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## **Implementing the Medicare Drug Benefit: The Stories Ahead September 27, 2005**

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[START RECORDING]

**ED HOWARD:** I want to thank you all for coming.

Prescription drugs in the Medicare program has been, probably, the biggest health care story of the last two or three years, the biggest challenge for those implementing it, and it's a story with all sorts of national and regional and state and local handles that you've been all pursuing. It's got multiple stakeholders. It's a terrific topic. It's, also, the chance to help 30 or 40 million people in a situation that they need help in.

We are very interested in this topic. We did a briefing, in the spring on the Hill; some of you were in attendance at. Following this one, we'll be doing a second fall session on the Hill with connections to the state and district Congressional staff offices as they are starting to ask questions about what they tell their constituents about this thing that's coming down the road.

We are under some time strictures, here; and we want to make sure that you get a chance to ask as many questions as possible, since there are a lot of moving parts in this enterprise. So, what we're going to do is, we have an extremely well-qualified panel of analysts, experts, and pundits for you to pepper with questions.

We've asked them to limit their remarks to the outrageous amount of five minutes so that we can preserve the

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time that you have to get at the questions that you want to ask. And, within that stricture, we have one other little fillip [misspelled?] to detail.

Our first speaker is Leslie Norwalk, the deputy administrator for the Centers for Medicare and Medicaid Services. And, I'm going to be even more brief in my introductions than I usually am. In fact, you just heard her introduction.

Leslie will give us some introductory remarks. She has to be in Baltimore, probably, 20 minutes ago; and so, she'll do that and take a few of your questions. And then, when she has to leave, we have the able Abby Block to respond to further questions. And, we'll hear from our other speakers. So, without further delay, Leslie, thanks for being with us and get us started.

**LESLIE NORWALK, ESQ.:** Thanks, Ed. I'm going to presume that most of you in this room actually know a fair amount about the drug benefit. But, let me just talk quickly for those who may not. One of the things that the MMA is define a standard benefit package and say that plans can offer that or something that is actually equivalent to that.

Of course, the Standard Benefit package has a \$250 deductible, 75-percent coverage between \$250 and \$2,250, a coverage gap or no coverage between \$2,250 and \$5,100, and then a catastrophic coverage after the total drug costs of \$5,100.

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And, if you add up all those figures, the beneficiary portion is \$3,600, which is why you see the true out-of-pocket cost for catastrophic coverage at \$36,000.

But, I think, one of the more interesting stories coming forward is that the drug plans and Medicare Advantage plans that are offering the drug benefit have been far more creative in what they will be offering beneficiaries than just the Standard Benefit package. Everything from plans with \$0 deductibles, they know that many beneficiaries don't like deductibles and, in fact, they would prefer to get coverage.

With Prescription One, so many plans will be offering a benefit package with a \$0 deductible. Likewise, there are plans out there that will have coverage in the coverage gap. Some of them may be generic only; some are both generic and brand. But, we have seen both and some PDPs as well, as in the Medicare Advantage market. Plans that are filling in that coverage gap, not surprisingly, it's not really a fun thing to explain to Mrs. Smith, so I think that will be useful. And then, low premiums.

And then, I'll talk more - a second more about the lower premiums in a minute. But, I think the - one of the things that we've been hearing, or certainly I've been hearing as I do Town Hall meetings around the country, is a more threshold question: "Gee, is it worth it for me to even go through the exercise? I only take one prescription a month, or

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maybe I take two. Is it worth it for me if - to take a look?"

And so, one of the things that we put on our web site is a calculator that is done by state that looks - that says, basically, what's your retail drug cost per month today? And, given the state that you live in, where would you come out with the Standard Benefit package that's provided at the lowest premium available in that state?

So, that an individual can say, "Well, A: Is this - could I answer the question? Is the catastrophic coverage worth this for me?" Or, given all of the financials, it's just a down and dirty, takes you maybe 30 seconds to complete, not even ten seconds as long as you know what you spend a month on drugs, and can give you a quick estimate of whether or not it's actually worth it to take the next step. And, again, that's something on our web site.

And, in terms of taking the next step, I think that's important as the plans start marketing this Saturday, more specifically in terms of what's available. One of the things that we've, also, put out, that's available on our web site, that you can get through the tool, is things that beneficiaries should think about when they're comparing plans.

And, whether that's coverage, costs, convenience, and peace of mind, or the basic categories; but even - we've got a chart in this particular document that talks about: Do you take specific drugs and you want a drug plan that covers the

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drugs you're taking now? And, you want to be sure, obviously, that the drugs that you take are in any particular plan's formulary.

Do you have drug costs that are over \$2,250? You may want something with a higher than average initial coverage limit, or something that covers in the gap for example, and to look for that when you're doing your comparison.

If you want your drug expenses to be balanced throughout the year, you might want something with a \$0 or a lower deductible plan. If you use a lot of generic medicines, obviously, you're going to want to look for plans that have generics as a part of their formulary and are in the lower co-payment tiers.

If you don't use any prescription drugs, perhaps you just want the plan and that's the lowest premiums, so that you can have peace of mind. If you like getting all of your health care coverage from one company, then a Medicare Advantage plan may be right for you. So, these are the sorts of things, in terms of providing guidance to specific beneficiaries, depending on what their interests are, I think is important.

I've read stories that talk a lot about the average premium. And, one of the things I wanted to mention about the average premium is that it's an un-weighted average. Obviously, we don't have any Medicare beneficiaries in prescription drug plans. So, that averages merely the average

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of all the bids that came into us.

If you were to ask me what I suspect the average would be on a weighted basis, after 2006 or after the open enrollment period closes in May, it would be significantly less than the \$32.20. And, the reason I feel that is whether its beneficiaries who simply don't want to pay a high premium or otherwise; and I'm sure that there will be many who would like to pay a little bit more and get substantially more coverage, whether that's coverage in the gap or a lower dollar deductible, perhaps.

I do think that many beneficiaries will take advantage of the fact that there are plans around the country. And then, depending on the state in which you live, premiums can be under five dollars, under ten dollars, under \$15; and in fact, when you do that calculator that I mentioned initially, it will tell you the lowest amount of the particular premium is in any particular state.

But, I think that beneficiaries all over the country will be surprised that \$32.20 is actually no where near as low as they might be able to pay. And, I think that's a terrific news story, because it's important for, particularly for those, even if they don't qualify for the limited income, that they, in fact, can get this benefit even in a stand alone drug plan at prices that are incredibly low.

And, in terms of drug premiums in Medicare Advantage

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plans, there are plans all over the country, for the most part, that will be available where the drug premium on a Medicare Advantage side is \$0. So, I think there's a lot of good news for Medicare beneficiaries out there.

And while I appreciate that the Standard Benefit package is what the Medicare Modernization Act has, I think the real news is that Medicare beneficiaries will have options that are different from that saner [misspelled?] that may be more beneficial to beneficiaries because of the \$0 deductible, the lower premiums, or the filling in of the coverage gaps. So, thanks, Ed. Well, there you go. Welcome to my life. It's all a hurricane. [Laughter]

**ED HOWARD:** Let's take this opportunity for you to get at a couple of questions for Leslie before she has to go. If you would, identify yourself. Hold your hand up and Bill Irwin, our communications director will allow you to use the microphone so that the folks in the far corner, with your hand out, can hear you.

