Medicare Part D:
What Now, What Next?
Alliance for Health Reform and Commonwealth Fund
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ED HOWARD, J.D.: Good day, I'm Ed Howard with the Alliance For Health Reform. I want to welcome you on behalf of our Congressional leadership, Senator Rockerfeller and Senator Collins, and the rest of our Board of Directors, to a briefing on how the Medicare prescription drug benefits work are partnered today as the Commonwealth Fund, a New York based foundation with a long standing interest in the problems of older people particularly those with moderate and low incomes. Stu Guterman from the Fund will be speaking to you in a moment.

The Part D benefit is now preparing for its third year of operation. Beneficiaries in the midst of the open season are having to choose a plan, and they can change plans if they choose to during that season. This benefit was, I guess you could say, born in controversy, but we're not here to replay the debates of 2003 – we have almost 40 million beneficiaries with drug coverage, most of it as a result of Part D or being supported by Part D. And we want to explore today how well this program's working for those who are now dependent on it, and how it might be improved.

As those of you who've been to these briefings before now, by Monday you can view a Web cast of this session on KaiserNetwork.org. I'm very grateful to the folks at Kaiser Family Foundation for arranging that. In a few days you'll also be able to see a transcript, copies of materials that you

have in your packets will be available both at kaisernetwork.org and at allhealth.org, our web site.

I want to make the pitch, if I can, for you to at the appropriate time fill out these green question cards and grill our panelists on the topics that we're talking about, and the evaluation form, the blue evaluation form in your packets on the right-hand side. I would appreciate if you would fill out those forms to help us improve these sessions for you.

We have a really distinguished line-up of speakers today. Before we get to them, I want to acknowledge the fact that not everybody who has something important to say about Part D is sitting on the dais. There are a lot of stakeholders, including pharmacists, drug companies, health plans, others who have legitimate concerns about different aspects of this program. And when our presentations are completed, and I've looked over the list of those who have registered for this event and I know you're out there, I particularly want to invite those of you associated with some of those stakeholders to join the conversation with your comments and questions.

With that very brief introduction, I'd like to ask you to turn your cell phones either off or to vibrate, and then let's get started. And the way we're going to get started is to turn to Stu Guterman, I mentioned that the Commonwealth Fund is a co-sponsor and representing the Fund today and serving as

our lead off speaker is Stu Guterman, the Senior Program Director of the Fund for its program on the Medicare future.

Stu's got a great deal of experience and expertise in Medicare having directed the CMS Office of Research, Development and Information. He also served as a senior staff member at CBO and at Medicare payment advisory commission. He's going to give us some of the basics about the experience under Part D based on a beneficiary survey that he and Tricia Newman and others described in a Health Affairs article published recently that’s in your materials. Stu thanks for being with us.

STUART GUTERMAN: Okay, on behalf of the Commonwealth Fund welcome, and I'd like to start out by certainly as Ed said recognizing the fact that what I'm presenting here was based on an article that come out in Health Affairs in August on the Web–

ED HOWARD, J.D.: Can you hear?

AUDIENCE: No.

ED HOWARD, J.D.: Stu in the back? If you can try getting closer or even moving down a microphone.

STUART GUTERMAN: Okay, can you hear me now? Okay, thank you. I'll just do this then. The article came out in August as a Health Affairs Web exclusive and the – I'd like to thank my co-authors on this, Tricia Newman who was the lead author, Michelle Kitchman-Strollo [misspelled?] and Dana

Saffron [misspelled?] and her team at Tufts New England Medical Center who all collaborated on these findings. In fact, the article frequently is referred to as Newman et al, so I'd like to introduce myself as al in this. [Laughter]

We did this survey in 2006 to look at the experience of seniors under the Medicare drug benefit; it was a mail survey that was conducted in the fall of '06, near the end of the first year of the drug benefit. It included about 16,000 non-institutionalized Medicare beneficiaries aged 65 and older. I'll just let you read through this at your leisure, I want to get into the findings here.

Basically what we were interested in was, as I said, to describe the experience of Medicare beneficiaries under the drug benefit. And I'd like to highlight a few findings. The first thing we noticed was that we had asked whether they had drug coverage in 2005, the year before the survey, and we found that 33 percent of the people who responded to the 2006 survey indicated that they did not have drug coverage in 2005.

And then we asked them if they did not have drug coverage in 2005, what their source of their drug coverage was in 2006, and found that 61 percent of that group was in Part D in 2006. There was a smattering of people picking up coverage from employers and the VA and other sources, and 20 percent of that group was left with no drug coverage in 2006 as well, indicating number one – and I think this is one of the general

themes of the findings here that Part D did reach a fair number of people in this sort of primary target group that they were trying to reach, which is people who otherwise would not have had drug coverage. But there still are a number of people who it did not reach.

We also looked among the group in 2006, what their primary source of drug coverage was, it was found that about half of Medicare beneficiaries had Part D coverage, another 31 percent had employer coverage, and if you look at the green section of this pie that 8 percent of Medicare beneficiaries had no drug coverage in 2006. So you can look at this as the fact that the lack of drug coverage went from 33 percent in 2005 among this group to 8 percent in 2006. So again, tremendous progress in covering people who weren't covered.

When we look at the characteristics of people who didn’t' have any drug coverage in 2006, we found that rural beneficiaries were significantly more likely not to have drug coverage in 2006. African-Americans and non-white Hispanics were more likely not to have had drug coverage, and surprisingly because there were tremendous incentives built in to the system for covering low-income beneficiaries the highest rate of non-coverage was among the beneficiaries with the lowest incomes.

We also found that by the number of chronic conditions, if you can characterize people with no chronic conditions as

being the healthiest of that population, they were much more likely to have chosen to get coverage through Part D then the people with multiple chronic conditions were.

However, one other thing we looked at was the differences depending on what kind of coverage you had. And the first column of numbers in this chart, we compared the odds of spending a substantial amount of money on drugs, and the odds of having non-compliance with drug prescriptions by no coverage versus Part D coverage. And you see that indeed people with no coverage were about 2.3 times as likely to have spent $100 in the last 30 days, about twice as likely to have spent more then $300 and much more likely not to have to filled a prescription or delay filling a prescription then with no coverage. So Part D certainly is better then no drug coverage and really help those people to whom it extended coverage who didn't have coverage before.

In the middle column in this table and the right-hand column, you see a comparison of Part D with employer-based coverage and with VA coverage. And you see here on the other hand that Part D enrollees were much more likely to have spent a substantial amount of money in the last 30 days, and also were much more likely then those with employer or VA coverage to have delayed filling or failed to fill a prescription in the last 12 months.

We also looked – I apparently don't have a slide on the deck here – but when we also looked at the share of seniors in Part D plans by whether they enrolled in stand-alone PDP plans, along with the fee-for-service Medicare program or an MAPD plan through their Medicare Advantage plan and found that among the enrollees in PDP plans and the traditional Medicare program, they were more likely to have been older, more likely to have been poorer, more likely to have been in a rural location, more likely to have had multiple chronic conditions, and more likely to have multiple prescriptions as well; although we also found that enrollees in Medicare Advantage drug programs seemed to be better – significantly better protected against drug costs.

We also looked at the low-income subsidy and there are a couple of points here that struck us from the survey. One was that we tried to identify people in the survey who would have been eligible for the low income subsidy under Part D and found a distressing lack of certainty of both their income status and their asset status among the beneficiaries that responded to the survey so we ended up having to sort of do a lot of filling in of the data for the beneficiaries based on their incomes, and we couldn't use the asset data at all because the responses were just all over the map.

