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Forum on Medicare Drug Benefit's Early Progress
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DIANE ROWLAND, Sc.D.: Good morning and welcome to the Kaiser Family Foundation Barbara Jordan Conference Center for this forum discussion on the implementation of the Medicare drug benefit. I am Diane Rowland, the executive vice president of the foundation, and we are really pleased to have you all here this morning for what is not a usual Kaiser briefing where we release a new survey or provide a new set of analyses. This one is a briefing intended to really let us share with some of the people who are implementing the new drug benefit as well as those on the ground trying to connect beneficiaries to their coverage, what some of the issues have been in the first month as this new benefit is launched.

We see and have data, thanks to the centers for Medicare and Medicaid services, that we can look at in terms of how many people have credible drug coverage, how many of those individuals are being covered under the stand alone plans versus under retiree and advantage plans, and today they are reporting 23.7 million with credible coverage. That is about 55-percent of all Medicare beneficiaries, but I think it is worth noting that 5.6 million of those are the duel eligibles whose coverage was transitioned from Medicaid to Medicare, and we will hear more about some of the issues facing that population. Another 5 million were already enrolled in Medicare advantage plans, many of which had their drug coverage through those plans prior to January, and 9.5 million came from both retirees in the federal government and in the private sector, leaving about 3.5 million to have joined the stand alone plans that have been much the focus of the reporting and the discussion in recent days. That leaves about 45-percent of the medicare population out there to be feature enrollees in these plans and so today's discussion is really going to focus on how the program has moved so far, and where it is moving in the future.

I am really delighted that we have an incredible range of perspectives to share with you this morning. We are delighted to have Leslie Norwalk, the deputy administrator of the Centers for Medicare & Medicaid Services, with us, and obviously Leslie has been dealing daily and probably 24 hours a day with the implementation issues around this plan. We are going to turn from our discussion of how the plan is being implemented to ask Karen Ignagni, president and CEO of America's Health Insurance Plans, to talk about the plan's perspective on the implementation and to Barbara Edwards, who is the former director of the Ohio Medicaid program, to put some of the issues for the duel eligible population in perspective. We have also been fortunate to have Debbie Garza, the director at the Walgreen Company of their pharmaceutical programs, to be with us as well as Barbara

Kennelly, president and CEO of the National Committee to Preserve Social Security and Medicare, and Vicki Gottlich, a senior policy attorney with the Center for Medicare Advocacy. Each of these individuals is able to give us a different perspective and different insights into how we are fairing so far in month one of the new Medicare drug benefit. But I would like to kick off our panel by turning first to Leslie and asking her to give us some of her perspectives on what has worked, what hasn't worked, and where you are going in the future.

LESLIE NORWALK, J.D.: Thanks, Diane. So, we have some good news and some bad news. The good news is, as I mentioned we have 24 million or so medicare beneficiaries with creditable coverage that is critically important, and we look forward to having more and more of them sign up every day. One statistic I find particularly interesting is over 1.5 million of the 3.5 or so that you mentioned, Diane, actually have signed up over the Internet. In spite of the concerns we heard that people don't use it, apparently many do or at least in some way, shape, or form perhaps, our partners in the ships for example, may use the Internet to sign people up and that is terrific.

Over a million scripts a day are being filled so many medicare beneficiaries are in fact getting the drugs they need. We hear stories on a regular basis how they are saving in some instances thousands of dollars and are very relieved to have the coverage that they so desperately needed for a long time. That is the good news. The bad news is that there are some glitches in the system and in particular, I think you can categorize them in a couple of different ways. The first is that medicare beneficiaries who are duel eligible who were automatically enrolled, most of them are getting the coverage that they need, but there are many that were switched at some point in time from the plan in which we automatically enrolled them in the late fall, November or so of last year. They switched plans as is their right to do to a plan that may better suit their needs from a formulary perspective, but in that switch while they may have been enrolled in the correct plan at the end of the day, the new plan may not have had the information that they needed to have in order to correctly determine their limited income subsidy amount which is to say what their copayment would be, and so many have showed up at a pharmacy and the pharmacist has asked them to pay $250 dollars in a deductible and so forth which can, certainly if you are duel eligible, give you great pause and it concerns us that if any one individual is being asked to pay more than they should, so we are spending lots of time internally working with all of our partners and I think almost everyone at the table qualifies because we like to hear specifics from everyone, from the advocacy groups, the beneficiaries themselves, the pharmacies, the plans, and so forth, so that we can diagnosis whatever the particular issue may be and solve it so that beneficiaries get the drugs they need. If one beneficiary can't get the drugs they need, that is certainly one too many, so I can assure you that all of us are spending morning, noon, and night, all day, all week long, to solve this problem and won't stop until we do.

The second issue is beneficiaries getting their card, or at least a letter with their member number on it. Currently how it is structured is that beneficiaries who sign up, for example, on January 31st have coverage on February 1st. Certainly it would be difficult for them to get their card overnight, and is not what happens actually anywhere, so from an expectation perspective, we just need to be sure that beneficiaries understand that the later they sign up in the month, the more difficult it may be when they first show up at the pharmacy and we found that transactions go much more smoothly, in fact we haven't seen very many issues if someone comes in with their drug card to the pharmacy, and so we are hopeful that in fairly short order, as those are distributed more widely, that these issues will become less and less, but we certainly appreciate each and every individual and all the varying constituencies who have helped us diagnose what these issues are and solve these problems so that beneficiaries can get the drugs that they need and that we can fill far more than a million scripts a day. Thank you.

DIANE ROWLAND, Sc.D.: Thank you, Leslie, and I know Karen that you have been experiencing some glitches as well as I hope some successes along the way, so why don't you share with us some of the implementation issues you've been facing?

KAREN IGNAGNI: Thank you, Diane. I am also very pleased to join this distinguished panel and look forward to the discussion. I would like to begin with basically two points. One, I think that it has become axiomatic but it's worth underlying the point that you made earlier, Diane, in your introduction. I think if we look back two years ago, no one would have expected that toward the end of the first month of this program that 55-percent of beneficiaries would be in the program, so I think that is first of all a major accomplishment, and it is a credit to CMS and the states and a range of individuals that have worked hard to make that possible. Second, and we know a number of those individuals by the way did not have prescription drug coverage before hand and a number of them now are getting subsidies that they never had, so that is a positive. Second, in the market, I think no one would have expected the pricing that's in the market in terms of premiums, in terms of deductibles, in terms of coverage in the gap, in the donut, whatever term you are most comfortable using, so I think our plans have exceeded expectations, so those are the positives I see, enduring positives from the perspective of the beneficiary, and advocacy groups who quite rightly concerned about those populations that have been historically underserved.

In terms of the challenges, they are threefold as we see them. First, I want to applaud CMS for issuing on Friday the 13th some additional guidance with respect to the transition. We have maybe quite surprisingly for some, we welcome that guidance. Everyone is aware that there are system challenges. We are working, I want to assure everybody, 24/7 with CMS that is also working 24/7 to bring in the best private sector experts to get the systems issues resolved. In issuing the guidance to give us some specific directions about what to do in terms of walk arounds or bridges until these systems issues can be addressed. It allowed our plans to very specifically target their efforts to deal with the challenges of the duel-eligible to make sure they don't leave the pharmacy without a prescription and also to smooth out the transition for people who have heretofore not had coverage, that is the 30 day transition, prior off, etc., so working very hard, CMS did something very important.

Also, I want to make sure, Diane, that I make it very clear from our plans perspective, we intend to make state toll. We appreciate he fact that states have intervened, have tried to help, again smooth away for the dually eligible and for the low income population. We intend to reimburse the buy down on the co-pay and we will reimburse for our contractual amounts in terms of the prescription drugs, and we have been trying to send that message very loud and clear.

Going forward, we are going to continue to work together with CMS. We think that more ground can be covered in terms of the systems issues, and again I want to applaud CMS for the time and attention they are putting on this issue, and together with our plans I am convinced that the data transition issues will be resolved in the very near future, which I know will be a very helpful thing from a pharmacy perspective, from an advocacy perspective, etc., so we are pleased to be at this point now with so many people in the program to be at this point now to have the opportunity to clearly communicate our commitment of making sure these beneficiaries are very appropriately and effectively served, so you will be hearing a lot of that from our plans and I am looking forward to the discussion.

