into consideration. And finally there are these other plans that are around the country HMOs, PPOs, and private fee-for-service plans.

I guess the point that I want to make—a broader point about this slide is the landscape is changing considerably for

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people on Medicare. There will be a number of plans that will be marketed, both prescription drug and other plans. They all have the Medicare logo attached to them. So there will be both new choices, but new sources of confusion for people as they try to sort through, "What are the different types of plans that are out there and what is best for themselves?"

This next slide, probably anybody who's talking to their family members and friends and neighbors could put their own picture in the middle because so many people that we talked to have different experiences in terms of what their current sources of drug coverage are. And, I guess, the point of this slide is that the first decision in any individuals likely to make is, "Should I sign up for Medicare drug plan or not?" And that decision depends a lot on what their current source of coverage is. And that will vary from person to person.

So, for example, a person who now has employer coverage, a retiree benefit may well choose to keep that coverage. But a person who has no drug coverage, obviously, would want to think seriously about signing up for a drug plan. And the way this translates into my family is my father-in-law has drug coverage, my mother-in-law does not. So, they each need to make two very different decisions. And that's really true for everybody on Medicare, depending on what they have now. That will have a big impact on the decision they can and should make about whether to sign up for the drug plan or not.

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But it is possible to get started, and it's important to get started and ask some fundamental questions. And the first question really is, "Should I sign up?" And people have, this year, between November 15 and May 15 to make that decision.

Assuming that decision is "yes," then the question is, "What type of plan is best for me or my parent or whoever I am helping?" Is it a stand-alone plan? Or maybe they're interested in a more integrated plan like an HMO or a PPO? And there are other questions that get a little bit more complicated to research. "Which plans cover my drugs?" Probably most important is, "Their most expensive drugs—what will I pay out-of-pocket under each of the plans if I go to a pharmacy that's very important to me, and how does that vary?" And finally, "Which pharmacies are in the network?"

And I guess I shouldn't have said the word "finally" because there are different aspects that are important to different people. Some people want to stay with their pharmacists, some people will do anything to save money. Some people can't make all these decisions, because they're going to be assigned to a plan that's at or below the average because of their low income. But there are some core decisions that people can make in order to facilitate these decisions.

I think it's fair to say that much needs to occur in the education activities that confront us all in the months

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ahead. Looking at the next slide, this is based on a survey that the Foundation did in August. What we found then is three of five seniors at the time said they really didn't understand the new drug benefit. And that, obviously, suggests that more needed to be done to educate people about the benefit. And while they don't need to be experts on the intricacies, because nobody needs to torture themselves with that necessarily, they do need to understand the basics in terms of whether they should sign up and how to sign up.

We also asked people—seniors—whether or not they were thinking about signing up. And at that time, 22 percent or about one in five said they were planning to enroll. That was August, and more work has been done and is being done. But, clearly, it would suggest that more people need to get to the basics about enrollment since, again, CMS is assuming that 30 million people or about two-thirds will sign up this year.

Wrapping up, I think it's fair to say that the Medicare drug benefit offers significant opportunities for people in the program to get help. That is particularly true for people with low incomes, people who didn't have drug coverage, people who may have catastrophic drug costs. There are dozens of plans that will be marketing—marketed in each state. Many have started their marketing and activities, but I think we'll be seeing more and more of that in the months ahead.

There are some immediate challenges, including helping

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43 million people decide whether to sign up for a Medicare drug plan or not and to choose the best plan for them. Another challenge will be identifying and helping 6.5 million people who now get their Med—their prescription drug coverage paid for by Medicaid—helping that group of people transition from Medicaid to Medicare drug plans without a gap in coverage and working to assist those with low incomes get the subsidies to which they're entitled. Because those subsidies really make a difference.

This is a huge education challenge. It's made more difficult because it's not one message; it's many messages targeted to people with different circumstances. But this is the time to do it because the benefit starts in the very near future. Thank you.

ED HOWARD: Thank you, Tricia. Pardon us while we do a little technical adjustment here. Now we're going to hear from Julie Goon, who's a senior advisor to the secretary and director of Medicare Outreach for the Department of Health and Human Services. So, I guess, you bear part of the blame for having met all those deadlines that Tricia had mentioned earlier.

Before joining HHS, Julie was a senior vice president for what is now America's Health Insurance Plans, Trade Association for Managed Care, and other insurance companies. Just so you don't shuffle through and get frustrated. Julie's

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slides are not in your packets. They are not yet on the website. They will be on the website later today. So we're very please to have you with us, Julie.

JULIE GOON: Thank you very much, Ed. And thank you to all of you for being here on this panel with me today. I wanted to just run very quickly through what we've been trying to do at CMS over the last couple of months to try and increase awareness as well as provide the kind of information that Medicare beneficiaries and the people that help them need to have in order to make an informed decision about the new Medicare drug coverage.

Part of this has been to try and encourage a national conversation, not just with Medicare beneficiaries, but with their families, with their friends, with the advocates for beneficiaries—people who are going to help them by providing continuous targeted outreach education and now enrollment assistance.

This whole awareness campaign started in the spring. You may have seen a Medicare bus come through your members. Congressional district—we have visited over 80 cities in 40-some odd states with the Medicare Mobil Office tour this summer. And the bus is back out on the road again this week. And we'll be making stops in Georgia and Florida and North and South Carolina. So we're going back to see some of the places we've already been.

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There's been a lot of media work that's already gone on. The Office of Legislation at CMS, I think, has briefed the congressional delegations from all 50 states as well as some of the different conferences and caucuses. And we have done a lot of work with our national partners, in particular with the Social Security Administration, and I know Bea will be talking in more detail about the low-income subsidy outreach the SSA has been doing. But, in fact, we're also working with the other government agencies to reach out to Medicare beneficiaries through the programs that those agencies also have, which touch Medicare beneficiaries.

We've been working with private sector associations and coalitions. There are a number of coalitions that have formed, primarily, here in Washington, but—here in Washington to establish grass roots networks. And many of you are probably familiar with the Access to Benefits Coalition, which is focused on low-income enrollment. The Medicare Today Coalition, which is also focused on enrollment issues, and then the Medicare Rx to Education Network, which is doing a lot of media work.

And then, of course, the plans have been doing a lot of marketing and awareness work on their own. Tricia went through some of the information about the plans that have become available. But just in terms of the general good news that we've been seeing since the plan bids came in, in August, as

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Tricia mentioned, there is a lower average premium than what was estimated initially. That average premium was estimated to be \$37. It's now \$32, and this is, in part, a result of the competition among plans that existed. There is a choice of at least one prescription drug plan with premiums below \$20 a month in every state with the exception of Alaska.

There are options in every state for coverage in the standard benefit's "coverage gap." There are plans with zero deductibles or deductibles lower than the standard \$250 annual deductible in every state. And there are plans with zero premiums offered by at least five organizations available to beneficiaries with limited incomes in every state.

And there are options for even more savings and additional coverage in Medicare Advantage plans. That was one of the other goals of the MMA when it passed was to expand coverage of Medicare Advantage plans to those areas of the country which did not have those kinds of choices available.

There are regional PPOs available in all but 13 states. And in 2006, 70 percent of all beneficiaries across the country will have access to a Medicare Advantage plan with a zero total monthly premium, not including the Part B premium.

In terms of getting started to enroll in Medicare drug coverage, and as Tricia mentioned this coverage—you can't enroll until the 15 of November. The first step is really to determine what your current drug coverage is. Are you covered

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by an employer retiree plan? Are you in a Medicare Advantage plan already? Are you Medicaid Dual Eligible Beneficiary? Do you have Medigap with or without drugs? Do you have no coverage whatsoever?

In all of the tools and information that CMS has been providing is designed to narrow the scope of what you have to look at. And part of narrowing that scope is really determining where your current drug coverage comes from.