**PAUL PRECK:** I'm Paul Preck [misspelled?] with "Inside CMS." There seems to be quite a range in the premiums that the stand alone plans are offering from below \$20 to \$68. What accounts for that? Is that, because we don't really know at this point what the coverage looks like - is that, that there is very different coverage structure or the formulary is different or people just guessing different about what it's

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going to cost? And, if that's the case, do you think in 2007 that they might find out that they bid a little low?

**LESLIE NORWALK, ESQ.:** I think there are lots of different reasons for that. And, many of them that you mentioned may be accurate or probably is going to depend on the individual company that offered the benefit structure.

Some of the participating companies have a significant amount of experience in dealing with drug benefits, either on a retiree basis or in the Medicare Advantage program, and may have some better sense of what they feel they can do in terms of managing the costs than other plans who may not have traditionally served that market. So, that may be part of it.

Differences in the formulary structure, step therapy, prior authorization, those sorts of things may also play a role. But, I think that a number of people will be waiting to see, "Gee, what happens in 2006 and how well can they manage these costs?" Of course, there is a fairly significant re-insurance from the Medicare program both on the specific basis, which is to say beneficiaries who reach the catastrophic coverage limit, the Medicare program will be reimbursing plans at 80-percent for that, as well as, if the plans significantly overshot their own medical loss ratios, if you will, their targets that the Medicare program will also help uncover some of those losses.

On the flip side, if they've done a great job with

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managing those drug costs, the Medicare program would also share in the savings. So, I think we'll all be waiting to see what happens. And, I suspect that every company had a different reason for putting in the bids in which they put in.

And, you can see, for example, if you were a low bidder, one of the reasons you might have bid low is because you want to particularly serve dual-eligibles [misspelled?] would be one reason. And the second is that, maybe, that you will get a - your actuaries may think that you, from a risk-pool perspective, that you will get beneficiaries that are both healthy and sick; and it would be better from an insurance perspective. I think there are, perhaps, a whole range of reasons that would lead any particular company to bid one way versus another. And, we'll see how it goes in 2006.

**REX RYAN:** Rex Ryan with Script. There's an awful lot of companies that have gone into this. Do you expect a big shake out next year? A lot of the companies are going to decide that they're losing money and they just want to get out of it and wind up with, probably, a lot less.

**LESLIE NORWALK, ESQ.:** It wouldn't surprise me if we lose a few. It's probably the beginning of any market. Most people, from my own personal estimate, not something that the agency's really discussed in particular, but my own personal estimate is if you didn't get in on the ground floor, it would be difficult to get in late. It's harder to get in, in later

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years - not impossible, but probably more difficult from a market share perspective.

And, consequently, people didn't want to lose out on the opportunity; and I suspect a number will say, well, either they didn't get significant enrollment for whatever reason, either the benefit design or premiums, or some combination thereof, and that they may decide that it's not worthwhile going forward. I suspect there'll still be a significant number in the future, because this market is not going away.

In fact, it's a growing market, simply because of the demographics of the population. And so, it may be that even those who have lesser enrollment this year may decide, well, we'll re-evaluate, perhaps do a different benefit package to be more competitive and try it again in the following year. So it would probably be some of both.

**BOB ROSENBLATT:** Bob Rosenblatt [misspelled?], freelance writer. This is a somewhat technical question about people who have insurance as retirees. This is what I was told at a briefing by a prestigious benefits firm that works with employers.

And, the way to simplify: Mrs. Jones retired from IBM. She has retiree health coverage. She gets mailings. She decides she likes the Signa [misspelled?] Part D stand alone package, fills out an application, sends it in. The CMS computers figure out that she worked for IBM. They send her a

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letter saying, "No, you cannot enroll in Signa Part D."

But, Mrs. Jones, having gotten that letter, apparently has a right of appeal; and she can say, "Yes, I really do want to enroll in Signa Part D." And, therefore, Mrs. Jones would have regular A and B coverage through IBM, Part D through Signa. Tell me how that works, if that is correct or not?

**LESLIE NORWALK, ESQ.:** Well, I think as a general rule from my experience in all the Town Hall meetings I've done, is that most beneficiaries - not all, but most beneficiaries really want to keep their retiree coverage.

And, I suspect some number of them, particularly if they're risk adverse, upon seeing either the *Parade Magazine* article on Sunday or seeing their *Medicare New Handbook*, or whatever it happens to be, in terms of planned material, may decide, "Gee, I need to sign up for this," without realizing that the retiree coverage is, particularly if it's creditable coverage, it's as good as the Medicare program and, perhaps, certainly integrated with their A, B benefits and other things that the retiree program does.

So, our first concern is to be sure that beneficiary intended to switch the coverage from the retiree benefit portion to the Part D program. I'm not sure that we say you can't sign up; but what we - we do want to be sure that they're aware that there is a difference in those two approaches.

And, that, in fact, if they do have retiree drug

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coverage, for example, that they wouldn't be penalized. Should, say, IBM, as your example, drops coverage, say, in 2009, if that would still be able to get the coverage without any premium additions.

If a beneficiary continues - still decides that they want to do a prescription drug plan, then fine. And, the employer health plan would not get the retiree drug subsidy that we would pay otherwise if they remained enrolled in the retiree plan. But, the individual would get coverage as an individual through whatever plan he or she decided going forward. I suspect that there, from a coordination perspective, maybe, some work to do with the employer; but that's something that we've been spending a lot of time with employer benefits groups to make sure that we can make it as easy as possible for the beneficiary.

No, no, I mean it's voluntary. Certainly, they can sign up. They may not have intended to, which I think is more of the concern.

**ED HOWARD:** The people in charge of getting you to Baltimore said you had time for just one or two more questions. So -

**JILL WEXLER:** Jill Wexler [misspelled?] with Managed Health Care Executive, Pharmaceutical Executive [misspelled?]. Are there any general differences in the type of options that MAPDs have offered as opposed to PDPs? I thought that only the

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MAPDs could offer the \$0 premium and the doughnut hole coverage; but you seem to imply that everybody's [inaudible] or that those [interposing]

**LESLIE NORWALK, ESQ.:** There are not - I think the lowest premium that I'm aware of on the prescription drug side is just under - just south of \$2 in the Plains States Region. And, that information is available on our web site. But, there will be a significant number; and I think this is, also, already up on the web site. A significant number of Medicare Advantage plans with \$0 drug premiums, and we're shifting through the data just to confirm how many beneficiaries - what percent of beneficiaries have access to overall \$0 premiums, not just on the drug side.

And, I prefer [misspelled?] that we confirm what that percentage is. They may, but none of - for whatever reason, from the bidding perspective, it didn't turn out that any of them did. The other difference, I suspect that there are some - my recollection is that there, in fact, are some Medicare or PDPs that do something to fill in the coverage gap; but you're far more likely to see it on the Medicare Advantage side than you are to see it in the PDP side. But, I believe there in - they've offered - they're offering above [misspelled?].