DIANE ROWLAND, Sc.D.: Karen, from the perspective of the plans, we see that a lot of the enrollment has been concentrated in a few plans and wonder whether that has some implications or do you think there will be as many choices and as many plans down the road, or is this part of the shake out here?

KAREN IGNAGNI: Well, I think that is a very good question. We hear from all of our plans, so I think that we have a very good on the ground view. The press has covered some of the larger plans and the involvement and that is certainly very good news to track that. On the other hand, we are also hearing daily from our regional plans and our local plans, and there is very good news on that front as well. I think that is a positive, so I am convinced that beneficiaries will have a spectrum of choices, whether they have exactly the same numbers in the future as they do now, I think everyone expects that over time there may be in particularly on the prescription drug only side, and there may be some shaking out. There may be some entities there that are now finding that they didn’t have experience with government contracting. All of our health plans that have been on that side had experience in government contracting and will continue to be there and have joined this program on both sides with the intention of being there for the long haul. In addition, we have some wonderfully innovative programs for the frail elderly, some of the demonstration authority that CMS has allowed doing very innovative things on disease management, which I think also provide a lot of core capacity, not only on the medicare vantage side, but also in the future for the service side, so I think we can attribute more there.

DIANE ROWLAND, Sc.D.: And Barbara, obviously the frail elderly have been an issue with regard to the medicaid program and as we have heard, many of the glitches occurred among the duel populations, can you sort of give us some perspectives from your post until November as the head of Ohio's medicaid program?

BARBARA COULTER EDWARDS: I had the opportunity to be involved with the national association of state medicaid directors and some of the advising around how this program might work with regard to the duels, and I know that unfortunately, much of what happened with the duel population was predictable and was predicted, and despite a great deal of effort by CMS, because I want to be clear. I think states recognize that CMS worked very hard on these issues, that any kind of a massive movement of 6 million people on one day that happened to be a Sunday and a holiday weekend was not a good idea. It was a holiday for physicians, and that is part of the problem, so this was not a good plan from the day it started to move all of those people in one day, and in fact the state's number one recommendation was that it ought to be phased in for the duels, and in fact I guess I would just like to say and then I will get off that, is that I was figuring this out. States have in combination about 2,000 years of experience in running health plans, and during that 2,000 years, we have probably made every mistake that is possible to make, and our best advice was this kind of a significant change, because this is a population of very frail people, very dependent on medication, who already had coverage, to be transitioned in to a new plan is best done in a planned, phased in methodology where you can work out the inevitable data problems and get them working before you move the bulk of people in, so having said that, I recognize CMS didn't believe that was an option. I think that states have done a yeoman's job at trying to step in to fill in the holes when it became obvious they weren't going to be able to get fixed fast enough in that initial system [inaudible]. There is still a lot of confusion among the consumers, but clearly everybody is working very hard to try to retrofit some of these issues. I think that what I would like to stress is that states generally feel relieved. I believe that CMS has said we will make you whole. I think if you look at the process that is being proposed to do that, it's enormously complex. There is going to be a ton of work behind the scenes to try to get those reconciliations to work because none of these data systems were set up to do this kind of retrospective matching, what states are paying to the pharmacists where they have had to step in is not what the plans have negotiated, so there is going to be a lot of unmatched payments to claims and very difficult record keeping that has got to be reconciled, so that is just yet another challenge in the future, but I think it is absolutely the right step that CMS has said we recognize states need to be made whole, and to recognize there are administrative costs involved in that, so I think that is a good thing. What I would like to stress as well from a state perspective and from a consumer perspective is that for the duels, there is still a challenge ahead, and that is actually finishing a successful transition into new formularies. The transition period was supposed to provide people with a period of safety in there where they could get their old prescription filled and there was a difference between the old formulary and the new formulary and then work through the process of either successfully transitioning to that new medicine, or getting an exception made in the process. That process is just beginning for a lot of folks and is largely untested, so again I think there still are some really important system challenges ahead and consumers are going to continue to need some support as they move through that because physicians continue to not be real clear on this, pharmacists are still going to have those challenges. The plans themselves, as we have learned, may or may not all understand the process equally, and whether the systems will support it accurately is still a good question, so there are still some challenges out there and it is very clear that everybody is working very hard on this and that is good. I hope we learn some bigger lessons from it as well, that we don't repeat what is not necessary about a process being this difficult.

DIANE ROWLAND, Sc.D.: Vicki, what are you learning on the ground from the consumers you are dealing with?

VICKI GOTTLICH: Well, in addition to the consumers that I generally hear from, and the advocates I generally hear from, this week I had the opportunity to do three web based trainings for members of the access to benefits coalition, and these are really the on the ground folks, these are the ships, these are the social service agencies who are working with actual individuals, and what I can say is that they are still very frustrated. In fact, somebody on our call yesterday was in tears because she was just so tired and I had explained the exceptions process and she just kind of threw her hands up, even though she was in Oregon and I couldn't see her [laughter], but you can hear it in her voice, and we applaud, like everybody else, the heroic efforts that CMS has been undertaking to get this program started, and everybody on the calls and everyone that we have spoken to applauds those efforts, but yet we still hear from people who say I've been working with my regional office and I have been working with my health plan, and they told me that this person would be able to go to the pharmacy and get her drugs and guess what? She went to the pharmacy and it still wasn't in the system and she still couldn't get her drugs, and one person said on a call on Tuesday that she called back the person in the regional office at CMS and that person was stymied as well, because he had done everything that he could, the plan had done everything that the plan could, and they couldn't figure out why the system wasn't working. So, hours between CMS, the plan, the advocates were spent, and yet this one person was not able to get her drugs. And we are concerned that the system is really complicated, and there are systemic problems that will be ongoing. I was really glad that Leslie raised the issue about what happens to people who enroll on January 31st, because we are starting to get those questions. We are hearing from advocates across the country that about 60-percent of the duels they see are in plans that don't cover all of their drugs, and so I am starting to get questions from people who say to me if my client changes to a different drug plan on January 26th, will they be able to get drug coverage under their new plan on February 1st, and we don't know what the answer to that will be. I mean, clearly that individual is going to have drug coverage because the individual has been automatically enrolled in a plan, but will they be covered under the new plan that covers all of their drugs? We don't know.

The other problem that question raises is something that Barbara touched on, and that is the whole issue of exceptions. During the transition, as Barbara said, you are supposed to either change your drug or apply for an exception, and yet these advocates who I speak with routinely have not thought about applying for exceptions rather than changing plans for their clients, and the exceptions process if it works can actually work much faster and they may be able to get an answer within 72 hours or 24 hours or even a shorter period of time, and so they don't need to clog the system, but it seems to me that the information about exceptions not getting forward to beneficiaries and their advocates, part of the problem is system and that is most of the information is going to be included in the evidence of coverage. People haven't gotten their evidence of coverage yet, and in fact CMS recently extended the date in which people can get their evidence of coverage, and we know when we change health plans you don't get your evidence of coverage on the same day.

There are notice issues as well. The system as designed places the burden on the beneficiary or on the doctor, and we are hearing that this can be very problematic. I spent yesterday trying to find prior authorization forms on websites for certain plans. I couldn't find them. One of our paralegals actually called the plan who dug very deep and found the sites so she could send it back to me so now I have the web link for those prior authorizations. That is a pretty difficult process for people as well. Another problem that we are hearing is still a problem with the copayments, and there is information about copayments. Some advocates said that they heard cries of help actually from a plan that said we still don't have the information telling us whether somebody is paying one in three or two in five, and everybody was sharing the same pain and the same frustration.