Beyond that, we want people to really think about what matters most to them and review their options based on that. Is it cost? If it's cost, you may want to think about what your monthly premiums look like, what the annual deductible is, what the payment is for the specific drugs that you take? Is it coverage? Are there benefits provided in the "coverage gap" in the plans that you are looking at? Are there enhancements to the benefit? What are the prior authorization requirements or the step therapy requirements on your drugs? What does the formulary look like for the drug plans that you're looking at?

And then, with respect to convenience, is it more convenient for you to stick with the pharmacy that you're used to? Or is mail-order drug coverage something that you would find more convenient?

In terms of the tools that CMS has available, there is a lot of information available currently, and I know that there has been a lot of anxiety and concern about the availability of

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drug pricing information in particular, which I'm going to talk about in just a minute.

The *Medicare & You* handbook was mailed to all beneficiary households in early October. There are web-tools available at www.medicare.gov, both for beneficiaries themselves and the people who are helping them make decisions. There is personalized counseling. There are customer service representatives at 1-800-MEDICARE. And then the plans themselves have been doing a lot of marketing as I mentioned earlier.

This afternoon the drug pricing information on the Medicare Personal Plan Finder goes live sometime around 3:00, I think. In addition to that, we have redesigned the Medicare.gov homepage and the initial information that comes up about drug coverage. And we'd be very interested in your comments on that. I looked at it over the weekend, and it's a much easier way to find out information than some of the things that have been on the Medicare.gov website to date. So take a look at that this afternoon and please—most of you aren't shy—let us know what you think about the information that's up there now.

In terms of the web-tools that are available for beneficiaries and the people who are helping them, there is a Drug Plan Cost Estimator, which is just—it really is just something that will provide you with an estimate of a

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beneficiary's potential savings by joining a prescription drug plan. And that estimate is based on the standard benefit package and the lowest premium offered in the area where the beneficiary lives. So it's not necessarily what a beneficiary is going to see in every choice, but it is a way to gauge whether even looking at a prescription drug plan is something that a beneficiary wants to do in terms of identifying what kind of savings is available to them.

We've also put together a landscape of local plans, which I think most of you have probably seen. It's laid out, sort of, like a consumer report type of spread sheet. It lays out the Medicare prescription drug plans by state and the Medicare Advantage plans by county and provides basic information in those three categories I mentioned before—cost, in terms of what the premiums, deductibles, and co-payments or cost-sharing look like; coverage, whether there's coverage offered in the "coverage gap," how many of the top 100 drugs are covered by each plan; and not yet, but the next time the landscape is updated, it'll also go through whether there's prior authorization of step therapy in the different plans on the landscape and then with respect to convenience whether a mail-order option is available in that plan.

The Prescription Drug Plan Finder is the website tool that most people have been waiting for, I think. And there is a lot of data available on that Plan Finder tool. And just

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getting to the point where all of this was inputted in a way where you could very quickly input your drugs, figure out what your total annual estimated costs were going to be by a plan based on the drugs that you currently take, and make sure that there were no odd anomalies coming up. It has taken, probably, a little bit longer than most people had anticipated.

The Office of Legislation is planning briefings. I think, later on this afternoon and throughout the week for people up here on the Hill to walk through how to use the Prescription Drug Plan Finder. And when it goes live, there is also something that's called the Flash Demo—which is a phrase I had never heard before—but it's a quick 10-minute pop-up kind of video that actually; you can link onto and it walks you through the Plan Finder tool and describes the decision points along each screen shot. And it helps you just kind of get a sense of how this works.

The Plan Finder Tool will provide customized cost information for prescription drug plans—the Medicare Advantage plans—based on a person's current prescriptions and their eligibility for extra help. And if you walk through the Plan Finder with somebody at the 1-800-MEDICARE website, you can get a *Customized Print on Demand* booklet, and you can also do that for yourself as you go through the options.

It allows users to determine their current coverage. So if you—and I'll get to this in just a minute as well—but if

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you input your Medicare number, when all the data is available, it will let you know if you are in a retiree plan that you've already been claimed by your employer. If you have coverage through a Medicare Advantage plan, that will show up. And if you are a Medicare dual eligible, that will show up as well.

Again, the Plan Finder shows a list of drug plans in an area sorted by the lowest total cost for the current drugs that you are taking. It allows you to narrow those choices even further. If you don't want to look at all the plan options available in your area so you can determine whether you only want to look at plans with deductibles at certain levels, if you only want to look at zero deductible plans, if you only want to look at plans with \$100 deductible or \$150 deductible, if you only want to look at plans with premiums below \$10 or below \$20, it will—or if you only want to look at plans that have certain brand names—for instance, you already know that you're definitely interested in a Blue Cross plan or a Humana plan, you can limit the plan search by those kinds of factors and just look at that.

The Finder displays the coverage that each plan offers and identifies as well, the preferred and nearby pharmacies and plans that offer mail-order prescriptions. In addition, many plans have negotiated discounts for all drugs, even drugs that aren't on their Formulary. So if you input all your drugs, the plans that show up with a total annual cost, you may in some

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cases find that the plan that has the lowest annual cost for you does not include all your drugs on the Formulary—on their Formulary—but they have negotiated prices off Formulary that are lower than you may find another option for, which is something that was new to me. And we walked through this last week and actually found this in a basket of drugs that we were looking at for a particular beneficiary.

When you're going through the Prescription Drug Plan Finder, there are a couple of different search options. One is this Authentication Route, which is the preferred method where you can enter a user's personalized Medicare number and information returned is customized, based on the status of extra help that beneficiaries eligible for, whether they are receiving the employer subsidy or whether they are currently enrolled in a Medicare Advantage plan.

And, I'm apparently coming close to the end of my time. Thanks, Ed. So I'll run through the rest of this quickly.

The general search route, you just—to answer question on the tool. And you'll end up seeing detailed cost-sharing information on available prescription drug plans. The search results—I went through before.

The Prescription Drug Plan Finder is also linked to Medicare Advantage plans. This Medicare Personal Plan Finder has been on our website for awhile. It just goes through the Medicare Advantage coverage options, but there's very detailed

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drug comparison information available on the Prescription Drug Plan Finder for Medicare Advantage plans as well.

The Formulary Finder is, also, linked to the Plan Finder, but you could go straight to the Formulary Finder and just look up the plans that cover all of your drugs on the Formulary.

We also are providing information on this eldercare.gov website. It provides links to those who need assistance with state and local area agencies on aging and community-based organizations that have agreed to serve older adults and their care givers with personalized information and one-on-one counseling.

As I mentioned, 1-800-MEDICARE is available 24 hours a day, seven days a week. Customer Service Representatives have been trained using these web-tools, and they'll be walking beneficiaries through the web-tool when people call in. We are monitoring the capacity on 1-800-MEDICARE, and we're getting reports twice a day. Currently, all the phone calls are being answered in under 10 seconds; and the average length of a call is about eight minutes. And that'll probably go up as this new drug pricing information is available.

And then, the fourth step is enrolling between November 15 and May 15. And you can enroll by telephone at 1-800-MEDICARE. You can enroll on the Internet at CMS's online enrollment center by fax or by mail or directly with a plan.

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And, just some important dates: The day after Thanksgiving, the 25th of November is the day that's been targeted as the National Day of Conversation. We're encouraging people to have those kinds of conversations with their family and their friends and their neighbors and their loved ones about Medicare prescription drug coverage. Thank you.

ED HOWARD: Thank you, Julie. Next up, we hear from Beatrice Disman. She's the regional Social Security commissioner for the New York region. Medicare beneficiaries are almost all Social Security beneficiaries as well, and they look to SSA for information on Medicare. In fact, most of you know, Medicare began life as part of Social Security. Bea has won every award that Social Security has to offer; and most relevant to today's discussion, she chairs the Social Security Medicare Planning Task Force. So we're very pleased to have you with us.

BEATRICE DISMAN: Thank you, Ed. Thank you, Ed; and I'm delighted to be here. I'm delighted to be on this panel. I've spent a lifetime in congressional briefings as has the staff in Social Security around the country. And you heard from Tricia talk about complex messages and many messages. And Social Security has one of these messages.