**KENDRA CASEY:** I'm Kendra Casey with CMA. I'm just wondering if you can respond at all or make any comments from the CMS perspective on legislative proposals to give Medicare

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the ability to negotiate drug prices and, also, the proposals out there or, at least, the one last week from Senator - or from Representative Stark that would delay penalties until the end of next year versus May.

**LESLIE NORWALK, ESQ.:** To your first question, both the Congressional budget office as well as the office of the actuary said definitively last year that the ability to [audio skip] negotiate [misspelled?] the drug prices directly, of course, I think it - a lot of people are under the misimpression that prices are negotiated.

That's exactly why we have premiums that are under \$2 in some places, because they were successful in negotiating, not just with the drug companies, but also with the pharmacies in a way that they could provide these plans to beneficiaries at a very low rate. And that, both the actuaries and CBO did not think that direct negotiations by CMS - by the way, no one on CMS's staff that I'm aware of actually ever directly negotiated a price with a pharmacy or the pharmaceutical company.

We don't really negotiate at Medicare, in case you were wondering. We just set prices. And, we don't have the infrastructure to do that. But, the drug companies, or the insurance companies that offer both MA plans and PDPs - that's exactly what they do for a living, where hundreds of millions of beneficiaries or regular commercial insured across the

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country everyday. That's their job; and they've done it so well that they brought in premium prices down to such a significant extent that beneficiaries will reap the benefits of that negotiation. So, negotiation is, in fact, happening on regular basis.

As to the suggestion about delaying the - or extending the open enrollment period through the end of the year, I don't know that we have an official position, but I can tell you, philosophically why there was a late enrollment - there is a late enrollment penalty and open enrollment period.

Of course, all of us, if you have commercial insurance, there's a typical open enrollment period. And, the concern is that if beneficiaries don't sign up for that enrollment - during that enrollment period, one of the reasons for that is simply because they're healthy and wanting to ensure that the insurance pool, that is available for all the drug plans and Medicare Advantage plans, that that insurance pool is broad enough to spread the risk, which is, of course, the point of insurance.

We wanted to encourage people to sign up during that open enrollment period. We are working incredibly diligently, whether it - tomorrow I've got a speech in Detroit on Medicare Advantage plans. We've been flying all over the country, as has the Secretary and, frankly, a number of people at HHS to make sure that we get the word out so that people have an

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opportunity to sign up during that six months.

And, that pressure, excuse me, that pressure or that - it's so important for us that we don't want people to miss that opportunity that we will be spending a whole lot of time, not just within the department, but with all of our partners, making sure that the word gets out so that they know, just so that no one after May 15 there are as few people as possible can say, "Oh, I didn't know about it." And, we are looking at unconventional ways of reaching out to them. So -

**MALE SPEAKER:** [Inaudible]

**LESLIE NORWALK, ESQ.:** Feel free, just if you've got other questions either to ask Abby or if, for whatever reason you don't get your questions addressed today, feel free to let Peter Askewnas [misspelled?] know and I'll see if I can talk to you later on after my awards ceremony.

**ED HOWARD:** And, if you don't know who Peter is, I can't imagine that being the case [interposing]

**LESLIE NORWALK, ESQ.:** Yeah, I can't imagine [interposing]

**FEMALE SPEAKER:** I'm sure he would be happy to answer the questions [interposing]

**LESLIE NORWALK, ESQ.:** Abby will do a fine job. But, if for whatever reason, there is a time -

**ED HOWARD:** Thank you very much, Leslie. I appreciate your coming on an obviously very tight schedule. And, this may

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be continued. Let me just call attention to a couple of things. I noticed Leslie had opened in front of her a much prettier version of what you have in your materials. It's a map which [background noise] you can click on. The URL is printed at the bottom so that you can get the up to date information about exactly what plans are available in each state and other information about that state.

Also, something you're not probably used to in the packets of materials that we put together. There's a much more extensive source list than you usually find with different categories of folks you can ask questions of and a set of story ideas that we hope will be helpful to you. And once again, Bill Irwin, our communications director who put those together with the help of some of the folks in our staff can help you if you have other specific questions.

Absolutely. He told me he did. [Laughs] And, now, if I can, I want to move to our other presenters.

I hesitate to call them speakers, because we're putting so many restrictions on the time that they have in our initial presentation; but John Rother could easily take on all your questions and fill all the time with the experience and the background that he has, which is chronicled in the Bios. From AARP, John Rother.

**JOHN ROTHER:** Thank you. Well, I think that there are so many stories possible that all I can do is give you some

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categories. But, maybe, a surprising category in my mind might be the performance of CMS itself at a time when there's been a lot of failures of government in responding to real pressure, I actually think that CMS maybe the success story of the year. I consider it quite amazing that they've come this far in an incredibly complicated legislative framework.

And, they got the rugs [misspelled?] out; they've arranged for a very robust planned participation. Most employers seem to be staying in. They're not out of the woods yet; but I think it's really quite amazing to see an agency navigate such difficult terrain so successfully to date.

There are two big remaining issues, this is category number two. Two big remaining issues, I think, from a health policy point of view, is this program going to work or not? The first, and most important, is enrollment. Will we get most people who can benefit enrolled? And, in particular, will healthy people enroll? Because, if only sick people enroll, then, there's no way to spread the cost. And so, the ability of all the marketing and all of us involved in this to get people with moderate or low drug expenses to enroll is really key.

The second big challenge that I think it will take a little longer to assess is cost management. How successful are the plans in keeping the cost down to beneficiaries? How successful are they in negotiating with manufacturers, and with

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all the other elements in the supply chain that add to sky-high cost of prescription drugs?

We know from our polling, that this is the number one issue in many people's minds as the cost of the drug. And, if this big experiment in having all these private negotiations, actually, turns out to be successful, that's big news. And, I think we'll probably get some feeling of that when we get a more detailed look at what the plans are going to offer.

So, the third big category is early indications of whether or not [coughs] the plan is going to work or not. And, right now, you'd have to say the jury's out in terms of enrollment and public acceptance; because even though I think we've had quite a bit in the public media about the coming of the benefit, we still know that at least half of beneficiaries don't seem to have a clue yet [coughs] that it's on its way.

And, obviously, we need to do more around awareness. Each one of you and AARP and government and everyone else is going to have an important role to play in that. But, we also know that [coughs] a lot of people really don't get very much of their information from public media. And that, really, what this is all about is person to person stuff. So, for those of you who are fans of the "tipping point," I think there's an interesting story here about how people get information and from whom. And, who's the "Maven" [misspelled?] in their community? And, there will be "Mavens," then. Some of you are

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going to be "Mavens" in your families and your social network. And, we see this in every other part of the economy when new things happen and people have to make decisions. So, I think there's, kind of, some - if we could only find out who those people are and what their attitudes are going to be toward this program, we'd have an answer; but they'll emerge.

So, I guess the big theme, really, for the next few months in my thinking about this is how people make decisions and what decisions they do make. And, they're going to be receiving an awful lot of information. I'm sure the airways are going to be clogged. Some of the companies have already announced massive advertising campaigns, using every conceivable way to reach this population.