The other issue that we are starting to hear is the issue of people who newly become dually eligible for medicare and medicaid, and what we are starting to hear are problems for people who became eligible for medicare in the month of January. These people lost their medicaid drug coverage, but they have not been automatically enrolled in a plan yet, so some of these folks, because they are not in the computer systems, have no drug coverage at this time, so there is a lapse in time for which these people may or may not have any drug coverage. The well point point of service option should be able to assist these people if they can show that they have medicare and medicaid, but again this is an issue that needs to be addressed.

The final issue that I want to raise for beneficiaries is the issue of reimbursement. In the first few weeks of this month, there were beneficiaries who are eligible for the low income subsidy or duals who ended up paying $250 deductibles, paying full freight for drugs, paying for higher copayments than they should be required to pay, and these individuals could really use reimbursement, they could use a simple system for reimbursement. Clearly, under the rules of the plan, if you pay for your drug you can submit your receipt to the drug plan. People aren't aware of how that works. A lot of these people don't have receipts, which means they are going to have to go back to the pharmacy who is already beleaguered, to try and get copies of their receipt, so we are hoping that CMS and the plans could come up with a system that would reimburse people easily to make them whole.

DIANE ROWLAND, Sc.D.: From the perspective of the pharmacy, Debbie, why don't you share with us what you are seeing at the counter?

DEBRA B. GARZA, R.Ph.: I think everyone has some snapshot of what is happening at the pharmacy counter, having either experienced it or seen it on the news or read it in the paper, and as you know the pharmacy is definitely where the rubber hits the road in this program. There have been glitches, and when you multiply those glitches by the sheer volume of people coming into this program and the sheer size of the program coupled with it starting at the first of the year when we have typical employer group plans that change anyway, that tends to get amplified and magnified from that perspective. From a pharmacists' perspective, we definitely want people to get their medications. It's in our best interest, it is what we do. We as health care providers have the utmost concerns for patients and we try to do everything we possibly can to take care of them and make sure they do not walk away without getting their needed medication. And pharmacists have stepped up to the plate to handle a lot of these administrative burdens that were more prevalent early on and it's been worked out, as Leslie and others have addressed. There has been fixes that have occurred, and there will be continued fixes so we will continue to see improvements along the way, but I guess to look at what we have experienced thus far, I would step back and kind of put it in three broad categories, and one being from the eligibility perspective, one from the co-pay perspective, and one from the covered drug perspective, and to understand what happened and what happens at a pharmacy counter, you kind of need to understand the world in which pharmacists operate. We operate online, real time, processing prescription claims, we count on it for [inaudible] we get back from plans to know how to help patients, what to charge patients, etc., and a lot of that, when you are really talking about our dependence on insurance cards to identify the eligibility of patients in the programs, and when you are looking at the masses of folks who don't have these cards, it becomes problematic and CMS has done a great job setting up their system. It's a super concept. A true facilitator. It's fantastic. When it works, it's a beautiful thing [laughter] but you have to have the information in the system to back up the technology, and that is where CMS has been very responsive and is now working with others, outside groups as well as the plans, to get the information so that we can more real time provide eligibility information for the patients to know what to do and how to process patients' prescriptions.

Then when you talk about, and excuse me let me step back, and when you talk about the eligibility concern, that is where you run in to having to make calls to the plans and experiencing a long hold time with the plans because again the sheer volume and how many calls that are being made, and everyone has stepped up to address that with regards to plans adding more folks as their help desk as well as CMS adding more people so that we really can get information and do our best to take care of these people at point of sale.

And then when you talk about co-pays, that has been one of our largest challenges, particularly with regards to the low income subsidy people and those that should be paying $2 and $5 dollars [inaudible] $3 dollars, many times people have letters from the plans that state what their copay should be so that when they then walk into the pharmacy and we go to process that prescription, in our world again, everything done electronically, we process the prescriptions, we expect to get a message back that adjudicates what the patient should pay, and many times the correct information is not in the system with regards to accurate co-pays, etc., and that is where as pharmacists we have tried to make phone calls to plans to find out what is the correct copay as such that we have it over-written at the time the patient is standing in front of us or we decided to give the patients a few days supply of medication so that they can come back and we can get it worked out, or we have gone ahead and decided to give it to them at that copay and we will deal with getting it back from the plans at a later date. Lastly, when you talk about the covered drugs, there is a challenge of course, as we all know there are particular drugs that Medicare Part-D does not cover, which are some very common drugs used in the [inaudible] population, your anxiety medications, or medications for seizures and such, so in that scenario, what could help is to have more consistent standard messaging from plans whenever we get a message back that says "drug not covered," is it really drug not covered, or is it because the drug is not a formulary? And that, pharmacists, what they get back with the message from plans, know what steps to take next and if we see a drug not covered, we will then know most states have stepped in to pick up some of these medications and we will know to bill that state, or if we get [inaudible] formulary, we then know to call the physicians, call the plan, or to find out what the plan is doing for the transitional part for that 14 day of coverage or what not, so I think that there has been some great steps made in terms of really kind of now talking about these things, [inaudible] out and making everyone aware of what happened and all the partners involved here, and pharmacists from learned from January 1st to now what types of steps and processes it takes so I would definitely have to say the bottom line, we have a vested interest [inaudible] support, it is important for us to take care of these patients and we want to capture the senior business, capture these folks that maybe have gone off to Canada or just never gotten their prescriptions because they could not afford to, so bottom line it's a great program. We are here to do what we can to make it work and serve our customers, and we are excited that we do have partners [inaudible] advocates willing to all come to the table, work together, so that we can take care of the people who are staring at us, standing in front of us at the pharmacy counters each day, and really the pharmacists in the trenches are the true "unsung heroes" on the back end, trying to burden a lot of this and they are doing a great job taking care of the patients that we have taken care of thus far.

DIANE ROWLAND, Sc.D.: Thank you. Debra, do you feel like the pharmacists are over burdened by their need to match people with the plans? Also, is that taking away from some of the counseling they might be doing about alternative generic drugs to some of what is being covered and some of the other patient education that has been increasingly a role we have asked pharmacists to play?

DEBRA B. GARZA, R.Ph.: As a pharmacist, I could not sit in front of you with a straight face and not say that pharmacists have not been over-burdened by this. Yes, as I said, just from the sheer volume coming at a time when we have changes, it has been burdensome. There has been a lot of confusion amongst seniors and we have been very active in communities, as have many other pharmacy groups as well as advocacy groups [inaudible] everyone trying to educate people to help with the educational process, but we all know the pharmacists [inaudible] as a question, and so it has taken us away from some of the other time we would spend for other customers, but by the same token I think that many of our other customers have parents and grandparents and seniors, so there tends to be an understanding that this is a great new program out there and there are going to be some of these transitional issues we've got to get past, and so for the most part it's worked well and the folks have understood. Our patients have been rather patient and allowed us to spend the extra time [inaudible].

DIANE ROWLAND, Sc.D.: I think the point is that most of the people on this panel haven't been doing much sleeping for the last few months, but Barbara Kennelly, perhaps you could share with us from the consumer's perspective some of the challenges and some of the successes here.