So, while you're hearing about the enrollment and all the other aspects of people needing to make decisions now to

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enroll in a plan, Social Security's role is defined as to what its role is under MMA. And I want to talk a little bit about that, because I think, in essence, we need to be very careful to distinguish roles and to see how we can assist people with various aspects.

But, the defined role that we were given is to help people—this Extra Help, to educate Medicare beneficiaries to Extra Help, that population above the D [misspelled?] population, that population that has limited resources and limited income, the population that's usually very difficult to reach, a population that tends to in action, the population that usually doesn't buy off the means-tested programs.

And so, in doing that, the education was not just from Medicare beneficiaries community-based organizations, states, localities, caregivers—you name the organization, we have been there to work with them to reach out to the community.

The second part is to help people apply for the Extra Help. In addition, we need to ensure that when people apply for the Extra Help with us, they also know that they can enroll in a plan with us. And you know this is going to be a little confusing to some Medicare beneficiaries because they enroll with us for Part B. And that is how they're really used to being with us.

But the enrollment is with a prescription drug provider. And Social Security cannot offer advice on

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enrollment or counseling. We will be referring people to the CMS website, the CMS 1-800 number, and also to your local SHIPs, your area agencies on aging, whatever are the community organizations that people can go to for assistance in enrolling.

In addition, we want to make sure that people are aware of other programs that they might be eligible for whether it be the Medicare Savings program as well as food stamps, because we're reaching a population that might be eligible for other programs.

And then lastly, once they enroll—and this is for the rest of the population because generally the Extra Help population—the D population will not have premiums. But if they've taken the mean premium or below—but if people enroll in prescription drug plan, they can have their premiums taken out of their Social Security checks. But they have to tell this to the prescription drug provider who lets CMS know, who lets Social Security know.

So again, many messages and we're really focused on the message that Social Security is trying to get out. What has our approach been? It's been multifaceted, one size does not fit all, as you can see by Tricia's design. It attempts to reach Medicare beneficiaries in multiple ways, touch them, different ways, different ways of getting information.

Partnerships have been very, very significant.

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Certainly, CMS is the lead in implementing this, and us working with CMS—but not just CMS, your states, your local government, non-profits, the pharmaceutical industry. It also involves very specific targeted outreach by us on the ground to try to find this population. And we too have set up online tools for people to use.

So, I'm going to run briefly as to how have we proceeded so you have a frame of reference and you can raise any ideas with us as we go forward. I think many of you know that we identified a targeted population. It really was larger than we had hoped to identify. It was an over sample. We were attempting to be all-inclusive. What we did is we used data that we had in our own records, data that CMS had sent us on the D population, VAOPM Railroad Board to identify people up to 150 per cent from the federal poverty level. What was missing was IRS data that gave us resources or other pension income.

So we know we sent more targeted mailings to the population than would be eligible. We did mail 19 million targeted applications between May 27 and August 10. That was just the first of our initiative. In addition, we have the on-ground strategies of working with community-based organizations and local governments talking about the Extra Help and what it really was, and trained some 7,000 organizations, to assist in the community as well as the state, to take the applications.

We focused on targeted outreach. We wanted to go to

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where seniors and the disabled population were to really identify and assist in filing an application. We have been doing it. This effort will not be diminished. You have name it and we've been there, whether it be senior citizen centers, adult homed, HIV organizations, mental health clinics, hospitals, pharmacies. We've done some 50,000 events. At this alone, we've given out over 1.5 million applications for the targeted outreach.

But you know what? It's finding that person. And we're even refining our targeted effort right now. What we are doing is we're trying a couple of other things—and I'd welcome, again, any ideas you have. We're using our own files now to invite Medicare beneficiaries in for a very specific targeted event. We're going to open some Social Security offices on Saturday to really assist the population in filing.

In addition, we're doing things—and I mentioned the state of New York. Or for example, EPIC [misspelled?], which is the state pharmaceutical program. They just gave us a list of all their pharmaceutical eligible people who they felt might meet our definitions. We screened it, and we are now holding events around the state with EPIC to, again, talk about the Extra Help.

We have something that we're working on with AARP right now. They have a special 800-number where people for the Extra Help will be calling to have a discussion. AARP will do some

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screening and then refer to us. And we will do some further screening, see if we have an application. If we don't, we're actually going to call people to get an application from them. Again, ways of identifying the targeted population that we all need to get to.

We also tried the approach of following up by phone. Okay. We knew that people sometimes don't read letters; they don't pay attention, or if you were like my husband, they filed it in a drawer, and you reminded him, and he thought about it. So we actually did a follow-up with the targeted Medicare beneficiaries that we sent the letter. The follow-up phone calls took place between August 18 and we just finished that this past Saturday.

And what it was, really, is to remind everyone about the Extra Help that they had gotten an application from us to, also, tell them if they wanted help from a Social Security representative, wanted to speak to one, we would make that available. And where we couldn't find a telephone number, we actually did follow-up letters.

For those that said, "I don't remember the application, but I do want one. I don't want to speak to a Social Security representative," we actually did send additional targeted applications out.

In addition, again, message repeat, repeat—we just sent letters to the Medicare Savings Program Eligible. And that was

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something that we do each year. We do about 20 percent of the population. So, we just sent another 4.2 million letters between September and the beginning of October talking about the Extra Help and the Part D benefit.

Our online tools, if you go our website www.socialsecurity.gov you'll see a qualifier, you'll see an Internet application, which was brought up July 1. We're getting more than 1,000 a day. As a matter of fact, right now it's up to about 2,000 a day that are coming in. We have facts sheets that we translated in 14 languages. We have our application in different languages so that people could use it as a model. I don't know how many of you have seen our posters talking about our 1-800 number on our website. They're on some buses. Around this country, we work with the localities to get them up.

And so we really want to be in every community. And it was interesting, I went into my local drug store last night to pick up some things. And boy, was it interesting to get an audio. I felt like I was in my office—talking about the Extra Help, and call Social Security at 1-800. So we have really gotten that message on the ground.

In summary, how can the Medicare beneficiary reach us? How can they file? Well, there's really a number of ways the Internet, the www.socialsecurity.gov, the scanable application, the target that we have out, a telephone. If they call our 1-

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800 number 772-1213, we'll take the application over the phone. If I don't have an operator available, we'll make an appointment and get back to them. Onsite, where Medicare beneficiaries are or this targeted outreach now of inviting Medicare beneficiaries into our offices or a location, and certainly our field offices.

We collectively—and all of us sitting here and all around the country—have a lot of work to do. We have work to reach this very difficult population. We have work to think of different ways of reaching out to them. We're not stopping; we hope you're not stopping. And I look forward to any of your suggestions.

ED HOWARD: Thank you very much Bea. Most of the websites that were mentioned both by Julie and Bea are in the materials that are either in your kits or on our websites. I commend the information that's been collected there to you. There are lots of resources that can help you respond to people who have questions.

Bea mentioned SHIPs. Now, one that has not passed in the night is our next speaker. That's Jack Vogelsong from the Pennsylvania Department of Aging, where he's coordinator of the APPRISE Program, which is a SHIP—that is to say, State Health Insurance and Assistance Program. He's also a member of the SHIP program's National Steering Committee. His program APPRISE is, in fact, the counseling program that uses hundreds

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of volunteers to explain complicated health insurance questions like the Medicare drug benefit to over 2 million Medicare beneficiaries in Pennsylvania. I'm glad you're on the job, Jack. And thanks for coming here.

JACK VOGELSONG: What I'd like to do is to give you some idea of what a SHIP is. Because for the most part, my guess is you're here to try to help your constituents. And if you're not familiar with your state's SHIP program, I think you're missing some excellent opportunities to help your constituents.