So, how are people going to react? And, I think that it's not possible to answer that question in a general way. I think you have to answer it with respect to the five, kind of, big sub-populations here. And, the first one is one we've already been talking about - people with employer coverage, and whether they'll understand that they can stay put and generally be better off with what they have in the face of all this marketing onslaught.

The second sub-category are the duals. And, very ambitious and difficult one-day transition on January 1 for the duals - and how successful that will be and what changes that will mean - a state by state story.

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A third group, or the other flow income seniors, the primary beneficiaries of this whole plan are people with limited incomes. And, they're proving to be very difficult to reach. Social Security announced earlier this week that they had received three million applications in response to their initial mailing, expected, but were no where near critical mass, in terms of getting most people who have the most to gain from actually applying.

And, one of the factors that I think could be important in that story is whether the presence of an asset test for the very first time in a Social Insurance program is a barrier to people's willingness to apply for the assistance. I personally believe it will prove to be a significant barrier; but [coughs] that's going to be an important story for policy as well as for how well we do.

And then, of course, the last two categories: Everyone else, just normal middle-income beneficiaries, who have MediGap [misspelled?] or some other kinds of coverage. And then, finally, those who are residents of nursing homes - a very special situation and a special set of problems.

So, it seems to me that trying to decide how people make decisions and what kinds of information they have to weigh [background noise] has to be broken down to at least those five categories and maybe even more. This is a hard story to write, because there is no typical Medicare beneficiary when it comes

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to drug coverage - all these subgroups.

So, one last thing. A different kind of story is the impact of this, and, impact on beneficiaries, impact on the market, impact on politics. I think there's going to be some pretty dramatic stories about impact on beneficiaries before and after people who did not have drug coverage before who are now going to be able to afford the drugs they need to stay alive. This will save lives; and there will be a lot of dramatic stories about people who can now get their medications.

But, what is the impact on the industry? Drug industry, today, is held in low regard by most of the public, the primary reason being high cost. Will the presence of a drug benefit in Medicare ameliorate that? Will it take pressure off the industry politically around issues like importation or secretary [misspelled?] authority? Or, will the fact that it is now on budget and adding to Medicare's cost put more pressure on the industry from the point of view of those in Congress concerned about expenditures? So, an interesting set of questions around the impact of all this. So, that's the big picture overview.

**ED HOWARD:** Very good. Thank you, John. Next we're going to hear from Alec Vachon, former Senate staffer. He's now the head of Hamilton PPB and the author of the most entertaining and lively insider newsletter on health issues in

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Washington. Thanks for being here, Alec. [Coughs] [Background noise]

**ALEXANDER VACHON III, Ph.D.:** Thanks Ed. Thanks to the folks at the Alliance for the invitation to be here this afternoon. We're just about to complete a list of the 57 corporate sponsors of the Prescription Drug Plans. If you have an email address, I'll be glad to send you this when we release it this afternoon. It's somewhat revealing about who's actually offering these plans. [Background noise]

Twenty-two months ago, the President signed the Medicare Modernization Act. And, I want to emphasize that the Medicare Drug Benefit is not just a social policy story, as important as that is, or a political story; but it's, which I think together, has been the focus of most of the press coverage I've seen. It's, also, an extremely important business story.

Just five bullets about the impact of Medicare Drug Benefit on the pharmaceutical market. First, after January 1, 2006, Medicare will control upwards of half of the nation's retail drug market, depending on enrollment, Medicare will buy outright - will pay for 28-percent of all prescription drugs up from about 2-percent today. By counting in other payers' out-of-pocket spending, Medicare will leverage one-half of the market. Or, stated another way, Seniors account for about half of the drug spending in the U.S. The "take away question" is

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what will be the spill over effects on the Medicare Drug Benefit on the commercial market?

Second bullet: The Medicare Drug Benefit will have significant presence in the U.S. Stock Markets. There are, roughly - I say a rough guess, 310 drug-related stocks on the New York Stock Exchange and NASDAQ and the MX [misspelled?]. Those include the manufacturers, big pharma [misspelled?], specialty, generics, bio-tech, wholesale distributors, PBMs, retail pharmacies - my rough estimate is those 310 stocks comprise by market cap the value of 12-percent of the nation's stock market. Again, with Medicare - and Medicare regulation has not been a big factor in the past.

"Take away point:" If Medicare payment policy and health service is any guide, expect volatility.

Third bullet: The Medicare Drug Benefit is reshaping the pharmaceutical industry and business alliances. For example, two of the ten national prescription drugs plan organizations, Medco [misspelled?] and CareMark [misspelled?] will be offering plans in every region. CareMark is a corporate parent of Silverscript [misspelled?] Insurance Company, which is listed as one of the ten national prescription drug plan organizations.

Now, two years ago, when the Drug Benefit was being debated in Congress, the PBM said they would not take on insurance risks. You remember, picking on one of these -

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executing a plan is bet. And, you hired actuaries to figure out how to make money on that bet. And we all know the actuaries were reformed [misspelled?] bookies. So, that is at the heart of being successful in executing on a plan.

So, they have changed their minds. I think that is important, and I'll explain why in a moment. Also, PBMs have never been in a retail pharmacy business before - have always been working with institutional customers with the large employers or other health insurers.

Medco and CareMark are, also, be competing against really for the first time directly - and I can qualify that a little bit against two long standing partners: Caremark with Humana and Medco with United Health Care. In the Drug Benefit, Humana has teamed up with Wal-Mart and United with Walgreen's to benefit management.

Fourth bullet: Investors care about winners and losers. Who will make money and who won't? I'm not going to offer and stock picks, but I will four guidelines. Winners and losers inevitably a company-by-company story. And, first we have to figure out who's playing. As I mentioned, Silverscript, CareMark - was [misspelled?] PBM, and other examples RX-America, which is out - a PDP there will be available in 18 regions, that's a subsidiary of Long Drugs Retail Pharmacy chain.

Second "take away:" The market will look different in

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2007. The benefit market, the players in the market will look different; the plans look different in 2007. Both industry and government are going to learn a lot in 2006. There's a lot of issues with the bidding tool CMS put out. And so, one would expect, naturally, that both parties will approach it somewhat differently next bidding cycle.

And, again, you're making bets here. You're making actuarial bets; and that's the basis of playing in this market.

Third "take away:" Many of the players are huge; and any profit margin impact may be modest, although it's still an important growth opportunity. Considering that Pfizer [misspelled?] has 7.4 billion shares and a market cap of \$186 billion. United has 1.3 billion shares and a \$70 billion market cap. It takes a lot of revenue to raise earnings per share by even a penny.

Fourth "take away:" It is a general matter players with strong, grand, or retail marketing partners, like AARP, will have an advantage.

And, final bullet, fifth bullet: The federal government, perhaps in partnership with other insurers, will increasingly be in the business of evaluating the effectiveness or the comparative effectiveness of pharmaceutical products.