BARBARA KENNELLY: Having just come off the White House conference as a policy member and being a chair of the leadership council on aging organization, so I have been hearing an awful lot, but I am speaking now as president of the national committee to preserve social security and medicare, it's a large organization, 4.6 million members and supporters across the country, and all we really do is address medicare and social security and the preservation of these programs. We just, and this couldn't be a more perfect time, Diane, because we just did our annual survey and we had our focus groups, and we could have saved a lot of money because what we heard and what we paid for is exactly what the national polls are showing. Our members feel that the program is complicated. It is expensive, and it often doesn't meet their needs, and I have to be honest with you, many of our members are a little above the older senior income level, and many of them do have coverage under their former job. Diane asked me to give examples of what our members are saying to us, and we have ten people on the phone all day, and our members are retired, so obviously they have a lot of time to call. [Laughter] I could keep you here all day telling you what we are hearing, and they are very sad stories. We have got the member who went to the pharmacy five days in a row for seizure drugs, and eventually she did have a seizure and ended up in the hospital, and I could go on and on, and I'm not going to because we all know it's been very difficult the last weeks and yesterday we had a shift person come in to the office because many of our members in the Washington area want to learn more about it so they can help their friends and neighbors get what they have to get, and the shift person, I have to tell you, was absolutely wonderful and absolutely exhausting. She has been working night and day. We know that these problems are going to be addressed, and I want to add my voice to the CMS that they have been doing a huge job in hiring new people to help with this situation and you know, some of the problems should not have been unperceived. They should not have, I mean, nobody knew how many people would sign up, but we all knew there were 6.2 million duals, and the fact of the matter that they were not prepared for that, I really find was a disgrace because if you're a dual, you are the most needy, and they shouldn't have had to go through what they went through, but there will be bills, and there already are bills. Senator Rockefeller has introduced a very broad bill to address some of these situations. There will be bills to maybe put the penalty off. Obviously, our president has already said that the federal government will reimburse the states and what I want to see, and I know these are health care people in this audience, what I want to see is this implementation debacle is just the top of the iceberg, just the top of the iceberg. These horror stories are going to fade away. A mechanism will be in place, and what I don't want to see happen is proponents of this legislation. I don't want to see them pat themselves on the back and say well everything is okay. This is simply not the case. There are fundamental problems behind this legislation, and these problems are not going to go away. Some of them aren't so dramatic. Our seniors don't know yet that the companies can change their formulary repeatedly, and they can only do it once a year, but what I really worry about is there is absolutely no cost containment in this bill, and maybe the donut hole [inaudible] can become a cliché, and maybe it looks benign, but if you are on a fixed income and that donut hole is going to become wider, it's going to hurt seniors. There is no doubt about it, but the problem is down the line this is really the privatization of medicare, and what I worry about are not hiccups in implementing a new program. These are fundamental flaws in the bills designed, and they are not going to go away, and when I think about it, I think we are going to hear a lot about health care, particularly next week in the state of the union message. We are constantly hearing that our entitlements are costing much too much money, and yet when congress and the president had the opportunity to create a new benefit, they were happy to give the money, the subsidy, the billions of dollars to private companies rather than create a simpler and most cost effective program within medicare.

I had the opportunity a couple of days ago to go out and talk with Bob Ball for a couple of hours, because I am fascinated with the whole history of the entitlements, and I said to Bob, what happened in 1965 when medicare came to be? Was there this confusion? Because I've heard some people say any big program, there will be massive confusion. There was no confusion because they had the social security records and the only question when somebody was going to go into medicare was do you want to go in, yes? Or you don't want to go in, no? And the next step was they followed up on the no's to tell them why maybe they should go in, and the program went on, and so I think the complications, I'm delighted that seniors have a new sport figuring out where they should go. [Laughter] It's keeping them all very, very busy, but I think down the line this is very worrisome, and I'll say something personal, as a member of congress for years, I represent Hartford, Connecticut. I understand insurance. When I hear well point, and I hear Aetna and Cigna, you know, things go on in my head and when you look at what happened and why is there so much of this confusion, and Senator Baucus sent a letter to the president, or whoever he sent the letter to, CMS probably, and by the way I think CMS is wonderful. I will never forgive Tom Skelly, never. [Laughter] Absolutely not! But anyway, Senator Baucus said he never thought when he was doing the legislation that anybody who said oh, I want to provide a prescription drug help or program that they would just be accepted. There are just too many, and I think what will happen is, as the program goes on, the big companies will make a profit and slowly but surely we will lose the smaller companies, but the big companies, even with the subsidy from the government, those billions of dollars, the big companies are only making about 3 or 4-percent profit, and I just want to say something. We know we have to have the healthier people come in to make this program work, and a lot of them have not signed up because they figure [inaudible] medication, but they eventually will sign up because as I said, this has become a sport of the seniors, but what is going to happen, and I think all of us should know, seniors, and I'm one, seniors get older, and as seniors get older, they need more medication, and the profit level will get smaller, and then what happens? So, I say to some of you, don't get totally wrapped up in the little bitty things, or the legislative changes that just address a few things, let some of us continue to say that we should have drug availability for seniors as part of medicare, and I'm not going to bore you all because you all know about it because right now people say oh, we want the government to negotiate like the veteran's program, we have no negotiating ability. Everybody is in a private plan. If we had a piece of medicare, being Part-D, and people wanted to go into that plan, then the government could negotiate the lower prices, so there is a lot to be done, and I just hope that we don't all get so involved in the nitty-gritty, we don't look that this is one more absolute plan to privatize the government program.

DIANE ROWLAND, Sc.D.: Thank you, Barbara. Leslie. [Laughter]

LESLIE NORWALK, J.D.: I'm going to leave that comment about Tom Skelly [inaudible – laughter].

BARBARA KENNELLEY: I've known him for years!

DIANE ROWLAND, Sc.D.: But maybe you could reflect a little on what you see are the transitional issues vs. some of the longer term issues.

LESLIE NORWALK, J.D.: Absolutely. I am relieved to know that people here at least have confidence that CMS is working diligently to resolve these problems and appreciate all the comments that folks have made because we are only going to solve them if we do it together, and that has been our approach thus far. I think the transitional issues will ultimately go away. We will figure out the computer systems and people will get the drugs they need in the way they are supposed to. Hopefully we can figure out a way that in working with the pharmacies, one of the things that Debbie mentioned was when you show, if you don't have a card, what happens with the pharmacy in having to call around and we set up a system, a real time system, so that pharmacists could determine even when someone didn't have a card, they can walk in to the pharmacy and figure out what plan someone is in so they don't have to call however many plans there are in that particular state to find out what the individual and where the individual should be getting coverage, and when that works, it works under a second, and that is fantastic. So, a lot of that should, even if someone doesn't have a card, we expect that those problems will diminish rapidly and we have seen that in fact already over the past number of weeks.

There are a number of things that Barbara mentioned that I wanted to talk about, and I actually think everyone here at least had one or two things where we can go back to CMS and provide additional information, whether it's the exceptions process, whether it is the drugs that aren't covered under the Medicare program, where we can provide information to pharmacists and beneficiaries about where that coverage may be, particularly if it's under medicaid. Benzodiazepines and barbiturates, for example, so there are a lot of good ideas here that I am grateful to bring back and start working on so we can reduce those particular problems.

As for the longer term issues, I have a slight or perhaps a great difference of opinion from our last speaker, although this is not the first time I have heard these concerns. [Laughter] One of the things that I have found interesting in working in this program, and I too have done a lot of research both in what happened in 1965 as well as what happened in the precursors to the medicare modernization act before 2003, and first of all from 1965 implementation, we probably have a stack over a foot long of newspaper articles between 1965 and 1966 that read almost identical to the articles we see on the front page of every paper today about the difficulty in implementation, the confusion, and so forth, so I have a slight difference of opinion, not because I was there reading the papers at the time but we have done a lot of research that actually dug them up now, and of course over time this became a very beloved program, the medicare program, and I suspect at the end of the day the drug benefit, too, will become a critical integral part of the medicare program, particularly as we work through these initial glitches.

One of the last things that you mentioned, Barbara, was the no negotiation issue, and I think people would be surprised to learn, as I was when I was doing some background on pre-MMA work and on March 3, 2000, I read a White House press release that talked about the structure of the medicare program that President Clinton and Senator Dashiell were working on, and one of the key tenants in that program was that private plans would in fact be the ones to implement this program and that the government should be prohibited from interfering with the negotiations, and it is that exact type of language that is existing today in the medicare modernization act, so across the board democrats and republications at one point in time believed that this was the way to go, and while I appreciate the confidence that everyone has that CMS could accurately price fix or negotiate or whatever it is that people think we do at CMS, visa via payments to provider, so I can assure you that we have had our hands full just generally and I can't imagine the amount of work it would take for us to go through and price thousands and thousands of drugs and I am grateful to have the partnerships of the plans and their negotiating power which far exceeds the numbers of people covered today that use private insurance and PBM's far exceed the numbers of medicare beneficiaries and as I am sure you will see in the future, the price of this prescription drug benefit program is doing a lot better than expected, whether it's just the premiums alone and what beneficiaries are being charged this year became $5 dollars under the average premium was initially thought to be by our actuaries, $37 dollars a month that came in the average at $32 but many beneficiaries are paying under $2 or $10, $15 dollars all have access to plans that are significantly less expensive than that, which is terrific, and because of that alone, the price of this program will be significantly diminished, certainly in this first year, and much less than the actuaries had anticipated. In addition, I would point out that a number of other things that she mentioned in terms of the donut hole, for example, Karen also mentioned that there are plans available to all beneficiaries where they can pay a slightly higher premium and not have a coverage gap. It actually depends on the state and the plan, and for many beneficiaries who have a need for many drugs and find themselves spending over $3,600 dollars, this is a terrific option for them to have complete coverage with no deductible and no coverage gap, so coverage from January to December where they are simply paying copayments. The point of that is the product market has come to play and has provided everything from inexpensive plans for beneficiaries who need very little as well as more expensive plans that provide more complete coverage, and I think that is a tremendous opportunity for beneficiaries to choose what it is that they need based on their drug needs, so I will take a breath and drink some water.