One thing we found along that theme was that of seniors who with incomes at or below 150 percent of poverty who said they were not receiving the low-income subsidy, 48 percent of

them said that they were not aware of the Part D low-income subsidy – that is the people who were not receiving the low-income subsidy, 48 percent said that had not been aware. And if you look at the distribution by income level, you see it's the poorer people who are significantly more likely not to have been aware of this subsidy that clearly helps them, and also non-whites were much more likely not to have been aware of the low-income subsidy.

As expected, the low-income subsidy, this becomes even amplified by the fact that we found that the low-income subsidy really did a very good job of protecting beneficiaries against both high costs and non-adherence. If you looked at people with the low-income subsidy, only 4 percent of them had said they had spent more then $300 in the last 30 days on drugs, while the proportion without the low-income subsidy was 9 percent, and non-adherence similarly was higher among the people without low-income subsidy then with the people with low-income subsidy.

The other striking, the less striking finding that I like to relate here is that there's naturally the assumption that people who didn't have the low-income subsidy who might have qualified for it, don't have it because they didn't sign up with a plan. But that is not generally true, nearly half of seniors who had low incomes who might have qualified for the low-income subsidy actually are in a Part D plan. Of course,

another 16 percent of them have no drug coverage at all. So you have a number of people out there who really could be benefiting from low-income subsidy, who just failed to sign up for it and have not been reached by this very valuable benefit to them.

That's all I'm going to say, I'll get back to the conclusions again. Medicare drug benefit reached most seniors who lacked drug coverage in 2005, that's very good. Seniors in Part D plans fared better then those who lacked drug coverage in terms of out-of-pocket costs and rates of costly related non-adherence. But Part D plans do provide less financial protection generally then employer based plans or the VA, and even though the low-income subsidy definitely benefits those who qualify for it, there seem to be a lot of people out there who potentially could qualify for it who have not yet been reached by that benefit.

ED HOWARD, J.D.: Thanks very much Stu. Let me just follow-up on something you said to clarify it. You talked about not being able to use the asset data, that's important because you have to meet both an income and an asset test in order to get a particular kind of low-income subsidy. Isn't it true that a large number of people who applied and were denied a benefit were told that their assets were the problem?

STUART GUTERMAN: Yes and a number of people were denied the low-income subsidy on the basis of failing the asset

test. Others studies have found however, that people with low incomes that have assets that exceed the limit for the low-income subsidy tend to be very similar in terms of their needs and their financial vulnerabilities to the people who have access less then that limit. So you're really distinguishing between two sets of people, both of whom could benefit greatly from this kind of subsidy.

ED HOWARD, J.D.: Thank you. Next we're going to hear from Laura Summer from Georgetown University's Health Policy Institute, where she's a senior research scholar directing research and analysis of how States carry out public long-term care and health programs.

In a previous life, for six years or so, she was the Deputy Director of the Institute Center on an Aging Society, where we did some work together. And today, Laura's going to focus on how vulnerable beneficiaries are faring under Part D. Laura, thanks for being with us.

LAURA SUMMER: Thank you Ed. I'm very pleased to be here this afternoon and I do want to thank the Commonwealth Fund for their support as much as the research that I'll talk about today.

Primarily I want to talk about some findings from the survey of more then 600 beneficiary counselors who work with Medicare beneficiaries across the country on a day-to-day basis. Last fall we partnered with the National Senior

Citizen's Law Center and the Center for Medicare Advocacy to contact these counselors, and to ask them how the Part D program was working, and particularly how it was working for more vulnerable beneficiaries.

And by more vulnerable, I mean people with low incomes, those who may have difficulty understanding the program because of language, literacy, or cognitive issues, or people with chronic or disabling conditions. So the population that I'll talk about today is a little bit more specific then the one that Stu was talking about, but still quite significant, and significant even in terms of numbers. When you think about the prescription drug plans, the stand-alone plans, about half of the enrollees in those plans have a low-income subsidy.

As many of you know, people who have a low-income subsidy are randomly and automatically assigned to a Part D plan. They have the option to opt out of that plan if they'd like, but most stay in the plan. And our respondents to our survey indicated that there are some difficulties that have been associated with that auto-enrollment process. People may be in more then one plan, may be assigned to more then one plan, they may not be assigned to a plan, or they may be assigned to a plan but the pharmacy has no record of that assignment.

Of course there are procedures in place to deal with this kind of thing, and anywhere from a third to over a half of

our respondents, depending on the issue, told us that these difficulties were resolved in less then two weeks. But the other respondents indicated that it took a longer time to remedy these situations, and at the time of this survey, substantial proportions of respondents said that sometimes these issues were not being resolved.

We also asked about plan formularies and utilization management rules, such as prior authorization or step therapy, and these are rules that affect all beneficiaries, but they affect the more vulnerable beneficiaries to a greater extent either because they tend to take more medicine or they have been randomly assigned to plans without the benefit of having their prescription needs matched with what the plans are offering.

Over 40 percent of our respondents told us that very often or often, their client's find that a prescription they had been taking is not on the plans formulary, the plans which they had been assigned, or that they have access limited to some extent by utilization management rules. What I think is very important to remember when we look at these numbers is that many of the people who are affected don't have good alternatives if they arrive at the pharmacy and find out they can't get their prescription. Some of them can certainly pay out of pocket, and some of them do. But many of them aren't able to do that while they wait for an appeals process to go

through while they figure out what they have to do next or simply while they wait for the problem to be resolved, if they decide to switch plans while they wait for that change in their plan status to be registered in the system.

Our respondents told us it's not uncommon for beneficiaries to delay getting drugs, to not take their prescriptions for a period of time, and they also told us that the health or well-being of their client's had been affected. You can see that 40 percent said this happened very often, 16 percent often, and 8 percent sometimes the utilization management rules were having an effect on the health and well-being of their clients.

With Part D almost 2 years old, I think it's tempting to say well these findings are from last year, they're represent growing pains, once the program has been in place and once people are more accustomed to the program we won't have these kinds of difficulties. But I can tell you that we've been conducting focus groups with beneficiaries and providers recently and we continue to hear these same issues. In addition, the Part D program is designed in such a way that it's a dynamic program, there's going to be change, there's going to be shifting among plans.

This next slide, which my colleague Jack Hosley [misspelled?] and I put together indicates that over 5 million beneficiaries will be having to choose new plans and

learning how to use those plans in 2008. This slide gives a sense of how the beneficiaries will be affected. In the first column you can see that checkmark represents about 2 million beneficiaries who will randomly auto-assigned to new plans in 2008, because they're in plans that have premiums below the benchmark this year but won't have premiums below the benchmark next year.

In the other columns are people who will changing plans, and they have to initiate the change on their own because their premiums will be higher or their co-payments will be higher next year then this year in the plan in which they're participating. And then this last column, we've got new folks who will be coming into Medicare and obviously will have to choose plans, as well as people who are in plans now but those plans won't be in the market next year, so they'll also have to choose. The last two columns show that for every one of these beneficiaries, regardless of how they get to the new plan, they will be subject to new formularies and new utilization management rules.

Now this next slide is here really just as a reminder that low income beneficiaries face other issues as well. These are issues that are generally, our experience has been, some confusion. And in fact, confusion or difficulty getting and understanding information, was the response that ranked highest when we asked our survey respondents an open-ended question

about the difficulties or the challenges that they encounter when they're trying to help their clients use the Part D program effectively.

We know from 2 years of experience and also from some case studies that we've just finished that there's a tremendous amount of good, creative, effective activity across the country right now helping Medicare beneficiaries use their benefits. We've seen States allocating funds for counseling and even legal assistance for Part D beneficiaries; we've seen some very effective public and private partnerships. We've seen linguistically and culturally appropriate activities going on in community-based organizations around the country; and there's certainly a continuing need for that kind of assistance, as well as for funding to sustain and even enhance that kind of assistance.