For example, in the current issue of the *New England Journal of Medicine*, there's the lead feature, the lead story, clinical story, research story is a result of a \$44 million

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government funded trial comparing the effectiveness of five anti-psychotic drugs. And, the article questions incremental value of some of the newer drugs, which cost ten times the older drugs. And, in June, 2005, what I personally think is the most underreported health story of the summer, Agency for Health Care Research and Quality announced ten comparative effectiveness research reviews comparing surgical procedures to pharmaceutical products comparing products within a category of pharmaceutical products.

That is a thin wedge that was authorized by AMA [misspelled?] that's a thin wedge of the government getting the business of product differentiation and having an impact on the losers. Thanks.

**ED HOWARD:** Thank you very much, Alex. Final presentation, and then we'll get to the rest of your questions, is from Marc Benoff. Marc is head of the Pricing and Reimbursement practice for Cambridge Pharma, which is a unit of IMS Health. And, we're very happy to have you.

**MARC BENOFF:** - on that lives in the heart of the pharma industry. So, I've been asked, at least unofficially, to provide a pharmaceutical perspective on this. So, I will try and, hopefully, do justice to it. I will, also, try to take less than five minutes. How's that?

So, I think there are two compelling questions. And, these are questions, to be honest, as we work with our clients,

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the pharmaceutical industry, that we're asked almost constantly. And, they're very much related.

The first question is what is the managed care environment or the PDP, the MAPD environment going to look like, not only in terms of what are the benefits going to look like and who is going to be out there playing, but almost more importantly, what are the formularies look like and how are they going to be managed? And, to that end, we, in essence, hypothesize or see two scenarios or two phases.

Phase I, which is '06 - get people in. Our view is that Phase I right now, we're going to start seeing a fair number; and I think we're already seeing the start of this, a good number of options in terms of what the benefits look like. And, relatively, and I should emphasize, "relatively," open benefit design or open formulary designs.

We think 2008 is Phase II. Budget constraints become more of a factor. People are in. There's a bit of inertia. They're in; they're going to stay in, hopefully. And, in that way, plans start becoming more aggressive in terms of managing their formulary and access.

And, that can play out a whole host of ways. We could see scenarios where if you have a very strong generic and a therapeutic area, that there's a great focus on moving shares to the generic. We could see situations where you have a number of relatively undifferentiated products, branded

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products. And, the managed care organizations, in a very Draconian way, forcing contracting - winner take all type of scenarios. Only one product on the preferred physician - the rest either non-preferred or an off formulary entirely.

The second question we are asked, and again, related to the first: Is this good for the pharma industry or bad for the pharma industry? And, to be honest, when I'm asked that question from the pharma industry, it's usually couched in one way. When I'm asked that question from my mom, it's usually couched in a somewhat different way.

The answer there in a traditional consulting fashion is, "it depends." IMS has done some analysis, and I think there are a fair number of these forecasts out there. We estimate in the relative short to medium term is 1- to 2-percent per year of incremental value based on this benefit.

But, the real question isn't in this sort of shorter term. It's really, number one, it's in the longer term; and number two, it's how's that affect my product, again, looking at it from the pharmaceutical industry. And, in that case, we see real winners and losers.

Again, companies that have a product that's competing against a very strong generic - unclear to us whether you're going to get a volume uptake. There are scenarios where you might actually see over time a flattening of growth based primarily on the benefit itself. In therapeutic areas, again,

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that are very competitive, perhaps you do get a volume uptake; but, perhaps, that's all set by contracting and your discounted pricing.

And then, the second question is: How's it look two, three, four years from now? And, that's, in large part, a political question, I think.

Is this a free market environment that looks similar to what it is today? Or, do we move to an environment that's a bit controlled either from a pricing or reimbursement perspective? Does health technology assessment or health economic reviews become more prevalent and a bigger factor? What are pharmaceutical companies doing in terms of differentiating their products? And, do we see new strategies that really begin setting these companies apart and allowing them to establish products or develop products that almost or must have [background noise] some formularies? So, I think that's probably five minutes.

**ED HOWARD:** It's actually four minutes and 23 seconds. Congratulations.

**MARC BENOFF:** No, actually, let me have my other 30 [interposing] [laughing].

**ED HOWARD:** Now, let's go back to your questions. I would ask if you would hold your hand up and let Bill Irwin give you the microphone, if you don't have it already, and identify yourself. I'd also ask, there are a few folks who,

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for one reason or another, are in the room but are not reporters. And, we'd ask that you let our reporter friends get precedence to ask the questions.

**BILL SALGANEK:** I'm Bill Salganek [misspelled?]. Bill Salganek from the Baltimore Sun. Have we yet seen any impact in price negotiations, and so on? People are jockeying to get on the formularies. Has there been anything trickling down yet?

**MALE SPEAKER:** In terms of, are the discounts higher in the Medicare environment than they were last year? The rebates and things along that line? Is that what you're suggesting?

**BILL SALGANEK:** Yeah. [Inaudible]

**MALE SPEAKER:** Yeah. Yeah, first, I think on a list price basis, and the way the pharmaceutical industry works is that there's a list price; and then there is a fair amount of rebating and discounting that goes on underneath that, that isn't necessarily transparent. So, on a list price basis, the answer is no. List prices are list prices; and they've continued the trend in large part.

On a discount basis or a net basis, it's hard to answer it, because there's no publicly available source of information. But, I think, anecdotally, what we're seeing is, again, in stronger therapeutic areas where you have a competitive - more competitive products, we are anecdotally hearing that the level of rebating is much higher than what was

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originally expected.

I'll also share. We've done a fair amount of work with pharmaceutical companies talking about scenario planning. And, about a year ago, when there was a much more uncertainty around this benefit, we were working with several clients on this issue; and we were, basically, working with the individuals in different companies who are responsible for contracting.

And, we would be going down the scenario planning route and the game planning; and we had the individuals responsible for contracting in two companies independent of one another in meetings, basically, have a little light bulb go off and say, "Hey, you know, under certain scenarios, price control is not a bad deal."

So, the free market can be quite effective. And, we expect it to be even more effective going forward.

**AUDIENCE SPEAKER:** [Inaudible]

**MALE SPEAKER:** I don't believe so, I don't know, Abby,  
if -

**ED HOWARD:** Yeah, let me just take this occasion to remind you that we have the expertise of Abby Block, who is a special assistant to Mark McClellan, and who has been dealing with health insurance questions both at CMS and at OPM for many years. Abby?

**ABBY BLOCK:** Well, all of the contractors are required to report to CMS on the rebates that they have received. So,

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CMS will have that data; whether that data will be made public, I don't know.

**ED HOWARD:** John?

**JOHN ROTHER:** I think there's a very strong public interest in making it public. And, I call your attention to the activities of a group of companies under the Human Resources Policy Association that are demanding a full transparency in the PBMs that they do business with. And if the private sector's going to do it, then, clearly the public sector has an even stronger reason to make these transactions more transparent.

**MALE SPEAKER:** There's a legal question here. I think MMA actually guarantees the confidentiality of proprietary information. There may be some interpellations, some guesses from the prices, the retail prices that are posted will be paid by Medicare members when the price comparison, the plan [misspelled?] comparison to go live on October 13. We've heard, also, some chatter [misspelled?] of some deep discounts.