DIANE ROWLAND, Sc.D.: I think Karen would like to offer some comments from a plan perspective.

KAREN IGNAGNI: Thank you, Diane. I think Leslie said it very well, I would just like to come behind her and give a couple of pieces of information that I think are relevant. On Monday, we are going to be issuing a study that Price Waterhouse Coopers has done for us on cost drivers. They have zeroed in particularly on the effect of plan tools in the pharmaceutical arena, how we have driven down premium costs for working families. We have taken pharmaceutical expenditures from average annual increases of 20-percent per year over the last several years ago down to around 8 as the modal number and in some cases less. I think that these are exactly the tools that are being leveraged here. I don't know of any other government program, and I guess I must confess I've been around long enough to have looked at a number of them, where the estimates that were issued, we come in better, that is to say, the real costs are less than the estimate. This is the first time that has happened, and I think from a beneficiary perspective, we are hearing from people on fixed incomes who find it particularly valuable they don't have to pay $38 dollar premiums, they don't have to pay $250 deductibles, they do have more coverage options in terms of costs sharing and so on, and in the donut, and that is particularly valuable.

The third thing I would say is we probably had, and I know our plans have had more, but in our shop we have had discussions with now about roughly half of the states about how their costs and their reimbursements to pharmacists exceed plan reimbursements. That is because again we have leveraged these tools that are part of the problem that the states have asked to be made whole because we have contracturally been obligated to pay certain amounts of money and the states find their own rates are much higher in a number of occasions. So I think that this is a demonstration proved positive of the ability to leverage tools effectively, but I suspect this won't be the end of the discussion. The town being what it is, I know this will be a very big political year. I am pleased we have data to contribute to this discussion.

Finally, I think Vicki read a very important point, and it really hadn't occurred to me until you said it the way you did. I have been concerned as an observer looking on the ground at the amount of switching that is going on. States have engaged contractors to work with specific beneficiaries to encourage them to switch. Some of those contractors are not necessarily doing it for the reasons that the state officials would have them do it, and we have to look into that, number one, but I think Vicki's point about having the exceptions process better known, seeing what we can do, and I heard from her messages can we creating some processing and formity among our plans to make that process easier, simpler, and I am going to go back with that message. I know Leslie's team has been working hard, and I suspect we can collaborate and get that done, because I think that is a very important point, but I do think it is a policy matter. This matter of switching really needs to be looked at because, particularly for dual-eligibles, for people with chronic illnesses, comorbidities, you want to make sure they are in a continued care environment where they can be supported, so I think the issue Vicki that you pointed out is a very valuable one and I am going to take that back.

BARBARA KENNELLY: Can I just say a word? We are talking about costs, and we all know in marketing when you are trying to get a customer the costs are lower, but I don't think we should just talk about costs in this particular program. I can remember when Senator Graham from Florida put in a plan that was part of medicare, and it was expensive, it was very expensive. I think it was 700 billion dollars that they scored it at, well we are about at 800 billion for taxpayers upon this program. The other point I would like to make is we cannot look at Part B in isolation. As we all know, Part B is becoming a huge problem and eventually Part B will take almost the whole social security check, so when you are talking about somebody on fixed income can pay $69 dollars so the donut hole is covered, we are not talking realistically about what the incomes [inaudible] are.

DIANE ROWLAND, Sc.D.: Let me ask a question about one group that we haven't really talked about here. We have talked a lot about the dual-eligibles who are the low income individuals who are on the medicaid program and getting their drugs from medicaid prior to the drug legislation, but one of the main features of that legislation was to help people who had low incomes with their subsidies, and the enrollment and participation in the subsidy program is far below the targets, and what is going on there and how do you think that can be remedied?

FEMALE SPEAKER: I do think that the actuaries estimated 8.4 million would qualify for limited income subsidies that were non-dually eligible. Thus far, although the last [inaudible] I saw from social security, over 4 million had applied, over 1 million had been accepted. That leaves quite a number to go after, and I think it is the hardest population to reach, by far, whether it's language difficulties or beyond language is cultural, actually understanding reading material and so forth, so what we have done is with all our regional offices and all of our partners, of which we have 14,000 partners on the ground, to actually focus on where these beneficiaries live, were working with all sorts of organizations to figure out how can we best reach them? They may not read the mainstream press. They may not look at the media generally, so we are looking at where they live, work, play, and pray, and any help that we can get from anyone anywhere to reach out to them, explain the process, help them with the application, and have them apply, and then the second step, once they have applied and once they have been accepted, they also need to enroll in a plan if they have not already, and that is the next step that we need to work on with these beneficiaries, but by all means, we always knew that they would be the most difficult to reach and require the most targeting in order to get the help that they certainly need and we would like them to have [interposing – inaudible].

DIANE ROWLAND, Sc.D.: But aren’t you also experiencing a high turndown rate among those who apply [inaudible]?

FEMALE SPEAKER: Well, the social security administration administers that piece of the program in terms of application in conjunction with the states, so the question is who is it that is applying? I think a number of people who have been turned down are those who meet the income test but haven’t met the asset test, and we are hopeful that there can be other [inaudible]. One of the groups that you don’t have on the panel are the pharmaceutical manufacturers and they often have provided assistance to these beneficiaries, and hopefully there is a way, even if they don’t qualify from an asset test from the medicare program that there may be some additional help, whether it's those groups or other [inaudible] groups that typically provide help to these beneficiaries that they can get help when they need it.

FEMALE SPEAKER: Diane, the low income subsidy has actually proven to be very problematic for a number of reasons. We are starting to hear from people now who have been found eligible for a partial subsidy and they can't afford the copayment, even 15-percent is too high for this group, and so they are really actually very disappointed because they thought they were going to get better protection. We are also hearing from individuals who are having difficulties filling out the application form. I am one of the people who reviews the application form so I can say this. It is very complicated. I had an attorney call me the other day because he had a client who has a resource that, if counted, would make the client ineligible for the benefit, but it is a resource that can't be disposed of within 20 days and so, under the regulations, it shouldn't be counted, but there was no way to accurately reflect that in the application so that the attorney is going to have to fill out the application saying that there is this resource, be denied, and then file an appeal, and I definitely intend to talk to social security about this, but we are finding that the application process is very difficult for people. We are also finding the two step process is incredibly difficult for people. Individuals who get the low income subsidy don't understand that they then have to choose a plan, and that is a very hard concept for people. It means you have to go back twice to whoever helped you fill out the application, maybe somebody different from who is going to help you choose a plan, and that is very hard. This is a policy issue that none of us on the panel can do anything about. There shouldn't be an asset test. Kaiser has done some great papers about the number of people who would be eligible for the low income subsidy if there weren't an asset test, and this needs a legislative fix. It makes the application process too complicated, and social security could turn this around much more quickly if they didn't have to do the assets as well.

DIANE ROWLAND, Sc.D.: Thank you. We've had a very patient audience, and now I would like to open it up for questions from the audience. If you could raise your hand and we will get a mic to you and then identify yourself when you ask the question.