I would argue that there's also really a need right now to take a look at the Part D program and think about how we might simplify it so that so many people won't need so much assistance year after year. And this speaks to the second most popular response that we received, that one of the biggest challenges for beneficiary counselors and the people they help is the complexity of the Part D program.

A couple of suggestions here, one is that I think many of the difficulties associated with auto-enrollment could be addressed if beneficiary-centered assignment were used instead

of random assignment. This is a process that was used early on and States that had pharmacy assistance programs therefore had information about the drugs that their beneficiaries were taking and so they could match those beneficiaries with a program plan. At this point in time, CMS has 2 years worth of that kind of information about Part D beneficiaries and so it's something practical to think about.

Secondly, requirements for plans to use standard procedures for prior authorization, for appeals, for exceptions, really would make it easier to monitor the plans, but also would make it much easier for beneficiaries to use the plans and people to help them use it. Certainly efforts to intensify monitoring and also to improve electronic communication would be very helpful in strengthening the program.

And finally, in regard to some of the points that Stu made, if the eligibility rules for the low-income subsidy were changed either to eliminate the asset test or to amend it and if the eligibility requirements for the low-income subsidy were better aligned with those of the existing Medicare savings program there'd be more opportunity for easier enrollment, easier recertification, and the people who really need this benefit would be more likely to get it.

These are some specific recommendations. I would leave you with a broad recommendation which is very much based on

what we heard from beneficiary counselors and from beneficiaries, and that's for a program that provides good coverage but also is easier is to use and to understand.

ED HOWARD, J.D.: Thanks very much Laura. Can I just clarify something that may not be immediately on everybody's consciousness – one of the big reasons people are changing plans has to do with a benchmark and not being below it. Would you explain what the benchmark is and why it's important that folks plans are either above it or below it in year one and not two?

LAURA SUMMER: Individuals who have the low-income subsidy don't pay premiums if they're in a plan that has a premium below what is called the benchmark. This year, of course, as I notice a number of low income beneficiaries are in plans that have premiums that are below the benchmark. Because there are going to be changes in the market for 2008, large numbers of those beneficiaries will have to switched out of the plans that they're currently in into other plans or they could remain in their plans, but then they would have to pay part of the premium themselves.

Most of those beneficiaries, the 2 million that I spoke about, will be automatically reassigned. There's a small group of beneficiaries who get the low-income subsidy because they've applied for it on their own, their premiums may also go up – I'm sorry, they pay partial premiums. They're premiums may

also go up, they also should change plans, but they'll have to know to do that on their own.

ED HOWARD, J.D.: Okay, thank you very much. Except for the beneficiaries themselves, I guess there's no Part D stakeholder with a bigger stake, or one more central to how the program operates then the Center for Medicare and Medicaid Services, CMS. Creating the structure for this massive new program involved scores of tasks. I remember Mark McClellan [misspelled?] 11 page memo that he brought to one of our briefings to illustrate what the tasks ahead were going to be.

And CMS accomplished the vast majority of those tasks on time, and probably within budget, and we're happy to have with us today the Deputy Director of the CMS Drug Benefit Group who checked a lot of items off of that list, Tracey McCutcheon. That unit has the major responsibility within the agency for making sure that drug plans perform up to standard, and she's going to tell us today how well those plans are doing, and the strengths and challenges facing Part D from CMSs standpoint. We're really glad to have you with us, Tracey.

TRACEY MCCUTCHEON: Thank you very much. Can folks hear me okay? Thank you. I'm going to talk to you about on-going improvements that directly affect beneficiaries access to information and their benefits and services.

One of the obvious characteristics of the Part D program is the large number of choices the beneficiaries have,

and that was to no small part a function of our uncertainty in the beginning of the program in designing what kinds of features, what kinds of benefits and designs beneficiaries could find valuable. I'm going to run through quickly some slides that just talk about what beneficiaries are choosing.

It's clear that beneficiaries are selecting alternative design plan types, not the standard benefit. So that's where you get into a lot of these complexities, these things differ by deductibles and the initial coverage limits, and co-pays and co-insurances and tiers, et cetera, but that’s the preference that beneficiaries have. Beneficiaries are selecting plans with no deductible. Beneficiaries are selecting plans with low or no premiums, not a shocker. And coverage in the gap is not a significant factor in plan selection. That’s not what beneficiaries are selecting. Obviously the benefit was designed to protect the low income beneficiaries, they don't have a coverage gap, but the rest of the beneficiaries are not in general seeking gap coverage.

In talking about what we're doing to improve the program, it's important to know that despite the large number of choices, which everyone find difficult to deal with, there are fewer plan choices this year then there would have been if it not for our efforts to work and negotiate some of the plan choices away. Plan sponsors like to have as many products out there as possible, and we spend a lot of time during the period

between June and September negotiating some of those away. With more experience in the benefit, we are finding, looking at what the beneficiaries are choosing and being able to look at differences between them, and we're working to develop more structure around what constitutes meaningful differences in bids.

For instance, is there much value difference between one benefit package and another, and if we don't see much value difference – for instance if you run that in a typical beneficiary's or just a sample beneficiary's experience through our drug plan finder for both benefit packages, you come up with substantial value difference, if not we make them withdraw a bid. With more information, more experience to go on as we go along, we expect to do more of this and help to focus the number of offerings in the market, really meaningful differences with respect to benefit plans and formularies.

But one of the things that clearly is working is that this competitive program is holding costs down, premiums are generally stable, and there is a slower growth then predicted in drug costs as we see in our bids. The kinds of details that we have about our plans that you've seen elsewhere, in press releases, et cetera, I won't go into, but it shows that the market is responding to the choices that the beneficiaries are making and that there are more choices available for people

seeking no deductible plans and low premium plans, and there are even less costly alternatives in the MAPD program.

Where I'd like to focus my remarks are in some of the improvements that we work on internally to make sure that the beneficiaries do get meaningful differences in value. As I spoke about the benefit reviews, we also do that with respect to formularies. We look to make sure that the formularies pass a large number of tests, there will be a slide on this later, and we look to capture meaningful differences between benefit plans that come up from year-to-year in our, what we call plan benefit package or PBP software, so that we can standardize the representation and the literature that the beneficiaries see on the Web and in print.

For instance, a detail that did standardize this year was to indicate whether or not beneficiaries had access to a national network. Whether or not they're in a national plan, do they have access to a national network, that became part of the standardized language.

Also did they have access to – did the plan restrict access to any specialty drugs in particular pharmacies, as opposed to making them available at all network pharmacies. And as we see these kinds of plan details evolve, we look to see is that something that a beneficiaries really needs to be able to see upfront and if so we standardize the collection of that information in our software, which then translates out to

simple standardized language in our beneficiary model materials.

Systems improvement is another area that we've been doing a lot of work on since 2006. Areas that we continue to work on, working out, both in our systems as well as in our partner systems are things such as the exchange of the low-income subsidy data between ourselves and the States and SSA. We also have worked on the ability to make changes to the data in our system as the result of those information exchanges, if we get good compelling evidence that in fact that data has not been updated correctly or is incorrect – we have actually created the ability to override that data in our systems, working with the plans.

We've also changed our enrollment transactions such that information necessary to build the plans, the so-called 4RX data, which has to do with the way benefits are billed in the pharmacy transaction systems to make sure that data comes in with the enrollment transaction rather then waiting for the plans to send it in afterwards. And we're working in 2008 to automate balance transfer processes between Part D plans to eliminate the manual process that we can't really directly oversee today.

In addition, we've worked a lot on developing performance metrics, and I think Mark McClellen [misspelled?] certainly talked initially about instituting those measures and

they have evolved and been validated and we are now measuring them and reporting on them and getting to a point where we can get them into a format that a beneficiaries can use. Some of this data is used strictly for CMS to do compliance monitoring, and others of it are used to put on the Web and used for beneficiaries and others to see plan performance.