You look across companies, also. Some companies, historically, have been treating their products like commodities and have proven very successful in government programs. Others have struggled. And so, that kind of nimbleness will be rewarded here as in any kind of market.

[Background noise]

**ABBY BLOCK:** Let me just add having dealt with this for

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many years when I managed the Federal Employees Health Benefits Program. There's a trade-off between transparency and the ability to get the kinds of discounts that you're actually seeking. Clearly, so long as that information is proprietary, it is more likely that deeper discounts can be achieved. Once you start making the information public, you lose obviously some of the negotiating advantages.

So, there really are trade-offs there. And, you are correct that, as of now, certainly the statute does protect that information.

**ED HOWARD:** Yes, go ahead.

**BRETT COUGHLIN:** Yeah, hi. Brett Coughlin, *Berkley News*. I have a question for the doctors, really. What are the challenges that they're going to face from their patients in the next year, and what advice would you give them to help meet those challenges? And, number two, is there going to be a nexus between the Part B drug payment system, the average sales price system, and the prescription drug benefit? And, what do you predict for ASP in 2006?

**ED HOWARD:** Who here speaks for doctors? Alec?

**ALEXANDER VACHON III, Ph.D.:** You know, I actually have one lobbying client. It's a public service client, a kidney patient group. And, there's multiple efforts going on currently within that community to educate patients. So, a little bit easier to reach in theory, because people go to

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dialysis three times a week.

And, I think we're going to see this, kind of, layering effect of information across different geographic communities, different virtual communities of people trying to reach folks. And, I agree with John's comment that this is a person to person, people to people, peer networking, viro-[misspelled?] marketing, kind of, endeavor. I've already talked to my mother about it; and I told her she has to sign up for a plan, better pick one.

And so, I think the story for the past two years has been confusion. There will be some confusion. And, I just wrote an article for this kidney organization, a publication. I said, "Forget about the confusion. Sure, it's going to be confusing. So, what?" The potential benefit to your health and your health care is so enormous, that you should, kind of, welcome the opportunity to, kind of, plow [misspelled?] through this.

So, for the docs, Brett, yeah, they're going to be asked a lot of questions by their patients; and what they're going to need is some numbers to call. And, it's going to be on a disease by disease basis, actually, in many cases.

On the ASP, that system's not going to change in 2006. The Congress has some interest in seeing the, what's essentially a medical benefit. Part B covered drugs are essentially a medical benefit. Those are confused

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[misspelled?] with injected drugs - come under the edges  
[misspelled?] of Part D; but I think that's downstream several  
years if at all.

**JILL WEXLER:** Jill Wexler. Sort of a marketing  
question. Is it possible for drug manufacturers to put out  
information to the public saying if you want to have posi-maxer  
[misspelled?] if you take this drug, these are the plans? And,  
that will have it on their formula, or is that steering  
[misspelled?] [Inaudible]

**ED HOWARD:** And, is it permissible that it is steering?

**ABBY BLOCK:** Well, our marketing [misspelled?]  
guideline really don't - they apply to the health plans, not to  
drug manufacturers. So, we have nothing specific in our  
marketing guidelines that would preclude drug manufacturers to  
put out that kind of information.

But, I think that that's really not the way anyone is  
going to go, because once it becomes clear what the formularies  
look like, first of all, the law requires; and we have required  
that every formulary will, in one way or another, cover all  
medically necessary drugs. And, I think, as someone mentioned  
earlier, the formularies tend to be, although there is  
certainly some variation, they tend to be very broad in their  
coverage, so that people will pretty much be able and,  
particularly, with the tools that are available, many of which  
will let a person actually add to the list of medications that

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they take and, then, determine from that which plans, formularies, cover their specific list of medications. I seriously doubt that it would be up to drug manufacturers to need to or want to guide people in that particular way.

**MALE SPEAKER:** I don't have the name in front of me, but, actually, one of the PDPs is a partner with Lackose [misspelled?] Smith Klein [misspelled?]. And it'd be kind of curious as to how that partnership is playing out. So, that's point one. Point two is, sure their pharma companies are going to find a way to market to Seniors, right? The question is who's clever enough to think it up? And, who's going to be making money teaching them how to do that? Consulting firms are generally private, so, there's not a public interest there in that sense. Yeah, so -

**MALE SPEAKER:** I have a question for Abby Block. When you were reviewing the bids, what did the agencies do ensure there wasn't, I guess, predatory pricing that folks weren't low-balling bids to get in? Can you talk a little bit about what standards you use if you require the same profit margins all across the board, that kind of thing?

**ABBY BLOCK:** Well, the Office of the Actuaries and their contractors review the bids extensively and there were no standards per se in terms of standard profit margins across the board. We're not in the business of regulating profit margins. However, the actuaries scrupulously looked at every aspect of

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the bid; and that included, of course, the cost of delivering the service itself, the benefit itself, the administrative cost, and also, the profit.

Those were all components of the bid process. And, every one of those pieces were carefully scrutinized to make sure that they were justifiable and made sense in a business sense. And, when there were questions, and I actually participated in some of those discussions, so, I know first hand that they took place.

When there were questions, the actuaries went back to the bidders and asked for further information, asked for documentation, asked for explanations, and various other pieces of information to make sure that that bid as a package made sense. So, that was basically the approach.

It was not to say we're going to accept profit margins of X-percent period. Not at all. The profit margin is very substantially, but they were all carefully reviewed by the actuaries. And, in the context of those bids and all the circumstances surrounding those bids, they make sense.

**ED HOWARD:** Yes, go ahead Larry.

**LARRY LITMAN:** I'm Larry Littman with Clox [misspelled?] Newspapers. We were talking about confusion earlier. And, the vast amount of information that the [background noise] beneficiaries are going to be receiving, and I'm wondering what is going to be different this go around than

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with the Medicare Drug Card? I think just about everybody in this room who wrote about the Medicare Drug Card heard back from readers saying "We don't understand it. It's so confusing." And, that was a very minor kind of a choice. This has so many more moving parts. What is going to be different? How are beneficiaries going to be assisted in making these comparisons?

[Laughter]

**ABBY BLOCK:** Well, in many, many ways - and thank you, that's a very good question, because it really provides the opportunity to give exactly the information that we would like to give. As you know, the plans will start marketing on October 1. CMS has done a few things leading up to that point. You probably all saw the [background noise] yes, the insert in *Parade Magazine* that appeared last Sunday. And, I actually have a couple of other things with me, if I can dig them out of my brief case. There were a couple of other things. Yeah, this was an important one. This is the "Getting Started" booklet.

**ED HOWARD:** And, there are copies of those available in the back of the room.

**ABBY BLOCK:** Good. So, so far that's what we've done in addition to establishing, as John knows, partnerships with AARP and many, many other organizations throughout the country to assist in this effort. As Leslie mentioned, when she was

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here, there is already a tool up on the web site that lets people go in and do a quick cost estimator and make a determination as to what savings they could achieve, given their prescription drug use and the lowest price plan in their state.

There will be another tool that will be up on the CMS web site beginning October 13. It will be a plan selector tool. And, it has many, many ways in which a person can answer that tool and, based on the key components of cost coverage and convenience, be able to determine which approach is best for them, starting with should they be looking at a Medicare Advantage plan or should they be looking at a stand alone PDP, what prescription drugs they use, what pharmacies they use, and so on.