MATT TOBIAS: Hi, my name is Matt Tobias. I am with Modern Health Care, and Leslie, I think finance was scheduled to meet yesterday with Secretary Levitt and Mark McClellan, and I think one of the discussion topics was an extension of the enrollment period. Could you give us an update if that is going to happen and if not, why not?

LESLIE NORWALK, J.D.: I wasn't at the meeting, although I wouldn't be surprised if that particular topic came up. It would require a legislative change. Currently it is January. I think it is a bit premature to say we need to extend that particular date. We are all human beings. I would be willing to bet that every one of us at some point in time has procrastinated and put something off until the last minute. It's not unlike what we saw at the end of December where we had fairly large numbers of enrollments. If you give people more time and they put something off, they will continue to put it off. Certainly, as the secretary says when he is on the road, it would be a shame if people didn't sign up because they never heard of it, which is very different from people not signing up even though they knew about it and had made a conscious decision to say hey, this isn't for me. So, at this point in time, I think it is premature for us to say we should extend that particular date and our position is let's wait and see.

ANDREA MORASCO: Hi, Andrea Morasco, with the National Association of Community Health Centers. Thank you all for your comments and the many concerns that were raised. As you can imagine, we have a population that includes a lot of dually-eligible beneficiaries, and the question I have, Julie you mentioned the patient assistance programs. I think that is what you were referring to. I had heard that there was going to be additional guidance, because our patients and staff are concerned about the decisions that are taking place currently to discontinue the programs or the decisions that people have to make in terms of enrolling either in a Part D program or in a PAP program, so can you shed any light on that? The second thing, and Karen you may be more appropriate to answer this, is for individuals who are LEP, limited English proficiency, and speak other languages other than, Spanish is often a common language that things are translated into, but also we have a lot of patients who speak Vietnamese or mandarin. Is there a way to connect people with interpreters through the plan who are calling for more information?

LESLIE NORWALK, J.D.: With regard to patient assistance programs, it should be one our website by now. We just put up the CMS perspective on patient assistance programs. I think the top line point is that there is nothing in anything that HHS does, whether it is the OAG or CMS that prohibits patient assistance programs. There are certainly, from an OAG perspective, although I promise you I do not speak for them, but from the overall department's perspective there are some hoops that people need to go through but there is no reason why they can't work together, and whether it be inside the benefit through other foundations, for example, that wouldn't come afoul the fraud and abuse laws, or even outside of the benefit, much like it worked before January 1st where beneficiaries could receive prescription drugs, they just can't bill the federal government for those drugs, which means no deductible, no copayments, no coinsurance and so forth, but the patient assistance program itself could still provide that drug to the beneficiary, so the guidance lays out some of those points, gives an example, and also I think the point is we want to work with pharmaceutical manufacturers who are interested in continuing these, whether it is helping them talk to the OIG or the federal trade commission if they are doing something more broadly together as manufacturers as a whole, or if they want to do it outside of the Part D benefit, one of the things that the office of the inspector general advisory bulletin does it require some data matching agreements with CMS, and so working on that particular piece so that we can make the process go as smoothly as possible. We know how much patients rely on these particular programs and would like to help them continue going forward, and given that, there is nothing currently under federal law that would prohibit them. Generally, they may need to be slightly restructured and I don't want to say that doesn't take some work. I think that it does, but I think that work is worthwhile.

I know that you asked Karen the LAP concerns, I just would like to say at 1-800-MEDICARE we do have a hundred different languages available. I guess the key thing is to figure out how to tell the operator that you need to talk to someone in another language. I'm not exactly sure how that works to be honest but we do have translation lines far broader than just Spanish, and Karen I don't know if you've got other –

KAREN IGNAGNI: Yes, and we do as well. I was going to mention until Leslie did the 1-800-MEDICARE is very well staffed in a whole range of languages. I was just out in L.A. visiting one of our small plans that has capacity for 18 languages, so it gives you a sense that all 18 individuals may not be on the customer service line at the same time, so I think the best way to do that is to have someone who speaks England or Spanish make the initial call to ask that particular plan that an individual may be interested in, their language capacity, particularly for the language that individual is concerned about, that would be the quickest way to get through all this, and then to get hooked up with the right person that could answer the questions.

FEMALE SPEAKER: [Inaudible] from The Republican in Springfield [inaudible], I have quick questions. Leslie, you want to switch seniors from fee for service into managed care, the question is can you actually manage care old people in health care? Karen, my pharmacist told me that generic drug prices have been tripling, and Barbara, Congresswoman, what is wrong with privatizing health care for seniors? [Laughter]

LESLIE NORWALK, J.D.: First off, I would point out that at some point in time, all of us in this room, God willing, will all be in the medicare program, and many of us today, I would say in the under 65 market, 95-percent of all people under 65 who are insured have some sort of managed care program, 50-percent are in preferred provider organizations, another 25-percent are in HMO's or the point of service option where they can go out of their network and see whatever individual they need, and another 20-percent are in a closed panel HMO. Those numbers may have changed, those are a couple of years old, but the point is only 5-percent of the under 65 market are in a fee for service program. As we all age into the program, and as I said I hope we all do, many of us will have been experiencing managed care, comfortable with the concepts, at least understanding them and so forth, and I do think that is appropriate for the medicare population to have the same types of options that are available in the under 65 market, and in particular one of the things that the medicare modernization act does is focus on preferred provider organizations. We have them available in the majority of states now so that people who do want to have the ability to see any provider but are willing to pay get the benefit of paying less for providers and that are willing to pay more if they want to see a particular provider, still having overall savings, perhaps getting additional benefits like vision benefits and dental benefits. We think that is an important option for beneficiaries to have. It is an option, and it will continue to be an option. The actuaries estimate that over time the fee for service population would remain stable, and those in managed care would grow, so as the medicare population grows, that growth change would more or less go to their managed care options.

BARBARA KENNELLY: I'd like an answer, on my visit to Bob Ball, and like Leslie, I have looked at the history of what happened during '65, and I said why do the insurance companies fight medicare? So obviously before medicare they didn't want to ensure the older people that didn't have insurance, and he said because they didn't want to have the government get into insurance. Well, now we have come full circle, but I would just like to mention that if you are over 65, you're the only one that has a universal health care. If you are under 65, you are in the private market, and I believe there are about 45 million people that aren't insured, so I don't understand why we want to take apart something that is working to put into something that isn't working, and I think that is what privatization would do.

KAREN IGNAGNI: I want you to swear that I did not put you up to your first question about managing folks or doing coordinated care in medicare, the fact is — no, I understand you asked me the generic, but I also want to also take a crack at the first point you made because the data from CMS show that we are doing a much better job managing and doing coordinated care on beneficiaries with comorbidities, and that is why CMS is trying to introduce the same tools, care, coordination, and disease management, into the traditional fee for service that we have pioneered on the managed care side. Onto your other point, I think it is very important that you made it. There has been too much focus in the policy community on simply the trajectory of pricing on the manufacturing side. We need to look at, and so it's simply been the focus, the contrast in pricing between the generics and the manufacturers. Now that more people are moving into the generic side, we absolutely have to look at the trajectory of pricing, and you are completely right about that, so I hope from this important discussion, there will be much more focus on that. You are right, and we should pay attention to it.

FEMALE SPEAKER: I would like to just pick up on the practicalities of why sometimes managed care can be very difficult for this population. When I have to drive across town to go to a doctor who is preferred provider for my PPO, I can drive across town and I can drive the 10 miles downtown to go see the ophthalmologist. My father, who is in medicare fee for service, must rely on the transportation provided by the senior community in which he lives, because you don't want him driving. [Laughter] That senior community will only drive him within a 5 mile radius. That means that he is restricted to seeing doctors within that 5 mile radius. If he were in a PPO and the preferred doctor was 10 miles away, he couldn't get to that doctor and it wouldn't be a choice of his to use a non-network doctor, he would be forced to use a non-network doctor. He would have expenses that exceed his current expenses under fee for service medicare and the supplement he has through his retiree health plan. So, we need to look at some of the practicalities first.