As we gain experience in the program and have access to more data to look at, we've looked that we're going to be able to do all of these processes – to continue to do this and to reach a point where we have even better information available for beneficiaries. I won't go into the details on our formulary reviews, but I would like to highlight the fact that we do evaluate the utilization management techniques that come into us on the formulary. We make sure, and we have a large staff of pharmacists that are reviewing those and making sure that they make clinical sense, and if they're not then they are denied.

We also do a large amount of work on so-called negative formulary changes that may be submitted during the year to make sure that if they're not a change that's in the beneficiaries best interest, for instance substituting a new generic that comes on the market for a brand that was previously in a more preferred tier, either that we deny those changes or that all beneficiaries – if there's a good clinical reason to do it – that beneficiaries are grandfathered for the rest of the year,

those that came onto those formularies with those drugs in more favorable tiers. We look forward to a date when E-prescribing will bring all of that information together to the physician at the point of prescribing so that it is not such a process that interferes with getting beneficiaries their services at the point of sale.

Here are some quick pictures about formularies; this is just to show there's a slight uptick in NDCs on formularies with utilization management tools applied to them.

ED HOWARD, J.D.: And NDCs are?

TRACEY MCCUTCHEON: Those are individual coding at the billing level for drugs, whether they be manufacture, dosage, package, size. You'll see that there's a very slight increase in the number of management tools, and there's a slight increase in the number of drugs on average on formularies. What you see is the plans balancing the need for greater coverage with the ability to effectively manage the cost of the benefit, which after all is a requirement – a statutory requirement of the benefit for cost effective drug utilization review.

I want to just talk about our performance monitoring. I'm just going to go to the pictures that speak a thousand words hopefully. This is the way we have put our performance monitoring data in on the Web, so the beneficiaries can see it. It's in three levels. The domain level is where we're talking

about broad, categories of beneficiary information such as customer service or the cost of the benefit. And you can see that we have information at the domain level with stars, we have information at the measures level that breaks out some of the subcomponents that are being measured. For instance in customer service, you're looking at time to average speed to answer and disconnect rates that sort of thing.

Again, in a sort of comparative number of stars note, and then you drill down to the data level to actually see actual measurements. What it was the customer service wait time, what was the disconnect rate, what was the pharmacy help desk wait time et cetera. This is the kind of information that we've been colleting, validating with the plan and working to get in drug plan finder.

With respect to the reassignment of the beneficiaries, we are working constantly to see what we can do to help balance the stability of the program with the competitive pressures and aspects of the program which are helping to keep the costs down. And we're working within our authority and using some demonstration authority to try to see if there are alternative ways to do this that strike that balance.

Even though there were no major problems in beneficiaries that shifted in 2007, there is a larger number in 2008. I think the new number is that we think about 2.1 million in total of which 1.16 million will actually be moving

to a new plan and a new organization. Another close to 1 million, 965,000 will be moving to a new plan within their sponsors existing organizations. And while that may include the same level of disruption, frequently it doesn't because there tends to be similar formularies, if not the same formulary amongst the plans offered by sponsors. That mitigates some of the transition issues, but not all.

We continue also to work internally to see are there things that we can do to help strike that correct balance, including looking at ways to calculate the benchmarks. I think John will speak later about the effective, including the MA rebate buy-down on the premium is an important factor to look at. And we also continue to look at issues around the transition of low-income subsidy beneficiaries from the Medicaid program to the Medicare program to see what we can do to work on that within our authority. We've created the TOS demo, and we look to see if there are any other ideas that we can come up with that would help us get to a position where we could do a prospective hand-off between the programs as opposed to a hard cut-over when many of those cut-overs turn out to be retrospective.

Just in short, we have worked a lot on our LIS outreach to those who will be facing a change in 2008, we've done a lot of work on the communications that will go out to them stressing that they do have options, and what to take into

consideration with those options. And for the LIS outreach, to those who haven't yet applied for extra help, there are a lot of campaigns that are going on and we've done a lot of work with estimating at the zip code level analysis of how many beneficiaries might be in each county and area to share with our partners that they've been asking for, to help focus their outreach efforts in the best places.

Some new materials I would highlight are some materials which are called photo novellas which are much more graphic in nature and therefore they help to get over some of the language issues and the lack of English proficiency, et cetera at trying to get new materials and get them out to a large array of partners that we continue to work with. Thank you.

ED HOWARD, J.D.: Thanks very much Tracey. Finally, we hear from John Rother. He's the Policy and Strategy Director for AARP. A lot of AARPs members I understand are Medicare beneficiaries, including me. And I should note also in full disclosure that a) AARP sponsors health plans in cooperation with United Health, including drug plans; and b) Bill Novelli [misspelled?] who's the CEO of AARP is on the Alliance Board of Directors. With that out in the open, we are very happy to have John on our panel.

John has led AARPs efforts to sign up as many of the beneficiaries as possible into Part D, especially the low-income subsidy parts of it, and making sure that those who are

eligible for those subsidies actually get them. He's – as we were talking before the program started – a veteran of the direction building, having spent a number of years as the Staff Director to the Center of Aging Committee whose offices are right across the hallway, under the late John Heinz [misspelled?]. He's also, we're pleased to say, a frequent panelist for Alliance programs and we're happy to have you in that role again. John.

JOHN ROTHER: Thank you Ed and I want to thank the Alliance and the Commonwealth Fund for sponsoring a very timely program. Just because I'm going last doesn't mean I don't get to say what some of the previous panelists have already covered. But first I'd like to look back just a second if I could at what the five principle goals were for AARP in 2003 when this legislation was considered. It's kind of a template for evaluating where we stand.

Our first goal was the Do No Harm goal, which was not easy to accomplish given a very determined chairman of the Ways and Means committee. Second, we wanted to get drug coverage to as many of the Medicare population as we could. Third, we wanted generous support for low income beneficiaries. Fourth, we wanted to prevent erosion in the employer-based retiree health plans that were so critical to so many. And finally we wanted a program that would operate to contain pharmaceutical prices effectively.

And just to get to the bottom line here, I think that we are in good shape on numbers one, two and four, and we still have some more work to do numbers three and five and that's where I'm going to focus much of my attention. This is a picture of where we were before the implementation of the program and where we are today in terms of the percent of those covered.

It is a voluntary program; we have still 7 or 8 percent of beneficiaries who remain outside the program – it's inherent in the nature of a voluntary program. When you have to look at this, you can't look at the entire group in an undifferentiated way, you have to look at the breakdown, because people are coming into the program through different routes and have different coverages as a result. You have to look at the total picture, not just those involved in Part D. I might say that we can't quite put our hands-on the exact figure of people who don't have coverage. GAO [misspelled?] says 4.7 million, and I think it's a Kaiser figure that's 4 million who are still without coverage today.

Let me now turn our focus to the low-income subsidy, and the first point is that enactment of the low-income subsidy as part of the drug benefit was the single most significant improvement for low income seniors since the enactment of Medicare – it was huge – if we could get the people into the program. As you can see, its worth $3,300 per year on average

for a low income enrollee and that is so significant that you wonder why people aren't beating down the doors to be enrolled. And of course, the program is valuable for everyone because everyone does get advantage of the subsidy, but it's particularly important and valuable for low income seniors.

Now we have a program that's today, running 30 to 40 percent under the original cost estimates, which you might say is good news except for the fact that a major reason for that underperformance in terms of the cost is the low enrollment of those who should be receiving the low-income subsidy. We thought there would be 14.4 million who would enroll and get the benefit of that subsidy, yet only 9 million today are in that situation. There are others who should be in our view, but who are disqualified by the asset limits – the Kaiser Family Fund estimate that's another 2.3 million who would be enrolled but for the asset limits. In a world where we're increasingly relying on 401k programs, IRA programs, all that kind of thing for retirement saving, asset tests as a general matter are really problematic because on the one hand we're encouraging people to save for their retirement, and as soon as they get there, then we're penalizing them for doing so.