As a whole, the SHIP program—I really kind of had a genesis with the AARP Medicare Medical Assistance Program years ago. At least, that's the way it was in Pennsylvania. And then, when they standardized Medigap insurance, CMS at that time, HIPPA funded the states to assist Medicare beneficiaries. There are currently a—is a SHIP program in all 50 states and the three territories, Guam, the Virgin Islands, and Puerto Rico.

One-third of those places, the SHIP program, which stands for the State Health Insurance Information and Assistance Program—in one-third of those cases, the state is elected to house that in their insurance department. And the other two-thirds, the SHIP program, as in Pennsylvania, is housed within its Department of Aging.

Now the crux of what makes the SHIP program work is

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they've—is a volunteer-based program. Across the nation there are over 10,000 trained volunteers to assist Medicare beneficiaries with a wide range of issues, and this Medicare Part D—it just, quite frankly, is a new issue that we've been doing these things in the past for a number of years.

We consider ourselves the information source on Main Street. Our counselors live in those communities, they know the communities, and they know the people that live there. People above the age of 65 and many of the people who are on Medicare because of disability really appreciate knowing somebody local and familiar with them.

We have trained these counselors; they're very well prepared to do that. And let me give you an example of what we went through in Pennsylvania to prepare for the Medicare Part D. And we started this actually about a year and a half ago. Where we analyzed our community, each of those demographics that Julie brought up, we knew the numbers; we knew those numbers in each county. So we knew how this was going to impact people. We knew that there was going to be about 650,000 people that, quite frankly, they needed to get back to their employer, because they had employer coverage.

We also knew we needed to, with such a complex plan needed to sequence this message. And we sequenced that message initially with the Social Security office.

The first message that we knew about, we could explain,

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was the Extra Help. And that is such a critical component of this benefit. It's a benefit that makes this prescription coverage affordable to all people and also expands the coverage to a greater number of people.

So we work with the Social Security office. We oftentimes went together—the local Social Security office and the APPRISE people, and that's true across the nation with all SHIPs. We then began to understand what this Medicare benefit was going to look like. And, quite frankly, it was a difficult challenge because we were trying to explain to the public what the law was. And we really couldn't simplify this until we had a handle on what the benefit looked like and how it will affect them. And for the past month to month and a half, we've been able to explain that to them. Then we could tell them that, no, not everyone has a deductible.

Some of them even have some coverage in that so-called "doughnut hole." The co-pays are different. We begin to provide some reassurance about the Formulary, which was such a controversial issue. We began that.

Now we're very glad to hear that all aspects of the Plan Finder is available, so we can begin helping people to compare, so that they come to November 15, we don't have everybody walking in seeking that very specific information they need. To illustrate this, during the past five months in Pennsylvania, we've—by the end of this week, we would have done

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2,000 town meetings, and we will be coming close to 100,000 people in attendance.

Now our next approach is how do we help people to sort through this, find the plan that's in their best interest, most economical for them, provides them the coverage they need, and get the benefit in a way they find most convenient. We set up a several stage—and this is something we hope your offices will be willing to participate in.

We began very early in June training community partners. And as Julie pointed out, that is critical. We trained over 2,000 community partners in a matter of three weeks of organizations that we knew came in touch with Medicare beneficiaries—people that would be asking them the questions, and we wanted them to get the accurate information.

We then brought those community partners together, and this is the outcome of it. We will be doing several different things. One is what we call enrollment events. These are special large-scale events where people can come, they can talk to their Medicare Advantage plan to find out how this is going to affect them. They will be able to talk to our S-PAPs so that they can coordinate this Medicare Part D benefit with our State's Prescriptions Assistance Program. We will have people there from the medical assistance offices. We will have the insurers that actually issue those policies for HINJ to talk about how they can convert them down in the cost. Those

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events—and then we will have multiple computers.

And this, quite frankly, is our biggest challenge across the United States is how do you get inner access at the— with such a large scale. Those are one approach that we'll be doing. The other approach is that we've solicited—and we expect to have close to 600-700 organizations across Pennsylvania that have agreed to at least one day a week open their doors, provide a staff person, a volunteer, to help people do a comparison.

And quite frankly, in Pennsylvania, one of our leading community partners is our state legislators. They will open up their district offices, their county offices to help people enroll, because it's critical that people have all the information, be able to look at it specifically through them.

And, of course, we have a large number of people that are homebound, that are frail, that are confused. That we will work family members—provide one-on-one counseling; that is a mammoth task. In about nine weeks, we expect a little over a million people to be approaching us. And that's quite a challenge to reach.

So the SHIP program in your district offices can be a tremendous value to you. It is an excellent place to go to coordinate your outreach efforts. You can provide resources through them through your newsletters. You can open up your doors and coordinate your outreach efforts with the local SHIP

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programs. You have tremendous influence in your communities. And one of our biggest challenges, as I stated, was to find places where we could provide Internet access and counseling to the Medicare beneficiaries. Thank you.

Ed Howard: Thanks very much, Jack. Jack mentioned the State Pharmaceutical Assistance Programs, S-PAPs, as people on the inside call them, I guess, along with SHIPs, the State Health Insurance Programs, and state-by-state lists of both of those organizations—and there isn't a Pharmaceutical Assistance Program in every state, but the ones that are there are here—are on the handout in your kits that is this shocking pink here. I commend it to you to try to get the kind of contact information that will help you follow up on what Jack and some of the others have said.

Now we're going to get to your questions. We have about 45 minutes or so. I would urge you to keep your questions short, direct them if you need to, to one or another of the panel members, identify yourself. We have microphones in the back of the room. You can put a question on one of the green cards and hold it up, and our staff will pluck it from your fingers. And let's start with a question from a real live person.

JOEL SEGAL: Thank you. I'm Joel Segal [misspelled?] with Congressman John Conyer's office. The first question I have is for Julie. What is the official cost of the

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prescription drug plan for annually, And then over a 10-year period—because there's been different quotes on that. And the second question I have is for the gentleman from Pennsylvania, and that is, what happens to seniors with chronic illnesses who spend \$2,250 in drug costs and they have to somehow find \$2,850 out-of-pocket costs? Will these seniors suffer health consequences as a result of the "doughnut hole"? So those are the two questions. Thanks.

ED HOWARD: Julie?

JULIE GOON: Sure. With respect to the cost estimates for the benefit, I'm actually going to refer your question to the Office of Legislation at CMS and have them get back to you because, as you mentioned, there have been different estimates. It depends on the years you use. There's one estimate when the bill was first—the law was first passed. There's been subsequent estimates. And I think the most recent ones probably came out of the mid-session review this summer, and they can get back to you with that.

JOEL SEGAL: So, the Office of C— [interposing]

JULIE GOON: Office of Legislation at CMS.

JOEL SEGAL: Do you have that number by chance?

JULIE GOON: 690-5960.

JOEL SEGAL: Thanks. Then my second question?

JULIE GOON: And Linda Fishman is in the back of the room [interposing]—

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JOEL SEGAL: Good.

JULIE GOON: -and can wave her hand.

JOEL GOON: Thanks.

JULIE GOON: Sorry, Linda. [Interposing] [Laughing]

JACK VOGELSONG: My answer to the second question. You know, certainly the Medicare Part D prescription is going to be an excellent package for the vast majority of Medicare beneficiaries. But, indeed, in its design, there was a period of non-coverage. Now that period of non-coverage can, in some plans, there is continuous coverage, such as for generic drugs.

Secondly, it's critical to understand about the Extra Help programs that would eliminate that, eliminate the "doughnut holes," and that's available for low-income. The following thing, and specifically in Pennsylvania, is we do have our State Prescriptions Assistance program, which we call PACE, PACENET, which will wrap around—if we can come to some level of agreement on it—would wrap around and provide the coverage where the Medicare Part D doesn't.

So the key question is if you have a person with chronic illnesses with excessive coverage, shop and compare the plans, because there is not necessarily a major "doughnut hole" for the whole plan. There's a number of choices to make. Look at alternatives, such as the Extra Help, that there is continuous coverage. Look at the State Prescriptions Assistance Programs to fill those gaps if they don't qualify

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for the Extra Help.

