

**Conference: 10th Annual Grassroots Conference -
Health Action 2005:
Plenary: The Medicare Drug Law - Where do we go from Here?
January 29, 2005**

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MALE SPEAKER: We're beginning our final day. We're going to start off with this session on the new Medicare Drug Law and then get a break and have some final set of workshops and then come back for the luncheon and what we know will be an exciting closing plenary with Joe Trippi. So we're very excited. I think it's always a little bit difficult to be the Saturday morning kick-off session, but Dee and Bill know that you all are very enthused and ready to go here. I talked to a couple of people who are wandering around saying they're looking for the good-news session. And I'm not sure we're going to be able to deliver that for you. The news that I can provide you is that as of today we are one week and two days past the halfway point of this presidency. So it's - so take your news where you can get it. These are the thin strands we must grasp to remain motivated.

Our session this morning again is the new group Medicare Drug Law, and you have the great advantage of having two of Family USA's terrific leadership team here to tell you about that. We'll start off with Dee Mahan who's going to talk about - who is the Deputy Director of Health Policy who is going to talk about what's going on with that law and what you all might do with it. And then Bill Vaughan is going to talk a little bit about opportunities for a legislative action. So let me first turn this over to Dee.

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DEE MAHAN: Thank you, Jack. And I think a lot of people have ideas of what they can do with the law. And, you know, I was hoping that I could be the good-news session this morning. I was kind of hoping that I would wake up this morning and there would be news that congress and the administration had gotten together and decided, wow, this was really a terrible mistake, this was a bad idea. There's going to be a comprehensive drug coverage administered by the Medicare program and everything would be great. Unfortunately, that's not what happened. So I'm here to talk to you about the benefit, a little bit, and then also talk to you about ways that you might be able to work with beneficiaries, things that you should keep in mind as you are evaluating health plans in your area, helping beneficiaries make their decisions. That is not as much fun as a presentation as if I had good news but it's what I've got

Because the fact is that on January 1st 2006, which is not that far away really, there are going to be very large changes in the Medicare program. All of you know that, and I'll just go over those real quickly, the dual Medicare Medicaid eligibles will see their Medicaid drug coverage end. Those who have not selected a plan during the enrollment period that began in November will hopefully had been assign today a plan by CMS, but whether or not that's a good plan or not, that's sort of Russian Roulette. And others in Medicare will

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have a drug benefit available, but they're going to have to make a lot of choices about what plan to enroll in, whether to enroll in a Medicare plan or not, evaluate their coverage options. And the way the benefit is delivered, a voluntary benefit through private plans is a fundamental departure in the delivery of Medicare services. These are huge changes and the ensuing confusion is likely to be just as huge. And the confusion is not going to be just from the changes at hand but also because of the benefit itself.

There's a basic benefit and that's what's going to be available to those in Medicare with incomes over 150 percent of poverty or who have assets that are too great for them to qualify for low-income assistance. It has an upfront deductible, 25 percent co-insurance until you reach a cap and in the first year that's \$2,250, and then coverage stops for the rest of the year unless you reach an out-of-pocket maximum, which in year one is \$3,600 of your own spending on drugs, and then coverage begins and just continues for the rest of the year and then you start all over again.

There's several levels of low-income benefits and what level you qualify depends on your income, your Medicaid status, your assets. They all have fixed dollar co-payments and they don't have a gap in coverage, but it is very confusing and possibly couldn't be more complex. Now, let's see if I can do this. Next one. Okay. And I'll take a little second I think.

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Okay. As advocates, you will have your work cut out for you. Regardless of how you feel about the law it is what we have to work with. Bill will talk about opportunities for legislative change, but I think between now and 2006, there's not a whole lot. And what you need to do is help those who could benefit from the law get help. Make sure that those who could really be hurt, dual eligibles, who will be losing coverage, get into the right health plan and don't get hurt. You will need to be prepared to help beneficiaries make the best choices, monitor what's happening with the drug plans in your area. It's going to be very important to get information on what plans are doing, what the plans look like, how beneficiaries are managing with them, because that's going to be the basis for making legislative change going forward. And you'll also need to be working between now and 2006, which is safe, to see if you can get programs that can provide gaps in coverage and also funding for education.