MARSHA GOLD: Thanks. This is a question for Leslie. I'm Marsha Gold from Mathematic & Policy Research. I wanted to shift it a little and talk about MA and I was hoping that you could help us understand the enrollment numbers that CMS put out on MA better as it relates to people and prescription drug plans. The latest data before this I think showed that there was 6.1 million people in MA plans, not MA, in any kind of private plan including demos and things in November, 2005, and there are 4.5 without duals who have drug coverage now in

January, so what I am trying to figure out is of that 4.5, how many are new and how many are existing, and of the people who were already enrolled in managed care plans in 2005, of which there were around 6 million, how do you get to the ones who you are counting as having drug coverage in January? Did they actively enroll? Were they passively enrolled? Which plan did they get in? Which did it take, and if you can help us figure that out, we can better understand how that relates to historical numbers.

LESLIE NORWALK, J.D.: Debra, do you have the number of the new editions to medicare advantage with you? We'll have to get back to you. I'm looking at the press release that we sent out. It doesn't like pop out at me, but I'll get you back [inaudible] a few hundred thousand is my recollection of the new enrollees into medicare advantage with prescription drugs this year. In terms of the process, those who were in a medicare advantage program that had some drug coverage in 2005, they were rolled over to the same medicare advantage plan with drug coverage. [Inaudible] I think that is correct, yes. I'm sure that is correct, actually, so that is the first point. There are other types of medicare advantage that didn't have drug coverage beforehand and my recollection is we did not, and Karen you might be able to confirm this, didn't passively enroll those individuals, so cost plans for example, demonstration plans that didn't have drug benefits and so forth, so those individuals obviously had the option to choose a medicare advantage program as part of the difference with the numbers, but if you will give me your card I will be sure to get you the specifics so maybe we can do a fax sheet for the industry at large on medicare advantage and how those enrollment numbers work.

KATHY HELVERSON: Hi, my name is Kathy Helverson, and I am a volunteer with the D.C. ship, and I've been a very big admirer of CMS over the last couple of years, and I thought they did some wonderful thinking about this program, the troop facilitator and the well point point of service in particular, but there have been huge problems, and I know that you discussed these system issues and I know that it sounds like you are going to fix them, but could you talk about them a little bit more, because we are spending a lot of time fantasizing about all of the things that are going wrong right now. Thank you.

FEMALE SPEAKER: So your question is to talk about some of the fixes in terms of both the problems and the fixes? As a preliminary, figuring out what the issues are, the first and probably the biggest problem we saw, and I will point out one of the things that has been very interesting in all of this is that the issues that we are seeing, they are not uniform across the states, that we are hearing, I heard a governor a couple of weeks ago come in and say geez, I read this article in the *New York Times* and we don't understand, we are not having any problems in our state, or very few problems in our state, certainly none of the type that were described here. In another state, they said well, we have 50,000 duals and we switched 10,000 of them and that is really where all of our problems are coming up are in these 10,000. I have another state that said we are having problems across the board with all of our duals, so the first thing that we need to do is determine from a diagnostic perspective what the problem is. Are the problems different? In some cases, I think the answer to that question is yes, and where do they occur? So, that is the primary and first objective is to figure out problems, particularly where they are systemic. Secondly, in addition to working with the states, obviously we are spending lots of time with the plans. What happens with enrollment and limited income subsidy information, we get it from many sources. You get it from the social security administration, you get it from the states, and you get it from the retirement board. The plans also have input and CMS also has input. That is five, at least, and the beneficiaries at some point or the pharmacy also has an interaction here. So, that is at least five, probably six different places where information can go wrong, and these are all varying computer systems, so while we have something set up for the pharmacy so that the pharmacy can determine what plan of beneficiary is eligible, particularly when the beneficiary doesn't have a card, we are working diligently with the contractor that has provided this information but that is all the information is, basically, what plan is this person in? That particular system does not provide information about the plan, coinsurance, copayments, and so forth, although we have been looking at whether or not something like that is possible, right now the answer is it is not possible in the short-term.

The next piece is what do we do to make life easier for a pharmacist? Because at the end of the day, as Debbie pointed out, it's where the rubber meets the road. If you can't get your drug at a pharmacist, you are in big trouble, so a significant amount of support for the pharmacists separate and apart from the eligibility query that we have set up. You mentioned the well point point of service option. For beneficiaries who do not have a plan, show up at a pharmacy, nothing comes back in the eligibility query, they don't have a card, they don't have a letter. Those beneficiaries can be put into a point of service option where the beneficiary can get at least a two week's supply of prescriptions and at the back end the insurance company well point will reconcile with whatever insurance company, or Part D plan the beneficiary should have been in, and if not, then well point would take that particular enrollment, so for dual eligibles in particular, that has been a very important piece of the pie. One of the things we have tried to do is make it easier for pharmacists by reducing the number of steps they have to take. We want them to spend time with the patient talking about the prescriptions that the patient needs, not having to do this administrative hassle. We have also set up a special toll free number for pharmacists who can get immediate access, we hope. I have found wait times under a few minutes to medicare customer service representatives. Similarly we have been working with the plans, particularly those who have high volumes of dual eligibles to provide special toll free numbers so that they can get through to the plans more quickly and the plans can provide the correct copayment information and particularly when you are talking about a limited income subsidy person.

Now, so those are some of the basic things in terms of fixes. Behind the scenes, we have done everything from create swat teams to work with the plans and the states to ensure that the information flow is accurate and determine where there may be an issue, and I can assure you there can be issues any number of ways. One of the things we have seen is that the social security administration, for example, may have a different birth date than the beneficiary. That is a critical way for a pharmacist to find out what plan someone is in using the eligibility query. So, how is it that we can reconcile differences of information that may be just a part of the system, and who knows why that particular thing would have happened? Finally, we have case work, so that when a beneficiary goes to the counter and for whatever reason can't get what they need or only gets a short supply because the pharmacist appreciates that this is a critical need. We have case workers, both within their regional offices through 1-800-MEDICARE and also working with the plans to make sure that we can behind the scenes, particularly in urgent cases, get people the scripts that they need on the day that they need them, so I think we are doing all sorts of things, appreciating that the transition from a computer perspective is going to take a little more time to work out then we would like. We would like for it to be perfect today, certainly. We have done lots of things to try and make it as easy as possible for beneficiaries to get what they need without totally overburdening a pharmacy who is already, because it's January, seeing lots of changes. May of us probably changed health plans and may not have our cards, and there is no eligibility system for people are large, so a poor pharmacist may be calling not just about the medicare beneficiaries but on behalf of the general population anyone who has switched their insurance company in January, so we do want to make it as easy as possible and appreciate Debbie and her colleagues, all the pharmacists who are doing yeoman's work and are really heroes to make this work and I can promise you behind the scenes, there is nothing we would like more than solve each and every one of these problems because until we do, we know how much casework we all are going to be doing and certainly those of you with the ships who are also on the front lines, if you see trends or anything systemic, we are very interested in that information and whether you are working with our regional offices or us at central office, and if you are seeing trends, both good and bad, they are both helpful from a diagnostic perspective and I invite anyone here who is seeing a trend to let us know what you are seeing, and we hope that it is people are getting the drugs that they need at the end of the day.

MARY AGNES CAREY: I'm Mary Agnes Carey with congressional quarterly, I think it was raised earlier, the concern about pharmacists trying to figure out if a drug is just not on a formulary or not covered under Part D, and I think the reference was to anxiety drugs, and I'm a little confused about this because the way that I understood the plan was all sort of drugs from all classes will be covered, and another speaker talked about the difficulty in appealing this to some of the plans, so what is going on with this class of drugs and why is there a problem? Thank you.