*The Medicare and You Handbook* is going to be in the mail beginning next week, I believe, and will arrive at the household of every Medicare family in the country. That handbook is very different from what you've seen in previous years. It, again, helps to direct people based on what group they fall into. And, some of those groups were mentioned earlier.

Are you an individual who happens to have coverage through your former employers' plan? Are you a Medicaid dual-eligible? Are you in some other category? And, based on those categories, people will be able to identify themselves and then

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go to the section of the book that really addresses their particular needs and helps them determine how to find the best fit for them.

So, all of the materials, and by the way, the web site is not only available to the public, but there is a special tool very similar to that web site that will be available to customer service representatives. So, if people call 1-800-MEDICARE, they will be walked through that same tool and get specific one-on-one assistance. So, the whole concept here is to focus people to help them figure out what their particular needs are and how they can find the best fit for them.

So, it will be very targeted. There isn't anybody that will need to look at the entire range of plans that are available, because by putting in appropriate information, everyone will be able to select what can best fit their needs.

**ED HOWARD:** John, you [interposing] want to add to that?

**JOHN ROTHER:** Yes. I think we learned a lot from the discount card experience. And, two things in particular: One is we learned that we needed to be on the ground face to face that mass media was not sufficient. And, the second thing is, it was a mistake to, in my view, to say that there's one best plan for you; and that your job is to figure out what best plan that one is out of hundreds of choices.

I want to echo what Alex said. For most Medicare

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beneficiaries, the important message here is to sign up for something, because the plan differences may not be all that great, and particularly for low income Seniors whose benefit is so generous that it really makes almost no difference which plan they choose [misspelled?]. And, in fact, if they apply through their Social Security office and get pre-qualified, they will automatically be assigned a plan, even if they don't choose. And, that's to their great benefit. And, the choice element is still there for them; but the differences are minor compared with the importance of getting signed up.

AARP is, also, putting out lots of publications, including we have our own *Parade Magazine* supplement; and we also have a booklet here that's on the back table. And Cheryl Matthias [misspelled?] of our staff is in charge of our whole outreach effort. Cheryl is here and can answer any questions you have about what we're doing. But, we're making an all-out effort.

**MALE SPEAKER:** Could I just add to that?

**ED HOWARD:** Yes, go ahead.

**MALE SPEAKER:** Actually, I think it's an interesting balancing act. And, I think the discount card ran into this. The people need to know and they need to understand. On the other hand, the more that people know and understand, and the more the media, the more ads, the more brochures, the more books, the more web based tools there are, the more confusing

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it is. And, I think confusion will lead to people not signing up, personally.

So, I mean, to be honest, there are lots of reasons; but, sort of, the notion of how do we inform people and how do we get them in? And, the large amount of confusion that we think is going to be in the marketplace, I mean, in many areas you could have 30, 40 different offerings available. I personally believe that some of the official estimates of enrollment are overly aggressive. And, the confusion out there, at least in the short term, is one of the big reasons why.

And, I think I agree with John, it's going to require getting out there - a real grass roots effort. And, it's not advertising. Maybe, the best advice to Seniors is take a deep breath. Kick back and, then, relax a little bit. And, then, get into it. Gosh, you know, this is a great benefit for low-income Seniors.

[Inaudible] social policy advocate and for other Seniors as well, so, a little confusion doesn't [inaudible] put some numbers on it. There's 566 plan sponsors across all the regions [inaudible] 698 plans. So, sure, there'll be a lot of choices; and over time, we'll see the programs stabilize as well.

The other thing, too, it's a lot more commercial marketing this time. Plans now have real incentive to bring

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people in. That's going to make a big difference over the discount card.

**ED HOWARD:** Howard?

**HOWARD GLECCO:** Howard Glecco with *Business Week*. And, actually, I would just like to follow that up. Marc, you said that you expect that [laughing] you said you expected that participation rates to be lower than some of the official estimates. And, I was going to ask, what people think participation rates will be in 2007? And, also, do you think the risk pool is going to be skewed and we're going to run into the kinds of problems that people are concerned about?

**MARC BENOFF:** Well, rates like 28, 29 million, I think, somewhere in that range. I'll give you my thoughts in 2006. I mean, my personal belief is - and some of this is anecdotally you hear as you, sort of, wander around the pharma industry, is that you might be 20, 22 million people.

It is also my personal belief that in some mid-term, we'll get to that 29 million. I think, and this is a political question, really. I think there's a lot of political clout or capital that's being expended on having this to be a success. And, enrollment is going to be one of the metrics of success. So, I personally think that ultimately, you'll get there; but it's not going to be in the first six months, for a whole host of reasons. The confusion is just one of them.

Another thing, Seniors are sticky, right? It takes

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some of them just a long time to make up their minds. That's another factor [background noise]. The question was asked earlier, will there be a grace period after June? CMS is not one [inaudible]

**ED HOWARD:** Abby, do you want to give us a number that you will consider success at a given point?

**ABBY BLOCK:** No, [laughing] there has been no official estimate from CMS; but the range that we're talking about is certainly the range that we heard. And, I think we'll just all do the very best we can and see what the outcome is.

**MALE SPEAKER:** Well, I'll take a shot. I might get shot doing it. [Laughing]

**ED HOWARD:** Those of you who didn't hear the question, it has to do with whether the risk pool in the first year is going to get skewed.

**MALE SPEAKER:** I mean, my personal belief is that we think that you won't get the 29 million, that you'll get some lower number. Then, it almost will mathematically be skewed, because you'll have all the dual-eligibles in. So, [background noise] my belief is initially, anyway, it will be skewed.

**MALE SPEAKER:** Okay, let's ask who's going to be in the pool? Look at some numbers here. They're going to count 11 million in retired employees; and I assume that any company that's smart enough to have an employee retiree benefit plan will be picking up the subsidy - it's 11 million. Okay, we've

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got 6.5 million Medicaid dual-eligibles, right, 17.5. You get a little extra money for those guys. I think you get a 1.05-percent premium in addition to your risk adjustment, in addition to - so, if you have a good actuary, your bookies are pretty good, that should be a pretty attractive piece of business, particularly if you're a lower bidder. And then, you pick up the healthier Senior on the other end. So, you got low bid, picking up your new eligibles; on the other side, you - the place you make money in this benefit is people who don't use drugs, and that's where the real money is.

Okay, so up to 17.5. The health plans. There's 5 million people in health plans. I think we're going to see a strong push to get those guys in. That's 22.5 million. Okay, the other kind of rich pool here, I think, the easy reach is the MediGap. People have been buying MediGap all this time. These are people who will probably go out and look for those drug benefits, right? They've been well-composed, about 6 million people. If your 28, 29 million, without a whole lot of stretch.

Remember, the original estimates are 37 million. That does seem pretty optimistic. I don't know, do we have "pay for performance" for the actuary's office at CMS? [Laughing]

**MALE SPEAKER:** Well, we have an office pool about whether CMS or the Hickfa [misspelled?] actuary was more on the mark. Yeah, I think my concern is the tools being offered,

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calculators, and such, are biased, and biased toward immediate consumption based decisions. This is an insurance benefit that people need to think about long-term, because of the late enrollment penalty; it's the peace of mind factor that's the intangible.