So we're making a step forward, but it's still--there is a particular circumstance where a person could have \$2,500 or \$2,800 out-of-pocket cost before they reach that catastrophic experience. And not all cases will we be able to fill that hole with either a state benefit or the Extra Help.

JOEL SEGAL: Thank you.

BURT SHORE: Burt Shore [misspelled?] from the newsletter, *Home Healthline*. Mr. Vogelsong, as you know, in Pennsylvania there is extensive use of a provision of this drug plan. It hasn't gotten much attention. Passive enrollment in Medicare Advantage plans for Medicaid beneficiaries that are coming out of Medicaid plans. Even though a very large majority of those beneficiaries actually are in Medicare fee-for-service because they have that option as dual beneficiaries--do you think this is a good idea?

JACK VOGELSONG: Well, the answer to that is yes and no, and it depends on the circumstances. It got my attention because all 115,000 of those people have my telephone number. [Laughter] So, indeed, it got my attention. What you're talking about is CMS has proposed where we have what we call "special needs plans" for the dual eligibles, the opportunity to have, kind of, a one coverage versus Medicaid/Medicare, but it was to wrap that benefit around. Now there are plusses and minuses to that whole issue. One of the plusses that people

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don't want to—have not been taken into consideration, there are certain Medicaid covered services that under the Medicaid fee-for-service system has caused problems, such as dental, certain eye care. Prior to us going to Health Choices in Pennsylvania, people had a hard time finding a dentist that would accept Medicaid.

Health Choices, which was our Medicaid program—they have the network and provided that. What people do have the option to do—this is purely, although they're passively enrolled if they do not act, they do have the option at any time to opt out of that, go to the original fee-for-service Medicare plan, and then the fee-for-service Medicaid program would be their secondary payer.

What we're having problems in terms of saying whether this is good or bad, these programs—these managed care plans are relatively new, and they have not fully developed their network as of yet. I know they're aggressively trying to get that. So I think it's going to be one, an individual circumstance in terms of the provider network, which is, of course, critical to people, but they do have the option to get out of that.

There is a 90-day transitional period from January 1 through the end of March to use their continuing, so that there is not a sense of urgency in that whole issue. But we have yet to see how this evolves, so I can't say whether I think it's

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good or bad, yet.

BURT SHORE: Thank you very much.

DIANE ROWLAND, SC.D.: We have a question here. The plans appear to be tied to residency in a specific state. What does one do who lives part-time in each of two or three states?

JULIE GOON: Well, there actually are, I think, 10 or 11 national plans. And on the Plan Finder website, if you click on important notes for any plan, it will tell you whether there is coverage available in other states or not. So many of the plans are providing coverage across the states, even if they are regional and only providing actual coverage in a certain state. There are many plans that are looking at providing coverage beyond the borders of that state.

DIANE ROWLAND, SC.D.: Okay. One more question. Is CMS or HHS keeping a website section that tracks scams and other marketing ploys that might confuse or mislead beneficiaries? If so, where is this information located?

JULIE GOON: CMS has put out information concerning the very important need to keep track of scams and frauds and anything like that that you're seeing. I don't have the website location at hand, but I can get it to you. But I know we're very interested in seeing what you guys are seeing with respect to this because we're very concerned about beneficiaries not being pushed into something that they shouldn't be pushed into or being scammed by people who aren't

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really Medicare approved drug plans. But I will bring—I'll get that information back to Ed, and he can put it on the website.

BEATRICE DISMAN: Yeah, I just wanted to comment because we're working very closely with HHS and CMS because new information comes into the Social Security. So, actually, I was at a meeting where both Inspector Generals of HHS and SSA are together. We're both focused to make sure that we identify where they are, and that we deal with them accordingly. So you have the commitment from all of us.

ED HOWARD: Yes, go ahead.

ISABELLE VIORCLAIN: I have—I'm Isabelle Viorclain [misspelled?] with the Committee on Ways and Means Democratic Staff. A couple of questions, and I think they are largely for Julie. I think they will be fast questions, although potentially there's something for Jack.

One is, we've been—in the absence of having accurate information available on Plan Finder yet—we've had a difficult time trying to get across that section of what plans are out there. Can you tell us what the—what percent of plans are offering the standard benefit?

JULIE GOON: All of—I believe that all of the plans are required to offer a standard benefit or the actuarial equivalent to that. In addition, they can offer other choices that are enhanced.

ISABELLE VIORCLAIN: Right. Now I understand that.

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What I'm wondering, at some point one other CMS official had been quoted in one of the trade press, but we've been unable to track this down, that 12 percent were offering these standards. Because, as you just pointed out, there's actuary equivalence in having—so we're just trying to get a sense of how many are out there with the standard as described in the statute.

JULIE GOON: I'll get back to you, Isabelle.

ISABELLE VIORCLAIN: Okay. [Interposing]

JULIE GOON: And I had never heard the 12 percent. So—
[interposing]

ISABELLE VIORCLAIN: Well, we weren't sure either where it came from. Uh, the second thing is whether there's been a calculation done at CMS alternatively by the SHIPs about the amount of time it's expected to take in one-in-one counseling to help somebody find a plan. I mean, I think I recall with the discount card it was eventually at some point SHIPs or somebody determined it was, I think, an hour and 15 minutes; and this seems to be much, much more complicated.

JULIE GOON: Well, I think the hour and 15 minutes was probably at the beginning of the drug discount card program. And I think that time probably minimized as time went on. The system is designed to let people move through it at a fairly rapid pace, particularly if they've been through training, you know, as a SHIP or as another counselor. Or, if you're calling 1-800-MEDICARE and working through the program with the

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[interposing] customer service representative, it's designed so that they can move through it fairly quickly, and particularly if a beneficiary calls with all the information at hand.

[Interposing]

ISABELLE VIORCLAIN: Right, but do you guys have a determined time, yet—I tried to do it without even using medication information yet, and I think I'm decently well-suited to this task, and it's been impossible so far and taking quite a long time to determine it was impossible, because of the snag is in the system, not even getting to the medication level information. And I think some of those things are being fixed today. We're supposed to see it this afternoon.

But I think it's a considerable amount of time, and for those of us who are spending a lot of energy directing people to SHIPs and unbiased sources of information versus the agents, many of whom have exclusive contracts that aren't apparent when you walk in the door. We're worried about the SHIPs being able to handle the volume of people, no matter how many volunteers they have. If they were open 24/7, they may not have the time to get people informed. [Interposing]

JULIE GOON: I think the only thing I can say is it depends on if you come in with the information that you need, and if you come in having a pretty good sense of what your current coverage is, what kinds of things are important to you, whether it's financial, whether it's coverage, whether it's a

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particular premium or not. If you are a decisive person that knows all of that and comes in with that kind of information at hand, you can probably run through it fairly quickly. And if you're not, it's probably going to take longer. And I think as the SHIPs and as the customer service representatives in other—as others get more used to working with the website, I think those times will, again, be fairly minimized. I'm probably an anomaly, because I never owned a computer until two weeks ago at home. [Laughs] So, in my family, my 70-year old father is much more adept at Internet searching than I am. And I've been working with him on it just to see how useful it is and how some of the changes that we've made are. And it's working for him. Now again, he's probably a special case as well. But I think it's designed to move through fairly quickly, and we'll be evaluating how fast those times go and what we can do to make those times move quicker if they're not going along fast enough.

DIANE ROWLAND, SC.D.: Julie, speaking of the Internet. We have a question here. What steps are CMS taking to safeguard the personal information of Medicare beneficiaries who use the drug Plan Finder tools on the Medicare website? And how can beneficiaries be sure that their Medicare number, their Social Security number will be protected from Internet hackers?

JULIE GOON: Well, it is being protected, but I can't

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technically describe [laughs] how it's being protected. If you go through and do a Web search, after you're done with that and log off, that information is not saved. And that has good points and bad points because if you want to go back and do another search, you have to start all over again and re-enter all your information as well as all your drug information. But the information that people are putting in there is being protected.