If I could just summarize why people are not in the program, we've already talked a little bit about the fact that they don't know about it. I think there is some welfare stigma, especially now this is an applicable to Medicare

savings plans people, but the asset test is a major problem. We've done focus groups and people do not want to put down on government form information about burial plots, life insurance, any kind of support, particularly if they're told that they do and they get it wrong that they're subject to Federal prosecution. It's a major, major inhibition to people applying to ask for that kind of information.

We do know what it takes to get people into the program, and that's face-to-face outreach and enrollment. Mass media are not going to do it. But we need to do a better job obviously and I'm glad to hear that we have some zip code data now on income, but I think we could ask the IRS to share some income data with the SSI under strict confidentiality standards so that we could target more effectively those people who are presumptively eligible for the low income benefit. And then we need to do a better job of funding outreach and enrollment at the community level – that's where this happens, and again it has to be face-to-face for it to be effective. It's not cheap, but it is important.

The other main problem area left in the program is the cost of prescription drugs, and it's true that the overall cost of the program has been relatively well contained. Most of that though is due to switches to generics from brand name use, it's not that the brand name manufactures have felt any kind of restraint on price increases; it's the fact that we're being

fairly effective in switching people to generics. The way to do that is through formularies or tiered formularies that give people a strong incentive to use generics and of course, we support that. But the problem of course, is that the low income group are exempt from those kinds of incentives from cost sharing, and as a result the usage on low income seniors dual is much higher, they're much more expensive to insure then those who are not enrolled in that program and that leads into the problem that many of those people are going to be forced to switch plans. Because they are more expensive, they're going to be pushed into the plans with the most restricted formularies.

This is an issue because obviously that's going to involve their switching drugs, many of them have achieved a certain balance in their medications through trial and error. I haven't asked CMS what the administrative cost is going to be of switching more then 1 million people who don't know this is coming, but I have to wonder if this is really worth it to the tax payer because they could well be in the same situation again the following year. Remember these that are higher users, the plans they go into whilst a result of higher cost and may not meet the benchmarks, and then they'll ping-ponged back again the following year. I really think it's time to re-examine this whole situation of the benchmark and forcing people to switch from plan to plan.

Probably the single most important thing, not only for the low income population but for everyone in terms of getting a handle on the costs of prescription drugs is better information research basis for comparative effectiveness. We still don't know which drugs work best for whom, and this is kind of information that is absolutely critical as we go forward. Funding this kind of work, in my mind, is critical to the on-going affordability and effectiveness of the program.

There are some, what I call friction points in the program, these are process issues that have to do with issues such as marketing abuses in terms of enrollment in the plans, problems with appeals – I think we've mentioned that already, and we've mentioned the issue of reassignments. But the key point here is that the current formula determining the benchmark includes Medicare Advantage plans, most of which are zero premiums. When you include those, it brings the benchmark down, in my mind, to an artificially low point and its really the source of this problem. If we could exempt the Medicare Advantage plans from the benchmark, we would have a much more realistic basis for determining which plans are actually doing a good job for the low income part of the population.

There is still a problem with keeping the Medicare Plan Finder information up to date, and obviously no one – I can say with authority – no one at the time of enactment that there would be this many plans participating or this much confusion

in terms of beneficiary choice. We were worried about the opposite situation, namely what if no one came and that way we'd have to have a fallback public plan. I don't think we really thought through the problems that are no in the market place of too much choice.

I really think it might be time for CMS to make some judgements about which plans are performing and which aren't, and we might want to think about narrowing the field on the basis of performance as we do now in other areas of healthcare where we can measure performance and we can reward it. Here I don't see any particular rationale for keeping plans in the market place that are not performing, that are doing a bad job in terms of enrollment and in terms of getting people the drugs they need, or customer service if they don't answer the phones. I don't think they should be in the program.

What can we do going forward to strengthen the program? The main thing is – two things – one to strengthen low income protections and two, to act on the cost containment agenda. We think that we should, at a minimum, substantially raise or preferably eliminate entirely the asset test. A program that does belong in the social insurance program, it's getting in the way, and it's simply not appropriate in a defined contribution pension environment where we need people to save for retirement. We could simplify the application, we could permit enrollment in Medicare savings plans at SSA offices so

that Medicare savings plans and low income programs are treated in an equivalent way. We could also bring Medicare savings program benefits in line with the low income level.

And finally we need to change the formula, as I suggested before, taking Medicare Advantage plans out of the benchmark to avoid this ping-ponging of the duals that will otherwise take place on a yearly basis. When it comes to quality and cost of prescription drug coverage, here I think we simply need CMS to continue to be more aggressive in their oversight of plan performance, and we need to substantially fund comparative effectiveness research and there's no excuse at this point for not requiring physicians to E-prescribe. Every pharmacy in this country is electronic and has the technologies available, and it's fairly cheap. This would save lives and save money, so we believe that to require E-prescribe.

Now finally, let me just say there's a big opportunity here because we do have the Medicare physician payment legislation as a vehicle to do all these things this year, and I hope we do. Thank you.

ED HOWARD, J.D.: Okay, thank you John. Some very tangible observations on the part of many of the panelists, now it's your turn to make tangible observations, ask tough questions. I would also invite our panelists to respond to anything that they have heard that they think evokes a response

they would like to have. If you would like to come to one of the microphones, that's a good way of doing it. If you would prefer to fill out a question card, hold it up and somebody will bring it up here.

Let me just ask, I know Tracey may not have an official view of any of these adjustments or changes that John and some of the other folks have put on the table, do you have some sense of how much leeway CMS has to make these kinds of adjustments within the constraints of the statute?

TRACEY MCCUTCHEON: That might differ from which one you're talking about. I think in my comments I mentioned that we've been exploring demonstration authority to work out some of the very same issues that you look at, and by that definition you folks are lawyers and we have decided that we don't have non-extraordinary authority. But if we look to the demonstration authority as a way to experiment on better ways to pay for the services, we may be able to get creative in some of those lines, but there's not a clear path in any of these ways to make the changes.

ED HOWARD, J.D.: Yes, as you come to the microphone, I would ask that you identify yourself and direct a question or comment to a particular panelist, if you care to. Yes?

RICHARD SETH: I'm Richard Seth [misspelled?]: with Pharma – rather then being a tough question as you put it, I'll just note this for Stu and for Laura. There's been a lot of

analysis of public opinion data and of focus group data, surveys of both beneficiaries as well as people who are helping beneficiaries make choices. I think you both made real contributions there. I just wanted to note that we've supported some work that actually looks at claims data and I think it helps try to triangulate the beneficiaries experience by looking at the actual claims data.

So I'll just take 15 seconds to note some of the findings that we had for 2006, which sort of overlaps with the period that you looked at. We looked at seniors and disabled persons. The work was done by Omenson [misspelled?] Group using various span data. We looked at those who were not insured for prescription medicines for 2005, but who picked up coverage in 2006 through Part D. And the key findings that I note are that the number of prescriptions used per month by these individuals increased from an average of 1.7 to 3.3, that the average number of distinct conditions per patient treated with medicines increased from 3.8 to 6.6. The out-of-pocket cost per day of supply decreased by nearly 70 percent, it was 69 and a fraction.

That the total out-of-pocket cost, which takes account of course of both cost per script as well the number of scripts declined by about 45 percent on average, even as the use medicines increased, and that the share of the population spending less then $100 per month in 2006 in Part D was 91

percent. I'll just note that there are similar findings around the disabled population, and of course to the low income population as you would expect. The access improvements were even larger, and the cost reductions were even smaller.