FEMALE SPEAKER: The two specific classes of drugs that the statute prohibits are benzodiazepines and barbiturates, so those particular drugs, I think in every state but one are covered through the medicaid program for those who are dually eligible, and those states by the way would get federal matching if they would continue to cover them under the state program. There are six classes of drugs that this year the medicare program required all plans to cover. Let's see if I can remember them all. There are antineoplastics, which are cancer drugs; seizure medications; medications for after transplants; antipsychotics; antidepressants; and drugs for HIV/AIDS, antiretrovirals; so for those six classes of drugs, we require all or substantially all of those drugs to be covered. I think there may be one or two exceptions but basically all drugs in those classes are. The other thing that we did was require, actually the statute requires this, that all medically necessary drugs with the couple of exceptions that I mentioned before and a few others, things like over the counter drugs, cough and cold medication, etc., you need to cover at least two of those drugs in every class. The classes were defined by the U.S. Pharmacopeia, and we went through every single formulary to approve it for that purpose. What we are seeing more generally are a couple of things. I have heard two different problems. One is what happens when a drug was covered or is covered under medicare Part B? Typically the physician benefit, and compared to medicare Part D, and there is some difficulty there because some drugs are covered on both. It depends on the circumstances of the beneficiary, so we have been working on a solution so that plans understand and what [inaudible] plans and pharmacists and beneficiaries can all understand when something should be covered under medicare Part B with a 20-percent coinsurance payment vs. the prescription drug plan, and anyone who, as a general rule when it was covered under Part B before, remains covered under Part B, and drugs that were not under Part D but it's not quite that elegant a solution, we do have some information at our website that talks about the difference and that might help you understand that.

The second category that I've seen problems are what are cold and cough medication, something else that is excluded, and how is it that the plans are administering that? That is something I heard recently, and we are going to go back and take a look to be sure that those medications that should be covered in some way are covered under the plans and at least two in every class would meet the requirements. So you don't have to cover all the drugs, but you would have to cover two of them, and to figure out why we are hearing about those particular emphases, those are probably the two most common things that I hear, or I've heard at least this week on that issue. I like to keep it current.

LESLIE FREED: Hi, my name is Leslie Freed and I have a question about a problem we are expecting in February which has to do with many people did finally get some of their drugs under their transition plans, my understanding is people were supposed to get a letter from the plan saying you got a one time fill, you are supposed to be doing something, either go to your doctor, get a different drug, or file an exception. We are not hearing of people getting those letters, so our concern is that people will go back to their pharmacy when their 30 day prescription runs out, try to get a drug, and be told no, you can't get it, you got your one time fill, and that is it, yet since they didn't get the letter, they didn't understand that there had to be next steps followed, so that is my first question. My second question has to do with really, if we hadn't done the random assignments of the duals, would we not see so many people having to change plans now because they were enrolled randomly in plans where their drugs were not covered?

LESLIE NORWALK, J.D.: Can I just say something interesting on that last point, we are finding that many people who "switch plans," switched into the plan they are already in. [Laughter] So, I'm not sure in terms of the switching and there is actually, I don't remember the specific number but I remember being surprised at how many people where that actually happened. I would go back to my original point that all of the plans are required to cover all medically necessary treatments except for the statutorily excluded drugs, and for those six classes of drugs that I mentioned before, where typically you need to take the particular drug that you are taking and they are not interchangeable and you have a particular drug regimen, because of those two things together and the exceptions policy that Vicki mentioned earlier, we really think that all of the switching that has occurred is probably not necessary because there are broad treatments in all of the plans. I appreciate that some beneficiaries feel very particular about whatever drug it is they are taking and so they can switch frankly every month. The random assignment is something that the statute required, so it's not as if we had a policy choice there to do that, but I do think that beneficiaries are protected by a number of things, all of which for the most part I have mentioned, so that is that. In terms of the transition issues and letters, I think it would be helpful for us to have a better understanding of which specific plans those are, and we will go back and do some research. I don't know, Karen, if you've got some thoughts?

KAREN IGNAGNI: Yeah, I have thoughts on two matters. First of all the switching, we are finding exactly what Leslie suggested and Kathy, we would be delighted to take you through this kind of systems issues and I've been very pleased that CMS has really segmented the problems. One of the most important things that we uncovered and CMS is hard at work is this E1 screen that the pharmacists have, the phone numbers that were pulled by the contractor, not by CMS employees but by the contractor that was used, were not the correct phone numbers, so from the get go the pharmacists didn't have the right numbers. CMS is really doing a yeoman's job of focusing on this, working with the pharmacy groups, getting that information out, and I think that they really deserve a great deal of credit for that.

There are issues with respect to, and this gets to switching, getting the time we send information to CMS and get it back, again CMS has put a top level team, a swat team, on resolving that issue. Then we get to the duals issues, and a number of our plans have people switching back into the same plan as Leslie said, so now that we are getting data from the system, we can track those sorts of things but I do think that for a number of the advocates in this audience, there really needs to be a look at some of the companies that are engaged in the switching process on behalf of a variety of folks, how are they funded? What is their motivation?

Etc., because I'm not sure it is the same motivation that the advocates have, number one. On the plans, if you have specific examples, I would love to hear them because that would be a great way. We are trying to be a bridge between the advocacy community and the health plans. I want to make sure that the processes are working exactly as they should, and I would be delighted to work with you if you have some specific cases, because that is a great way to just track, and this is exactly what we do in the systems steps, to add micro level track where the breakdowns are, what is happening, it's helped us really to provide the kind of information that CMS has needed, and I would be delighted to do the same with you. Our plans are committed to sending messages and to provide the education that people need. There is an issue of 4 million people coming in to this program in addition to the 20 in three weeks, so I would be able to find out if letters are backed or what the issues are and give you a better comfort that people have things under control. So, I would be delighted to work with you to do that.

FEMALE SPEAKER: May I just add one point regarding that transitional issue, that transitional supply, for those of you who are advocates in the room. Maybe encourage these folks to come back to their pharmacies for refills when they still have about three to five days left of their medication, and not waiting until they are totally out of the medication so the pharmacist can do something for you, help you out, and work with the other folks involved in the process you've heard about to get them their medications to move forward.

FEMALE SPEAKER: Except that the exceptions process and the appeals process is a systemic issue. The way it was developed both by congress and implemented by CMS, it is very user unfriendly and when you think that this is a population that is very diverse, then you do have people who are frail with mental incapacities, with physical incapacities, it's not a system that has gone to work well for them. So, this is an issue that we are going to see. This is a future issue that is going to exist with this program.

JUDY CAHILL: Judy Cahill with the [Inaudible] Advantage Care Pharmacy, Leslie I would like to add my thanks to CMS for all of the hours and the ongoing work that you are doing. My question is looking a little bit further down the road. We know that people move on and off the state eligibility requirements for medicaid, and I'm curious about how CMS anticipates handling updates in status. As this occurs amongst dual eligibles, who will receive notification of that? What is the anticipated turn around time for that type of change? Because as we all know, it affects the benefit level.

LESLIE NORWALK, J.D.: It is my understanding that the medicare program and the limited income subsidy [inaudible] is an annual process, so even if you are on the rolls and you qualify and you later come off the rolls, even within the same year, you maintain your dual eligible status for Part D purposes, and then on an annual basis that would be updated, so if you weren't eligible at the end of the year, then it would be annual. If you became eligible during the year, of course, then you would be, let's say you were off the rolls in November, came back on in March, you would be covered from March until the end of the following year.

FEMALE SPEAKER: But this is a very big problem for a number of individuals because we are going to find people who are no longer eligible for medicaid because they don't have drug expenses. They are not going to be recertified for the low income subsidy. They are not going to be able to afford their drug benefits. They will go without drug benefits or then they will become eligible for medicaid again, they will be paying penalties because they disenrolled from their drug plan. The other untended consequence of this program is that there are a number of duals who do become eligible for medicaid because of their drug costs. They won't be able to use these drug costs to continue their medicaid eligibility, so they are in essence going to lose health care that they have now.

DIANE ROWLAND, Sc.D.: Well, I think we have raised a lot of issues. I have seen a lot of note taking at the table, which I think is a sign that some of these issues are going to get put high on the agenda when people go back to their offices. I think you have all been a great audience in terms of giving us more ideas, so I want to thank the audience and the panelist for a great discussion, and let's keep working on getting this benefit right. [Applause]

[END RECORDING]