DIANE ROWLAND, SC.D.: Okay. And for Social Security, how many of the low-income subsidy applications have been approved? And if people are approved for the subsidy don't enroll in a plan by May 15, what will happen to them?

BEATRICE DISMAN: We are in the middle of processing applications right now, as a matter of fact. Individuals are receiving decisions, so that we're really working through all of our applications, you know, as we had indicated over three million applicants have filed with us. So people should be receiving their individual decisions. We will have data shortly as to how many have been approved and how many have been denied.

Also, as of May 15, I have to turn that to CMS, because people will stay on our records as eligible for a subsidy. And we have actually worked that through with CMS as to what happens.

JULIE GOON: And, as to what happens, is we get close

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to May 15, and people who have been approved for a low-income subsidy have not yet enrolled in a plan. We will be working through a passive enrollment system with those folks at that point in time.

ED HOWARD: Yes.

SHEILA DAVIS: Hi, I'm Sheila Davis with the National Medical Association. And my question is for Beatrice Disman. I'm curious about the details of your targeted outreach approach. Can you say something about the 50,000 events with the town hall meetings? Did you go to public housing communities in the Bronx? Was it just sort of hit-and-run thing, or did you go back and—you could say more about all of that?

BEATRICE DISMAN: Certainly. Knowing that I'm the regional commissioner from New York, you know we were back and forth in the Bronx a number of times. But, let me just say, it really was where individuals with disabilities and seniors are. Initially, we started town hall meetings, you know, to educate the community and to educate third parties. But we actually worked with senior citizen centers, adult homes, HUD housing, different aspects in the community. We actually worked with them to help us screen the population, because actually directors of HUD housing know what the population is like. And they actually set up appointments for us.

So we have gone back. We are making rounds again

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because as you have the enrollment piece for the prescription drug plans, we need to go back to a lot of the same places we have been. But if you look at it, we have actually been at the locations, town meetings for informational purposes, but we need to be where they are to take the application, and that is the approach that we have throughout the entire country now.

If you want to talk to me later about, maybe, what we did in the Bronx, we can talk about it.

SHEILA DAVIS: Okay.

DIANE ROWLAND, SC.D.: We have two questions here related to the way pharmaceutical companies are running their Patient Assistance Programs as the new Part D program comes in and concerned that in some areas the Pharmacy Assistance Programs from the pharmaceutical industries are being shut off, and what's being done to help those people through the transition?

JULIE GOON: I think the office of the Inspector General is releasing information about Pharmaceutical Assistance Programs today. It is my understanding that those programs can continue to exist outside of Medicare. And so, depending on the rules that the individual Prescription Assistance Program that a pharmaceutical company has, or are operating under, they can continue to exist and provide for assistance outside the Part D benefit.

If they want to provide assistance that qualifies for

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TROOP [misspelled?] there are certain concerns that the Office of Inspector General has about fraud and abuse and perceived kickbacks that they will have to be working through with the Office of Inspector General.

The Office of Inspector General is also moving ahead, I think, to provide some guidance on where coalition or collaborative type of activities can exist between pharmaceutical companies who want to continue jointly, offering such programs as well. Pharmaceutical companies can provide assistance and funding to legitimate charitable organizations who are providing this kind of assistance as well.

MARK STIEN: Thank you. I'm Mark Stein with Families U.S.A. One of my questions was already asked, but I have a follow-up. I think this is mostly for Bea, although if anyone else has information, that's great too. How long is it taking Social Security to process an application, and what should a beneficiary expect—when should he or she expect to get a response?

BEATRICE DISMAN: The answer really is it depends. As you know, with the application, it depends on how complete the application is when it is filled out. It depends whether or not we need to verify certain information with the beneficiary, as a result of what they were attesting to. And so, it also depends upon what advocates are now telling people in the community, because we've seen it and we've said we will take an

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application in whatever condition it is. So we are really calling people to really complete the application. So it really is dependent. And if it comes on the Internet, it's a complete application that you send in to us. So it really is dependent upon what is the information that we are receiving.

ED HOWARD: I just want to point out to you that the folks who are bringing the green cards up have been making a lot of trips up here. We're not going to be able to get to all these questions. All of our panelists have agreed to try to respond to those questions that we don't get to that are within their area of expertise or responsibility. So if you've written a question that doesn't get answered or even addressed in this time, look for the kaisernetwork.org and the allhealth.org website; and we'll try to get as many of these answers posted in a timely fashion as we can.

Also, if you really want to get your question answered now and satisfactorily, I urge you to go to the microphones, if you're within the room. That's the only absolutely certain way to get it done. And there is someone who has done that.

PETER RICKLETTLEMAN: Yeah. Hi, I'm Peter Ricklettlemman [misspelled?], health economist from Silver Springs. I think Tricia Neuman said it to be in her talk, the choice of what-where you're going to go depends on where you are. And if you, particularly if you have an existing retiree Medigap plan that provides drug coverage, there have been a

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number of stories in the paper recently about if you drop your plan, you won't be able to get back to that plan. I understand there's a penalty if you do not sign up when the program is first available to you, and the penalty increases the longer you stay out of the program. But, and this is where I'd like some clarification, I understand if your current plan is as good as the Medicare plan that you're being offered, that there will be no penalty if you choose to switch later on. The important question is for the benies [misspelled?], how do they know that their plan is as good as a Medicare plan that they might be offered? Where do they get that information? Or, is there an existing plan? Or, is the Medicare plan supposed to tell them that they could stay where they are without having any penalty?

ED HOWARD: Tricia?

TRICIA NEUMAN, SC.D: Letters are going out. Employers have been looking at what strategy their going to take for 2006. And those who have decided to apply for the subsidy that's available to them now know that whether or not they're going to take that approach, and they are sending out letters this month to their retirees. So some of the newspaper articles you've seen are the result of these letters that have gone out telling their retirees, one way or the other, whether or not their plan meets the test of being at least the same as the Medicare plan. If a retiree stays in that plan, you're

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right, they would not face a penalty for late enrollment if they, subsequently, change their mind. There is an issue that doesn't often get attention about the decision for retirees. Well generally employer plans are more generous than the Medicare benefit. There is an issue for low-income people who can't take the low income subsidy to their employer plan. So for that group of people, there's kind of an issue about whether or not they should shift to a Part D plan with a low-income subsidy or go with the employer plan. But, as a general rule, employer plans seem to be a more generous option for people.

JULIE GOON: Let me just answer that by saying, as Tricia said, those letters are going out right now from employers as employers who qualify for the subsidy are also sending CMS the names of their retirees. That is also being loaded into the websites, so if somebody goes through the Plan Finder either with a customer service representative or on their own with their Medicare identification number that—it will indicate that they have been claimed by an employer and are already receiving, or could already be receiving, coverage through their retiree plan. And if they choose to join a Part D plan would, subsequently, potentially lose the rest of their employer coverage. So there are a number of belts and suspenders to try to make sure people are aware of what's going on with respect to retiree coverage.

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PETER RICKLETTLEMAN: Is there a deadline for those employer plans to put up or shut up—[interposing]

JULIE GOON: I think the deadline for application for the retiree subsidy was October 31 but the data and information is still coming in. In terms of all the information that—

PETER RICKLETTLEMAN: Okay. I just—

JULIE GOON: —being uploaded. [Interposing]

PETER RICKLETTLEMAN: I don't know anyone that has asked me that has gotten anything from their employer or former employer saying, "Yes, you're covered or no, you're not."

JULIE GOON: That wasn't the deadline for the letters to go out I apologize that was the deadline for employers to apply for the Retiree Drug Subsidy. And then, as they're approved for that, those letters will go out, subsequently.

PETER RICKLETTLEMAN: Okay. So they should go out before—

JULIE GOON: Yes.

TRICIA NEUMAN, SC. D.: I think the deadline for the letters is the end of November.

MALE SPEAKER: Okay.