Just to sort of help triangulate around the various types of opinion data and reporting of experience of beneficiaries and from those helping beneficiaries, I thought I'd add a perspective from the claims data analysis. Thanks.

ED HOWARD, J.D.: Thank you Rick. We have some questions coming up. I've got some ones that had been submitted in advance as well. Let me also just – without wanting to put you on the spot – this is I think a softball question.

And it goes to the observations about administrative costs and the process of switching so many people from one plan to another. The open season runs to December 31st, and then on January 1st, you go with your New Year's hangover to the pharmacist and try to fill the prescription and they have no record of you having made whatever change you think you made, or that drug not being covered now. Would it help to have some kind of an interval between the end of the open season – say December 15th or something like that – and the start of the new benefit year?

TRACEY MCCUTCHEON: Yes, I think that's clear that that helps. That's certainly the way the commercial insurers work

and the more the interval the better. I believe that we've looked at that repeatedly to see whether or not we could do that and if I'm correct, and I may not be, but if I'm correct we saw that we had some flexibility on the D side and not on the C side. We didn't want to try to – because so many people are in MAPD plans – we didn't think we could manage an open enrollment system process that was working differently for C and D. I believe that that was our conclusion there.

ED HOWARD, J.D.: Yes, Stu.

STUART GUTERMAN: This is a good time to point out, first thank you Rick for those numbers and it's certainly comes through from any days that we have that Part D has done a lot of good for a lot of people by providing drug coverage for many people who didn't have it before.

The key here though is to keep looking at this program, trying to avoid if you will, declaring mission accomplished and trying to keep looking at the program for ways to improve it. It's gratifying to hear the actions that Tracey has described and all our efforts are to try and focus on areas where the program could continue to be improved. And the purpose of having a session like this with the audience that we have is that there are times when CMS might need more tools to be able to work on improving the program then they currently have at their disposal and this is the audience that could come up with a way to give them those tools.

ED HOWARD, J.D.: That's right, we expect you to be taking very good notes in this session. A question from John Rother, John your first goal in 2003 was to do no harm to the Medicare fee-for-service program yet many consider Part D as a major step towards privatizing Medicare. How do you respond to that?

JOHN ROTHER: Well I certainly don't consider it a major step that way, what I meant by that was the proposals – I think they were called competitive bidding demonstration – proposals that would have directly forced the Medicare traditional program to bid against managed care programs and then have premium be adjusted. That in our mind would have completely undermined the traditional Medicare program and getting that out of the legislation was a very, very difficult job. It was done over the determined opposition of the chairman of the Ways and Means committee. It really deserved to be up there as number one, in our view that was critical to protecting Medicare going forward.

But Medicare has obviously a role for private plans in it, an appropriate role as long as the design is funded in a way that doesn't undermine traditional Medicare and we do not view the Medicare drug program as undermining the social insurance nature of Medicare.

ED HOWARD, J.D.: A question for Tracey, and forgive me if I stumble over this because there are a lot of moving

parts to this question. In chart number six, you say there are fewer Part D plans in 2008 then in 2007 – can you please clarify whether this means a decline in total Part D offerings or does it refer to the number of stand-alone plans that are available in 2008? The total would include not only the stand-alone plans but the Medicare Advantage prescription drug plans. Given the increase in Medicare Advantage drug plans, it was surprising to see a decline in Part D plan offerings as you described it. Can you clarify that?

TRACEY MCCUTCHEON: Yes, and that's a good catch. It is a decrease in PDP plans. There was an increase in MA plans, largely due to new service area expansions and segments et cetera, but the decrease in stand-alone Part D plans. Thank you.

ED HOWARD, J.D.: Go ahead, Laura.

LAURA SUMMER: I just wanted to follow-up on that question and ask not only about the numbers of plans from year-to-year, but how much turn over in plans? How many plans have left the market, are coming into the market? Are there regions where there are a substantial number of plans that are leaving the market?

TRACEY MCCUTCHEON: The answer is that most of the turn over that you see really has to do with a sponsor deciding to not offer the benefits design anymore rather then organizations leaving the business. We have some very small number of plans

that leave due to financial solvency, generally very small plans.

We have plans leaving the market because they've been consolidated, they've been purchased by another entity and a certain benefit package is leaving or a certain entity no longer exists because it's been acquired, but there's very little, actual leaving in any area of the program.

Hence our need to find more refined ways to get meaningful differences in bids and to find what represents value in the bids to beneficiaries so that we can find a better way to get more discipline in the market, fewer plan choices out there if they don't really represent meaningful differences.

ED HOWARD, J.D.: And following up on what John was saying, do you think that narrowing the number of plans, maybe even substantially narrowing them, is something that you have the power to do now? Or is that something that Congress needs to hand you? Or can you do it in a demonstration or somewhere in between?

TRACEY MCCUTCHEON: How we love our demos – I don't know that I can comprehensively address that specific question. I do know that we – having started the program – I think it was John that mentioned, that we initially thought that no one would come play and as a result of that we've designed the program with fewer barriers to entry and controls that right

now that if we wanted to back in, I'm not sure whether or not we've addressed the question whether we have the statutory authority – we'd certainly probably have to do it with notice in common rule making if we were to do something, substantive. I just can't comment on whether or not we're discussing that.

ED HOWARD, J.D.: I've got a question on a slightly different topic – part of the topic I guess. There are bills before the House and Senate focused on prompt Part D payment to pharmacies. Can anyone on the panel speak about whether mandating prompt payment to pharmacies would have an effect on the Part D premiums and on beneficiary's access? That last part was mine. Anybody? John?

JOHN ROTHER: Yes, I'll take it. Some of these plans, the poorer performing ones are generating profits by simply holding on to the money longer, and again, I think that's an item that’s performance related. It doesn't directly affect beneficiaries, but it could indirectly affect them if it puts so much pressure on community pharmacy that it forces them under. So in the name of preserving access as well as just good program administration, it seems to me that we should demand prompt payment. I don't have any problem with that. I don't think it would raise premiums, but it would protect access.

ED HOWARD, J.D.: I've got a factual question for anybody on the panel – what's the average Part D premium for

2008? What was it for 2007? And if you have it, differentiating it between stand-alone prescription drug plans and Medicare Advantage drug plans? [Laughter] Don't we have that in your packets?

TRACEY MCCUTCHEON: It must be somewhere. I think the national average for 2008 is $225.

ED HOWARD, J.D.: Jack do you have those numbers at the top of you answer sheet?

JACK: I actually have them.

ED HOWARD, J.D.: You want to identify yourself?

JACK: Kaiser Family Foundation is actually going to be putting out a sheet that we've done for them within the next week or two, but the enrollment weighted average premium on the PDP side is going up from abut $27 to about $32 from '07 to '08, which is about a 17 percent increase. And the enrollment average premium again on the PDP side, it would be much lower on the MA side because of the number of plans with zero premiums that get to be zero because they're able to cross-subsidize it with some of their savings from the Part A and Part B spending levels.

But that actually relates to the comment I wanted to make, which is we are seeing this increase in premiums and this is part of what's sort of playing with this question of the benchmark and the low income plans. The benchmark in statute is supposed to be an enrollment weighted average as has been

noted about the PDP premiums and the MA premiums. CMS did use its demonstration authority to phase in the enrollment weighting, if they had not done that we would actually be seeing even lower benchmarks because of the fact that people do tend to enroll in the less expensive plans and because this includes the MA enrollment weight in that.

But there is a phase in path to fully phase in that enrollment weighting over the next couple of years, so I really wanted to just amplify on this point that we're seeing a couple million people who are switching plans, or needing to switch plans this year – that's going to continue to be the case with the potential of squeezing them into fewer and fewer plans over the next couple of years as we phase this transitioning time. And we really do, as John mentioned, have a potential to see these enrollees ping-pong.