Beneficiary attitudes give a little bit of insight into the task ahead. Surveys have found that beneficiaries don't know a lot about the benefit and those who do know something about the benefit have a pretty poor opinion of it. In July a Kaiser Family Foundation survey found that over half the beneficiaries surveyed had an unfavorable impression of the law, but impressions really a key word here because nearly half knew so little about the law that they couldn't say whether

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they were really confused or not. And on Election Day things hadn't changes a lot, there was still a lot of confusion and a lot of dissatisfaction. So regardless of the huge problems of the law, with the law, it is going to be important that you help those beneficiaries who could benefit from drug coverage to get access to the plans that are best for them.

Past experience can help frame what we have to expect in the future. And the most recent and relevant past experience we've got is with the Medicare drug discount card. And the lessons we can learn from that, and get an idea of what to expect going forward, is that there was a lot of confusion. With the discount card there were too many choices, 72 plans, about 40 national plans, it made it very tough for beneficiaries to decide what was best for them. There probably won't be as many plans with this program because the plans themselves will have a lot more financial risk and a lot more at stake. But even if there are fewer, there are so many variables that people have to sort through and make decisions that even with a few plans it can be a very tough process. The second lesson is don't rely on CMS's 800 number overly. There was a lot of confusion, a GAO study found, that these programs are also confusing to people at CMS. The accuracy rate on answers on the telephone line was very low and probably most dishearten was the fact that accuracy levels were worse for questions about low income assistance.

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Outreach from CMS and from the plans that were providing discount cards didn't really reach the people it needed to reach. The standard ways that these plans communicate through internet, mailing, television, just isn't the best avenue. What people really need is one-on-one counseling and more direct help from groups that know how to work with them and know where they go to get their help. So on a tight time frame and with a lot of people having unfavorable impressions, I'm going to run through some things that you're going to need to look at and evaluate as plans come up that you can help people consider their options. But first I think it's good to get an idea of who beneficiaries are going to be signing up with, what are these private plans going to look like.

We don't know yet and won't know for awhile how many plans there are, exactly what plans there are, but we can say that most of them are probably going to be prescription, Pharmacy Benefit Management Plans, Pubs, that are going to be signing up, or insurance companies that have a drug management arm. There are a lot of different things about the PBM industry that makes it seem like it's not necessarily the best vehicle to be providing services to a large group of seniors, people with disabilities or low income individuals. PBMs have primarily served in the employer market. They don't have a lot of experience with outreach issues that are relevant to this

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population, certainly not on a very large programmatic basis. And the PBM industry is highly concentrated. There are three main players. There have been a lot of lawsuits related to violations of consumer protection law, related to improperly hiking prices, and there's not pricing transparency in the industry. The industry makes its money through rebates, discounts concessions, favoring certain drugs. And what they actually pay for those drugs is a mystery and it's going to remain a mystery because with the Medicare drug benefit PBMs are going to be negotiating with drug companies for prices and discounts, and they don't have to pass along any set percent of discount to those who enroll with the plan. CMS is only going to get aggregate information on discounts and aggregate information on the discounts that get passed on to enrollees. But these are the entities that are going to be out there that enrollees will be signing up with.

So I'm going to go through things that you're going to need to look at to help people make decisions and monitor the plans in your area. The first thing someone is probably going to ask is what's it going to cost. Because if you're not eligible for subsidy assistance that's going to pay your premium, then you're going to have to pay something every month in order to access the drug benefit. Right now the number that's getting tossed around is \$35 a month, that's an estimate. What the monthly cost is is really not going to be

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known until the plans are making their bids, and it could vary. The statement on the screen is based on a review of the Federal Employee Health Benefit Program, and it was a study that found huge variation across states and across plans, related to prices in that program. And it's not a bad model. Now plans will have to charge the same thing for every one in their region for the basic benefit, and every plan is going to have to offer that standard benefit. So you might say, well, maybe there won't be quite as much variation within a region because all plans are pricing the same thing. And if you've ever gone out and tried to price auto insurance or homeowner's insurance, you know that sometimes you think you're buying the same thing but you just can't figure out why the prices are so different, and it's probably what you're going to see what a lot of the plans.