And, the more we emphasize the calculators and you're deciding whether or not to sign up based on your current level of expenses, the more, then, we're pushing risk selection in the plans. And, I have a very great concern that that's going to be the emphasis; and that's the easy thing to do. And, that's what people do when they're unprompted anyway. And so, unless all of us together are stressing the insurance nature of this benefit, we could well see some skewing of who comes in, maybe, more than anticipated.

**ABBY BLOCK:** This one thing I'd like to add, the focus of the discussion is on the PDP, the Part D program. But, what you'll see and what we've already seen in 2005, and certainly moving into 2006, is an enormous increase in the number of Medicare Advantage plans with prescription drug benefits that will be available in geographic areas that we've never seen before, a lot of movement into rural areas, which we think is an enormous achievement, the new regional PPO product, which came about through the MMA and we will be seeing regional PPOs, as we said in our release last week, in 37 states, which is a lot more than many predicted.

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So, I think that we're going to see growth in that area as well. And, that growth, of course, will include the prescription drug benefit.

**MALE SPEAKER:** Thank you. I have a very simple, kind of, real world question. I'm taking a few drugs. My understanding is that if I call up a plan and say "I'm taking drugs A, B, C, and D," I can ask them, "Do you cover these drugs? And, how much will I have to pay for them?" Likewise, it's my understanding that if I call a plan and they'll have a web site with that kind of information; and they can refer me to that. If I call a plan and say, "I'd like to get a paper copy of the list of the drugs you cover, and how much I'd pay for each one?" Am I entitled to that if the first two other options are not satisfactory to me?

**ABBY BLOCK:** Paper formula, paper copies of the formularies available - they're probably going to look something like telephone books. So, I'm not sure how useful they'll be to most people, the electronic versions and the telephone versions probably are more practical; but yes, anybody that requests the paper copy of a plan can get one.

**MALE SPEAKER:** With prices.

**ABBY BLOCK:** I'm not sure. I believe with prices; but I'm really not positive.

**MALE SPEAKER:** I would expect it wouldn't be prices, but rather patient out-of-pocket costs, right?

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**MALE SPEAKER:** Right.

**ED HOWARD:** Yes, go ahead.

**IRV CHAPMAN:** With several references to retirees who are lucky enough - [interposing]

**ED HOWARD:** You want to identify yourself?

**IRV CHAPMAN:** I'm Irv [misspelled?] Chapman, Bloomberg [misspelled?] Radio - retirees who are lucky enough to continue to get health care. But, some people at the table are pressing for the people who care to work past the age of normal retirement. But, when they retire, they will lose their medical benefits. What is the place for them in the plans that you are discussing? What should they be doing?

**MALE SPEAKER:** This is for people who work past the age of 65, presumably covered by their employer plan.

**MALE SPEAKER:** Yeah, so they have credible coverage and they can go in without penalty. Yes, as long as the coverage is creditable.

**DEBRA GRAY:** Hi, I'm Debra Gray, with Gannett News Service. Just a follow up on Larry's question. John, you pointed out that, even with Social Security, there was a lack of response to those forms. So, how do you tap into or how do you reach out to that market, the minorities in particular, or the real low income - who, how do we respond? It's beyond the web sites and all of those things that they probably don't have access to, how do you reach that group and really bring -

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[interposing]?

**JOHN ROTHER:** Well, there's no one answer to that question. We're part of a coalition called The Access, The Benefits Coalition, that's funding community level grass roots groups, especially in minority communities and low income communities around the country to do this. But, it's also the case that non-traditional marketing is going to be a big factor, and maybe a new factor in this story. Church groups, viro-marketing on -

But, I think, ultimately, it's going to end up being face to face. And, whoever is a student of marketing could probably write a whole textbook, when this is over; because, the stories I'm hearing from some of the plans is they're really pulling ideas off the shelf that have never been tried before to reach this population, particularly the low income population.

**MALE SPEAKER:** Well, I would say that there are, sort of, analogues [misspelled?] here to learn from in the late '90s a number of states and parts of states which to manage Medicaid programs, you know, I'm from Philadelphia; and there was a big switch and there was a huge effort to reach out to those communities and get them in. So, I would just imagine that there are plenty of lessons to be learned; and it's not necessarily re-inventing the wheel, It's trying to take the wheel and sort of tweak it some just, particularly, to reach

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out to those -

**ED HOWARD:** We don't want to impose on your time. We're somewhat beyond what we said we were going to keep you. We can take, maybe, two more questions. And, folks have to leave can leave; and, maybe, some of the speakers can stay and follow up. Yes, you have [interposing] a question.

**KATE TRAINER:** Kate Trainer, with the American Journal of Health System Pharmacy. We all know that the dual-eligibles are going to be auto-enrolled in the next few weeks. My question is, what about the duals who are in nursing homes? What advice do you have for the nursing homes, as far as giving patients and their families information about what plan to enroll in, without triggering conflict of interest, especially since nursing homes don't want to use a lot of different pharmacies? They typically just contract with one.

**ABBY BLOCK:** Well, we have met repeatedly with representatives of the nursing home industry. They, of course have a lot questions along the same lines as the question that you're asking. What we're trying to do is ensure that every long-term care pharmacy, that the nursing homes are currently dealing with, and others that want to enter this market, are actually contracting with every PDP in that region. So, that regardless of what plan nursing home enrollees - nursing home residents end up in the pharmacy, that the nursing home deals with, will be available through that plan.

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And, that's the mechanism that we've worked out, so far. And, we anticipate that that will be effective in just ensuring that regardless of what plan individual residents are in, including the ones that are auto-enrolled, that they will have - will continue to have access to prescription drugs in their nursing homes.

**MALE SPEAKER:** Yes, we have one, maybe, this, sort of, Carnack [misspelled?] like the last question.

**SHAWN MUSSEN:** Shawn Mussen, [misspelled?] *Media General Newspapers*. This question is for Abby. You mentioned that the profit margins for the companies that are offering the PDPs are - they vary. I'm wondering if you can give us a range of what you're saying, maybe a low and a high or an average or something like that?

**ABBY BLOCK:** I really can't, off the top of my head; I don't have that data available.

**MALE SPEAKER:** What will be meaningful is the loss ratios, based on years' worth of experience. I don't know what actuaries, I guess, today will tell you, except that they're different actuaries. But, after we actually have a year's worth of experience and see how efficient the plans have been, then I think it's going to be a much more interesting question.

**ED HOWARD:** Okay. We have far - not far exceeded, we've slightly run over [laughs] time. But, the questions have been insightful [misspelled?] and the answers have been quite

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useful. I want to thank all of you for being here. And, I also want to thank our speakers for really responding and giving you, I hope, a bunch of story ideas. Let me reintegrate Bill Irwin, on our staff, is here to help you. Thanks for coming [interposing]. And, we'll see you next month at the Hill Briefing. [Laughing] Yes.

[END RECORDING]