You can just look at the total number of plans that are eligible for the subsidy, it hasn't changed that much. But what's happened is a lot of the more popular plans, the United Healthcare and the Humana [misspelled?] plans are the ones that have jumped up above the benchmark this year and are causing some of that enrollment change to happen.

I think it really is something that needs to be looked at in terms of how to figure in this enrollment weighting, whether to take the MA plans out of the picture so that we don't continue to see a lot of this really rather large

churning of beneficiaries in and out of different plans – the low income beneficiaries in particular. And of course the higher income beneficiaries have to look at those same choices and mostly are not making choices to re-examine what their plans and have considered making switches.

ED HOWARD, J.D.: Thanks, Jack. A question related to the relationship between Part D and Medicaid. With Part D implementation state Medicaid agencies lost access to patient data related to medication use. These data for many states are important for patient care, when does CMS expect to be able to share data from PPPS – the nature of which I have no idea – private – [interposing]

TRACEY MCCUTCHEON: Or DDPS, the drug data processing system. That's where our claims data is stored.

ED HOWARD, J.D.: Okay, with States.

TRACEY MCCUTCHEON: This access to the claims data is an on-going issue that is being looked at all levels of the organization. We have our lawyer's interpretation of the D15 Prohibition, that's the statutory language limiting our use and disclosure of the data for payment purposes. They believe that it's a very strict construction, in other words, we can look at that data to pay a plan under its risk sharing and reinsurance subsidy, we can go through the reconciliation – that's what the DDPS, the drug data processing system, was built for – to collect that information and translate it into payment.

Our lawyers and policy folks continue to look to figure out how best to provide access to data, we did put out an MPRM through discussions and clearance of a final are still underway. It's an authority issue that the lawyers are grappling with, but our hands are tied in using the data just as much as everyone else's. We also are anxious to get that to a closure so that everyone can look at it, or as many people as possible.

ED HOWARD, J.D.: People are reluctant to go to the microphones I guess, but I will tell you that there are a significant number of green cards sitting in front of me and if you want to make sure that your question gets addressed by our panel, I would advise you to vocalize it. In the meantime, some low-income subsidy provisions of MMA were designed to help increase enrollment of eligible beneficiaries into the Medicare savings programs – have been mentioned here a couple times.

What is known about the Medicare savings program enrollment trends? Has the low-income subsidy for the drug benefit contributed to a higher participation of these Medicare savings programs as intended - the general notion of dual eligible people getting subsidies through Medicaid for their cost sharing in Medicare, anything known about that? Stu?

STUART GUTERMAN: No.

ED HOWARD, J.D.: Anything known about that? I'm sorry, Laura?

LAURA SUMMER: I can say that in some of the States we visited we've certainly heard that all of the publicity about the Part D program has made people more aware of the Medicare savings programs. And certainly when people come in for one-to-one counseling sessions, if they're working with good counselors they're hearing not only about Part D but about the Medicare savings programs.

What makes it difficult though, and the reason that enrollment is still low for the Medicare savings program is that there's not a good streamlined way for most of these people to enroll in both programs at the same time. There is a provision in the MMA that says that people can apply for the – I'm sorry, for the low-income subsidy either at the state Medicaid offices when they're applying for the Medicaid or Medicare savings programs or at SSA, but in practices almost all of those applications for the low-income subsidy come through SSA or sent to SSA. Provisions that would allow Social Security Administration to share more information with Medicaid and vice versa would certainly help enrollment in both programs.

ED HOWARD, J.D.: Anyone else? That's good. Thank you. The materials, presumably the materials in the folders, show 6.3 million dual eligible's participating in Part D. The original number based on state Medicaid roles were .5 million higher. Do we have fewer duals now? And has Part D had an

impact on that? Speculation? Solid facts? Anybody? Research question?

[Laughter]

It does underscore how much we don't know about the low income eligibility and how we get at those folks – identify them first and get at them after we identify them.

LESLIE FREED: I'll ask a question.

ED HOWARD, J.D.: Why not? You want to identify yourself?

LESLIE FREED: Yes, I'm Leslie Freed [misspelled?] and I direct the Medicare Advocacy Project for the Alzheimer's Association and we've heard talk about the increase in premiums, but there's not been much discussion about the increase in cost sharing that's going to happen in 2008. And we're getting calls and E-mails from folks who have gotten their annual Notice of Change which marks a significant increase in premiums, but also in cost sharing, and particularly in tiers two and three. And in fact, some of the drugs are being switched from tier two to tier three, so it's a dramatic increase. I'm wondering Tracey, if in your review of the formularies and the tiering whether CMS looked at that – those issues?

TRACEY MCCUTCHEON: Yes, we reviewed plan benefits differently whether or not if we're looking at them for a new year, in other words if cost sharing increased between 2000

plan and it's 2008 variant, we don't look at those changes – there's not a process to say that that change in benefit plan should or shouldn't happen. But what we do look at – versus if a change is happening to tiering or utilization management tools within a year then we do look at that and do control for that. There has to be a really good reason such as the entrance of a new generic on the market for a brand to move from tier two to tier three for instance. But sort of start anew when you look at a new plan year, it's not compared to its predecessor.

But with respect to looking at cost sharing levels overall, I would say that we do have a concern that left unlimited premiums can sort of fall and cost sharing can rise. Left unlimited, that's certainly not the intent of the program to shift everything to the beneficiary or to the low income cost sharing subsidy. We have actually negotiated down a lot of cost sharing that you have not seen. And we weren't given specific instructions in our interpretation of the statute for what is the right level. That's one of the reasons we want to look at the PDE data, the claims data, we do want to be able to do some more sophisticated analysis about cost sharing and given benefit designs and who's choosing them and who isn't, and see whether or not there's more control we can have in that area.

But absent that, we tend to look at outliers before we have any benchmarks or standards to work off of and so we have used sort of a curve, and we have kept cost sharing – for the most part – within a curve of tier two cost sharing and tier three cost sharing. We have negotiated down folks that came in with benefit packages that exceeded those outliers. It is a matter of concern for us, and we hope to be able to do more analysis and to determine other standards in the future.

ED HOWARD, J.D.: Stu?

STUART GUTERMAN: I think this is a good context for reminding people that when we talk about market that is indeed the way markets work. If you want more, you pay more one way or another. That points out two things. One example is it's frequently pointed out that there are plans available that provide coverage through the donut hole. But those plans tend to be considerably more expensive then the plans that don't provide coverage through the donut hole.

That makes perfect sense. You're providing more coverage, and so your premiums are higher. But that rarely gets brought out because plans tend to get lumped together and you tend to look at sort of benefits and premiums separately when it's all one picture. The cost sharing aspect is another aspect of benefits that is determined coincidentally with premiums. If you look at premiums alone, you're going to miss

that aspect of it, CMS is trying to stay on top of it, but just remember that market forces work that way.

If you as a consumer want more, you will generally pay more and the difficulty and the challenge is to make sure that the information is available so that people can make fully informed choices on all the dimensions they're choosing on.

ED HOWARD, J.D.: John and then Tracey.

JOHN ROTHER: Well on that point, I believe that the next year will see many fewer plans offering coverage in the donut hole. So the choices for consumers who have high drug usage are going to be much more restricted if they want to have coverage for their entire range of costs, again, due to competition and due to risk selection. The plans that had offered coverage of the donut hole, not surprisingly, attracted a sicker group of enrollees, and they're not going to be repeating that next year.

ED HOWARD, J.D.: Laura?