ED HOWARD: Well, could I just follow-up? Because this is something that I don't think has gotten a lot of attention, Julie, I—did I understand correctly that what you were saying is if someone who is eligible for one of these employer programs and decides to go into a Part D program, not because

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they're low income, but because they think it's more attractive and they don't like it, they may not ever be able to get back into the employer program.

JULIE GOON: That is dependent on the employer's rules with respect to that, yes. But the gentleman was also correct that if that coverage is considered equivalent, they will not face a penalty a couple of years from now if they, subsequently, decide to join a Part D plan.

DIANE ROWLAND, SC.D.: Some really quick questions. First of all Julie does the Plan Finder offer county level plan options?

JULIE GOON: County level plan options for Medicare Advantage Plan, yes. All of the prescription drug plans—the stand alone prescription drug plans are regional or statewide in nature, so that information doesn't go down to the county level. It's just all the way across the state.

DIANE ROWLAND, SC.D.: And for B, like the Social Security notifications for new Part B eligibles, will Social Security notify future Part D eligibles about initial enrollment periods?

BEATRICE DISMAN: Let me take that question two ways. One is for people that are attaining age 65 or have 24 months of disability and are Medicare eligible. We will be telling that population—CMS will be sending the normal package about the Medicare program at age 65, and we will be sending—doing

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the screening after we get it from them, identifying the population that might be subsidy eligible or eligible for the Extra Help; and we are going to be sending the target applications out. So we actually will be doing the target applications on a monthly basis as people come in for the attaining.

On the new filers, when you file with us or you've never filed before, you are now filing for Medicare. What we will be doing is discussing with you on the phone whether or not you might be eligible for the Extra Help; or if you go into our field office, or there's also a question on the Internet. So we're treating the populations differently, because we don't know who the new filers will be. Yet, we do know people who will be attaining age 65 and are already getting Social Security, and we know the packages are going out.

DIANE ROWLAND, SC.D.: And for Jack the state of Pennsylvania has a very generous State Pharmacy Assistance Program to help low-income people with drug costs. What will happen to this program after the Medicare drug benefit takes effect? Will it wrap around the drug benefit?

JACK VOGELSONG: Well we haven't made a final determination there. Two things that--what we want to stress to the participants in the PACE or PACENET that they will not be--they will not lose any of their PACE benefits, and they will not be worse off than what they currently have with PACENET.

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All the options that the PACE or PACENET program is looking at, that we would work with the Medicare Part D program, would work financially to their advantage. We also, of course, want to look the financial advantage to the PACE/PACENET program. But at this particular time I don't think a final decision has been made on exactly how this benefit is going to work with PACE. So what we're telling people is keep your PACE/PACENET benefits, and that's—they're not going away. And your costs will not go up at all.

ED HOWARD: Okay. Let's take a question from the microphone. Before you do that, I just want to say some folks are having to leave before we finish this program. I just want to remind all of you ought to take a moment to fill out the evaluation form that was in your information kits and that information—that form rather is also in the kits that were mailed to the congressional state and district offices. And I'll have a further word about that later. Yes, go ahead. You've been very patient.

JOHN RISENWEBBER: Thank you. John Risenwebber [misspelled?] of Congresswoman Capita's office out in West Virginia, and I'm also on the board of directors of the local senior's center out there. I want to first thank all of you all for your hard work. We're hoping this program's really going to help out folks from West Virginia.

Secondly I'd like to invite your bus out to our senior

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center in West Virginia. We'd love to have you out there, also, if we can get on your schedule. Someone had asked about the national plans for folks that maybe live in one state get their prescriptions across the state line. That's a common problem out in West Virginia. Will a mail-order option mitigate that, or do you still recommend the national plan?

JULIE GOON: I think a mail-order option certainly could mitigate that. I think you're just going to want to look at the—each specific plan and maybe talk to a customer—service representative of that plan before making a final decision. But the easiest way to think about it is the national plans that are available as well.

JOHN RISENWEBBER: Okay. And then another quick question. If a doctor changes a prescription for a Senior, particularly, maybe one of their more expensive heart medications or something like that, are they able to switch programs outside of the normal open enrollment period?

JULIE GOON: I don't think so. No.

JOHN RISENWEBBER: All right. Thank you.

JACK VOGELSONG: There are some cases when a person can switch. If an individual is under Medicaid, they have the right on a monthly basis to change. Individuals currently residing in a nursing home also have the right to change on a monthly basis. Other than that, between January 1 and May 15 Tricia, I think they can also change one time as well.

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JOHN RISENWEBBER: What if the new drug that they've been prescribing is not on the formulary of the original plan that they signed up for? I guess that's my—gets to the meat of my question.

JULIE GOON: Well and I think that's why we're as much help to doctors as we can so that they know what the formularies of the plans that their patients are enrolled in cover. But the plan itself has to provide access to all medically necessary treatments. They can appeal a formulary decision. They can appeal a tearing decision. There are going to be ways where they can get that drug. And as I mentioned earlier, many plans have negotiated prices even for the drugs that are off their formulary. So it's not necessarily true that you'd be paying an enormous huge amount for drug off formulary as you would for an on formulary drug. You just have to look at it on a case-by-case basis.

DIANE ROWLAND, SC.D.: That goes to a question that's here. If one of your drugs is not on the drug list and it costs \$100, does that \$100 count toward the \$3,600 out-of-pocket costs before a "catastrophic" kicks in?

JULIE GOON: No it does not. So you better appeal it.

MARSHA MARSHALL: My name is Marsha Marshall I'm a health care consultant, and I'm a former CMS insurance regulator and on Medigap. One point of information is that employer plans have never been required to take people back if

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they decide to leave. So historically even before this Part D coverage, if you decided to try managed care plan and it meant leaving your employer plan, in order to do that, you were always cautioned that it was purely at the discretion of your employer to get that coverage back. The problem today is that employers are telling people, if they sign up for Part D they lose their coverage and their spouses lose their coverage. And it creates much more pressure for people to make a decision.

That however was not my question. My question is, and I put it in a green card, but I decided to ask it in person. There was a huge amount of instability in the early part of the Medicare Managed Care plan Medicare Plus Choice. What is CMS doing to keep some kind of stability in the Part D provider plan? And by that, I mean Medicare Plus Choice was an annual contract. If companies found they didn't get enough enrollees in a particular area and it wasn't in their interest to continue to do business in that county or that city or whatever that particular area was, they would drop out and leave people to select another plan. Are we going to see rounds of this a year from now, simply because there are so many choices that people are going to be spread much too thinly for companies to make it worth while to do business in any particular area?

JULIE GOON: Well I don't know that it's the role of CMS to make sure that everybody that decided to get into this business this year gets to stay in it forever. And I think

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that there is--this being a new business, there is some expectation that there will be some change, over the next year or two, as plans determine whether this is a business that they can really make a go of or not. I think one of the things that will help with respect to that is the payment methodology or the method of paying for Part D plans is completely different than the Medicare Plus Choice payment methodology, which was based on what fee-for-service costs in a county were and was it an administered pricing system.

The Part D plans are essentially paid what they're bid what their bid is for providing this benefit. So they're the ones who are determining what it's going to cost them to provide this benefit, what kind of cost they think will make this attractive to people they're selling the benefit to, and then that, as you know, the government pays a certain percentage of that; and the rest is made up for by the beneficiary. So if they're not a competitive plan they may-- there may, in fact, be decisions made by plans that this is not a business they want to be in long-term.

ED HOWARD: Yes. Tricia, you want to add to that?

TRICIA NEUMAN, SC.D.: Yeah I think it's really too soon to tell what plans are going to do a year from now or three years from now, and that might be an important thing for you to tell your constituents, your boss's constituents, because these are plans who will make a decision annually about

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whether or not they want to continue to offer the drug benefit or be a Medicare Advantage plan. So people need to think about the decision about what to do, perhaps annually, and not make a decision this year thinking, okay, they're done for the rest of their life because they're in a drug plan. I think it'll take some time before we see how much stability there really is.