LAURA SUMMER: And I just wanted to add to what Stu said, we always talk about markets when we're talking about Part D, but from experience with beneficiaries, this isn't a pure market. People are looking at the cost, but they're not only looking at the cost. You hear from beneficiaries, well I know it'll be a little bit higher next year, but I don't want to change because after what I went through this year, I just don't want to rock the boat. I can't even think about

changing, so I don't even want to look at that. It's a question of getting the information out there, but also realizing how that information is or is not being used.

ED HOWARD, J.D.: Yes, Tracey?

TRACEY MCCUTCHEON: Just my last point was we do encourage individuals to go back and use the Medicare Drug Plan Finder, not just rely on the fact that it was the best plan for them this year because of those kinds of changes which are possible between benefit years.

ED HOWARD, J.D.: This is kind of an extension – by the way we have about 10 minutes left, and I would appreciate it if you would take some part of that 10 minutes to fill out the evaluation form while we get it and cram in as many questions into this gap that we can.

This is an extension of the same topic really, its nominally addressed to you Tracey. Has CMS analyzed why beneficiaries are not seeking coverage in the gap? Is it because perhaps this is related also to not understanding the gap or that there are so few plans offering coverage in the gap? All of the above?

TRACEY MCCUTCHEON: I'm not sure that I can answer anything about what research is being done, and again, access to the PDE data – it would be very handy. But given that we do get some information now for 2007 off the reporting requirements about how many people are reaching these levels of

the benefits. Not that many people get to the donut hole and the catastrophic, so you don't have every beneficiary seeking that because their expectation is that they don't need it.

But certainly given the fact that the brand coverage is no longer available in the gap does mean that people who are seeking gap coverage if they don't use generics, there isn't a good choice there for them.

ED HOWARD, J.D.: Go ahead.

ERIC WEEDAM: I'm Eric Weedam [misspelled?], I'm with GAL – I'm sorry its kind of a technical question is for Tracey. You have in your list of highlighted improvements for 2008 for systems improvements and one of the first items is for LIS data exchange between CMS, States and SSA. Could you elaborate a little bit on what that entails and what the plans are and what the impact will be as far as an improvement?

TRACEY MCCUTCHEON: I can't give you too much detail because I'm not actually the systems analyst working on those, what we call CRs, change requests, to our systems, but I do know that in both our November release and in our April release we have slated certain systems changes to better synch up our process with state processes and with SSA.

We're also moving to be able to receive and use state files more frequently. Right now based on how we thought the world would work going into this program, we get a monthly state file which runs through one deeming program per month.

That's when our system looks at the state data and says, oh it's given this person's dual status – do they get the $1 - $3 or the $2 - $5 or the 15 percent? And we deem them eligible for subsidy level and then that information either puts them into an auto-enrollment or a facilitated enrollment and it passes that information to the plan and makes it available for queries.

That's a one-time a month process. Well, we had to get the one-time a month processes working, which we've done in 2007, and now we're moving to being able to do those more frequently, sometime in 2008, so that we will be more able to get – our ultimate goal would be to be able to take in these files as frequently as the States wanted to update them and run them through deeming processes quickly and auto-enrollment processes quickly to cut down on some of the timing gaps that are caused by the processes between the parties.

ED HOWARD, J.D.: A question for Stu related to the kinds of assistance that's available for enrollees who didn't qualify for low-income subsidies under the Part D program. With respect to the survey that you talked about, some types of assistance, like the state pharmacy assistance programs may have been outside the survey scope, but did they come up in any significant way? Are they doing a significant amount of work in providing drug access to the Part D enrollees who don't qualify for the low-income subsidies?

STUART GUTERMAN: The state pharmacy assistance programs and other programs came up in the survey in an interesting way. Many respondents actually said that they had drug coverage but didn't have complete drug coverage because of various programs including the state pharmacy assistance program.

I think many States are pursuing efforts to try and plug what they see as gaps, including people who are low income but don't qualify for or otherwise don't get the low-income subsidy. Actually Laura's doing some work on that issue.

LAURA SUMMER: Yes, there are a number of different approaches that States have taken. Some do provide coverage in the gap, some have increased their income eligibility limits and eliminated the asset test for the Medicare savings programs so that enrollment in those programs goes up in those States, those people are deemed eligible for the low-income subsidy, they receive the Medicare benefit and the funds that had been used through the state pharmacy program can then be used to do things like fill the gap.

As I mentioned briefly before, there are a number of these programs who do try to use beneficiaries centered assignment or at least initially did when they had access to information about people's prescription drug use to match their own enrollees with the plans that would be most helpful for them. A number of the plans are providing some sort of wrap

around coverage for their folks who also are enrolled in Part D.

ED HOWARD, J.D.: A question that I've been trying to figure out how to phrase that came in, in advance, it's actually just a factual clarification that puts together two assertions that don't seem mutually exclusive to me, but may be confusing.

In its analysis of public available CMS data, Avalear [misspelled?] Health reported, and I think there's a piece in your materials that tracks this, that premiums for the average Part D beneficiary are expected to rise 21 percent in 2008 in the same plan from 2007. There's also in your packets a September HHS release saying that more then 90 percent of beneficiaries will have access to less expensive premiums in the coming year. So are seniors spending less or more on drugs for the coming year? Or don't we know yet? Laura?

LAURA SUMMER: [Laughter] I guess my question is when we say have access to – what do we mean by that and I'm guessing that what this may be about is looking at existing plans and what's happening to their premiums in Part 1, and in Part 2 thinking about new plans coming into the market. That would be the access part.

ED HOWARD, J.D.: Stu?

STUART GUTERMAN: Actually there's, again, this points out the need to look at more then just the premium as well.

There's in every area, and one of the things that people have pointed at repeatedly is the array of plans available in any area, and that includes an array of premiums and an array of benefit packages. The fact that a beneficiary has a plan available that's cheaper all depends on two things. One is the basic willingness of the beneficiary – or the ability of the beneficiary to switch to the lower priced plan.

And also what the lower premium plan offers in terms of its benefits package, and whether that's comparable to what the beneficiary feels that he/she is getting under their current plan. You would think certainly that Zerv [misspelled?] behavior over the first couple years of Part D is that beneficiaries are reluctant to switch plans.

I would expect that many beneficiaries are going to stay with their plans because they still feel that they're a good deal, although for many beneficiaries, the plans, premiums and their out-of-pocket requirements and other aspects of the benefit packages are also going to change. But given the reluctance of beneficiaries to switch from one year to the next, you'd expect that many of them will stay with their higher priced plans.

ED HOWARD, J.D.: We have at the microphone at the back of the room, the last question.

MARK STEINBERG: I hope it was worth waiting for. Mark Steinberg, Families USA. I actually wanted to respond a little

bit to that earlier question about the missing dual eligibles. It wasn’t my question but I was thinking about it. There was a lot of speculation in 2003 that there would be a woodwork affect among the low income population, particularly if States were going to be processing applications for the low-income subsidy, they would find people eligible for Medicaid as well.

I don't know if that' what the difference is, I know that certainly representatives from the States were very concerned that was going to end up costing them additional money, and because States haven't' done that enrollment at a large scale, that may be part of the reason why we have fewer dual eligibles then was projected back in 2003. It would mean that there are people out there eligible for Medicaid who aren't' getting it.

ED HOWARD, J.D.: Perfectly plausible. Yes, and what better note to end on then plausibility? Let me ask you to fill out those blue evaluation forms as I sum up our gratitude to Commonwealth, the Commonwealth Fund for its co-sponsorship and support of this briefing and its contribution of Stu Guterman to its panel.

Thank you for sitting through a lot of acronyms and some very technical questions and answers in a program that is incredibly important for 40 plus million Medicare beneficiaries. And I ask you to thank our panel along with me, that is to say join me in thanking them for fielding an

incredible boray [misspelled?] of questions and providing us with a great base on which to make some adjustments when this Medicare legislation is processed through Congress. Thanks very much, folks. [Applause]

[END RECORDING]