DIANE ROWLAND, SC.D.: This is a very practical question. If a family member is receiving long-term care in a nursing home is the nursing home responsible for the paper work required to transition to Medicare Part D or is she or our family responsible?

JULIE GOON: Generally you and your family are responsible for that paper work, yes. [Laughs]

ED HOWARD: Wow. Yes, Allen.

ALLEN GLASS: Allen Glass Senator Vine's office. Two questions. One about the information and one about the appeals. On information, are there plans to use any testers to call in to Medicare 800 number or the SHIPs to see how accurate the information is that's being provided? And the question on appeals, it seems to me I recall that CMS was moving away from using the SSA administrative law judges and was going to this four-site appeals process by teleconference. Is that now all set up for purposes of people that want to appeal their Part D drug decisions?

JULIE GOON: I actually don't know the answer to your

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second question. And I will have to find that out I don't know if anybody else on the panel knows that administrative law judge question. Okay. All right. And your first question was again I'm sorry? Oh testers yeah. Those—yes, definitely, we have got testers constantly operating with both 1-800-MEDICARE and doing mystery shopping, and we also actually did a fair number of this going on from congressional offices, which I think is terrific. And just one suggestion I would make is that if you run into a problem, or your constituent runs into a problem, that you want to forward on to us it's very helpful to know what phone number that person was calling from and what state they were in because we can track down what customer service representative was giving what information in order to try and correct that. So it's much easier—the more specific information you can get about where and when a call was placed and from what number, the easier it is for us to address the concerns that come up as a result of that.

ED HOWARD: Good suggestion. Yes.

JOANN VOLK: Hi I'm Joann Volk with the AFLCIO, and I want to go back to the employer sponsored coverage to clarify one point and to ask a question. The notices of credible coverage that you were all talking about as the mail-in that comes from the employers. They have to do that by November 15. But that only speaks to what the one-pager in the packet described as the gross value of the benefit. It does not

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Speak to who is actually paying for the coverage. So it only tells the retiree if they would be subject to the late enrollment penalty if they waited past the 15 of May to enroll.

So it doesn't tell you if, based on how much you pay out of pocket and how much the employer is subsidizing, if you'd be better off in Medicare or in a Part D plan. For example, employers could offer what we would call an access-only plan whereby—sort of like COBRA—here's a plan, but you pay the entire premium yourself that is credible. But that does not necessarily tell the retiree they're better off staying there than going into a Part D plan. And my understanding is employers don't have to do a mailing on that specific piece. It's recommended, but not required.

And then secondly, a question really. It refers to this problem of retirees showing up in two different places, Julie, that you talked about in the web-based tools. Employers submit their name and someone they're going to collect a subsidy for. The retiree doesn't know those options are there really and whatever, gets confused with the marketing, and also enrolls in the PDP. My understanding is if you don't use the web-based tool that CMS recognizes they show up in two places. They tell the employer someone signed up and they tell the plan someone could be with an employer. And in both cases, they recommend those parties tell the

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beneficiary. But I don't—haven't heard yet that the beneficiary is told directly. It relies on the employer and the plan saying this is the deal. You can't be in both places at once. And it may allow for some funkiness if it's like a high-risk retiree; for example, maybe the employer won't contact them and say, "No, actually, you can stay with us." And so I'm just wondering if my understanding of how that works in the dupes cases is right and what could be done to help the benies really understand what their options are?

JULIE GOON: Well I think there is a lot more going on with respect to the employer retiree coverage than there is with—for example, I know some of the Medicare Advantage plans have been concerned that somebody might mistakenly sign up for Part D plan and disenroll themselves from Medicare Advantage. And we are not doing the same kind of thing with that as we are doing with the retiree coverage, which is trying to through belts and suspenders, get as much information to those beneficiaries as possible, both from the plan from the employer, so that they're aware of what their situation is. Is there going to be nobody fall through the cracks? I'm not sure I could answer your question that way, but we're trying to do everything we can to make sure that that person is making an informed decision with all the facts at hand.

JOANN VOLK: I appreciate it. I guess we just do a

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plug that since we've also heard about the high stakes implications in making the wrong choice, signing up for PDP when you had an employer option you may not be able to go back to and [interposing]. I guess we're to urge that everything be available to the retiree to help them make that [interposing] decision if possible.

JULIE GOON: And we're trying to make sure that all that information is available to them.

DIANE ROWLAND, SC.D.: This question is will the beneficiaries be sent the equivalent of the Medicare summary notice like Parts A and B to document their receipt of prescription drugs and to help them track their milestones?

JULIE GOON: The answer to that is yes.

DIANE ROWLAND, SC.D.: A question for Pennsylvania. How do you think SHIPs will be using local volunteers to help beneficiaries understand Part D? I think you might have some volunteers ready to sign up out there.

JACK VOGELSONG: Well actually we—we have a number of skills that we need. We spent a lot of time last spring training volunteers to go out and do public speaking. That was an absolute critical. We knew we wouldn't be able to reach everybody on a one-to-one. We knew if we provided them some basic information, they could take that information and use it. Right now we are desperately in need of people with computer skills. People that feel comfortable going on the

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Internet, have a speed to enter the data quickly, but we also are looking for volunteers for one-event kinds of things.

For example, if you come to one of our group events, you will be greeted at the door, and you will be essentially asked were we helpful when you leave, so that we can rectify it. So we're going to many businesses who are donating some of their employees' times that they just to do those kinds of things. We also have what we call walkers, people that walk around the group, to make sure that if somebody's lost or confused, that we can focus them in the right direction. So, essentially, we're looking for all kinds of people to assist us. But right now, we really need people that feel very comfortable with a keyboard and the Internet.

JULIE GOON: Well can I just add to what Jack said? You know in my remarks I focused a lot on the hardware of the tools and resources that CMS is making available. And I didn't focus enough on the soft resources or the human resources that are so important to beneficiaries as they make these decisions. And I think we have spent SSA, as Bea talked about, 50,000 events over the summer. All of the mobile office tour events that we did was really--were really focused on building up local networks of community-based organizations that were willing and able to help beneficiaries make these decisions.

The work we've done with the SHIPs who have been completely invaluable partners in this. I think it's been

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incredible. All the area Agencies on Aging we have 12,000 different groups who are committed to being partners to CMS citizen enrollment process across the country. The AARP has been terrific. A lot of the organizations who are located here in town have really utilized their stay and Grass Roots Networks to help us.

And what we are really hoping to do is as we get into enrollment, Jack mentioned the demographics in Pennsylvania, and how they've broken down by county who is low-income subsidy eligible who are retirees, who are Medicare Advantage beneficiaries. We've been trying to do that across the board for every county in the country, so that when enrollment information starts coming in, we'll be able to look, match up that demographic information with enrollment information. And in addition, match that up to the partners and the counselors we know we have in those counties, match that up to the events that we've done, and match that up to the plans that are available in those areas.

So if we see problems in enrollment, hopefully we'll be able to identify them quickly and direct additional resources, whether personal resources or event or media resources or plan marketing resources at those areas to make sure that everybody gets the information they need to make these decisions.

ED HOWARD: Thank you, Julie. Diane, you have final words?

DIANE ROWLAND, SC.D: Well, I think this was the

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beginning of getting more and more information out. I hope you found it informative. I certainly did. And I want to thank all our panelists, along with Ed, for contributing to furthering the understanding about a very important benefit for some of our very needy, elderly, and people with disabilities who depend on Medicare for their health benefits. And now they'll have a drug benefit as well.

ED HOWARD: Thank you. And before you leave, I urge you to fill out the blue evaluation form. Those of you in congressional offices, I would urge you to fill out that form and fax it to us at the number on the form or online where the materials are listed at the allhealth.org website—you'll find an online evaluation form if you find that more convenient and if you have computer skills.

Thank you all for coming. And I ask you to join me in thanking our panelists for an incredible tour-de-force [misspelled?].

[Applause]

[END RECORDING]