You'll need to be prepared to help beneficiaries sort through the premiums and evaluate those premiums in light of the benefit being offered. And I say that because even though plans are going to be offering the basic benefit, they get to make a lot of decisions about that benefit and what it really ends up looking like at the end. There seemed to be a question, first, does the plan cover the drugs that I take, the drugs that are right for me? Because every plan is going to have an opportunity to develop a formulary or list of covered drugs. They can have these restricted drug lists and only

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drugs that are on the list are going to be covered or count towards your out-of-pocket maximum. Now there's going to be appeals processes that I'll talk about later but the best bet is to try to get into a plan that actually covers the drug that you're taking right now. The U.S. [inaudible] was contracted by CMS to develop a list of drugs and classes and they came up with 146 categories and classes. And the law requires plans cover two drugs in each. Now I've heard pharmacist say that for some classes two is too many, you really only need one. There's almost no variation when you switch people. For a lot of other classes two is far too few. Now, CMS has just issued guidance on the formularies that says that in certain classes like antiretroviral and anticonvulsive, most drugs need to be covered, and that's a good thing and we'll see what happens and how must ends up getting defined in practice. But if someone found a therapy that works, they need to look at the plan, what they offer, and sign up for a plan that covers that therapy. And even so that's not a guarantee; plans can switch in the middle of the year. They do have to provide notice, but one of the things that you should look at as you evaluate plans in your area is how often they make changes in their formulary.

And formularies aren't going to be the only limitation on access. Even though plans have to offer a basic benefit, they can offer something that is structured a little bit different or a lot different as long as it comes out being of

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the same value or actuarially equivalent to the basic benefit. So that means plans can limit the duration or amounts dispensed for therapy. There can be prior authorization requirements, set therapy, different co-payment tiers from generic to preferred to super preferred to not preferred at all. And there's no limit on the number of tiers that can be out there. So this can be very, very confusing and is probably going to be as big a barrier to access as the formularies.

The study cited on the screen indicates, you know, chronically ill patients. It's just one of the management tools that can be available to plans. Chronically ill patients have really limited access to therapy when there are multiple cost sharing tiers. These are things that you're going to need to look at and also see how confusing the benefit is for the plans that are in your area. Now as the plans are coming out you'll probably hear a lot of plans like the ones on the screen, 50 percent discount, 30 percent discount, all brands [inaudible] discount through a really great deal, and that's going to matter because price is still going to be very, very important for any beneficiaries who do not have a fixed dollar co-payment. They're going to be paying in a lot of these plans percent of the discounted price of the drug. So knowing what that discounted price is is going to be critical.

And what are the discounts? The regulations and the loss of the discounts can be whatever the plan elected to pass

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on to consumers, and they can change it at any time and they can vary by drug. So there is nothing right now in the regulation that specifically requires plans to provide price information, but C. M. S. says it's going to be coming out with marketing guidance and plans have to provide enough information for beneficiaries to make informed decisions, and I think that knowing what the price is is really important in making a good decision when you're signing up for a benefit like this. So hopefully pricing information will be readily available, and CMS does say that they are going to keep their pricing website up.

As you're working with advocates, looking at the prices of drugs and cross plans in your area will be very important and it will also be important to monitor how frequently those prices change. You'll also see claims about service. We can answer phones in a nanosecond and give you a correct answer 125 percent of the time. Now plans are not going to be able to do things to get beneficiaries to enroll like offer you a toaster or anything like that, but they may be claiming a lot of high service standards and a lot of expertise, and it will be important to monitor those claims. CMS has indicated that they are going to be watching the marketing practices. So they think having somebody else watch as well as a good idea.

Another thing that is going to be really important is access, making sure that access is convenient and that the

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plans have a wide pharmacy network. So pharmacy network standards for urban, suburban and rural areas and plans do have to contract with any pharmacy willing to accept the standard contract that the plan is offering. And that's great but among network pharmacies plans can have preferred pharmacies for the cost sharing flow and then not preferred pharmacies. So it's going to be important to help beneficiaries look at the networks, keep watching how quickly or how often the networks change. One thing we saw with the discount card was a lot of pharmacies dropped out of the program over time. And also looking at how much mail order is favored and making sure that there is access to preferred pharmacies across all areas and that it's not skewed against inner city or rural areas.

And finally, what if things go wrong? Every plan has to have grievance and appeals processes for getting access to non-formulary drugs, appealing cost sharing and there are turn around standards that are specified in the regulations, which I will say were a great improvement over the proposed regulations, the turn around standards, but it's a complex process, and I did actually did try to diagram it for this and I couldn't do it. So I think you're going to have to be prepared to help beneficiaries work their way through that after they've already worked there way through figuring out what plan to enroll in. And as you're looking at plans in your area, plans are going to have to over time provide information

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on their grievance and appeals record. That's obviously not going to be available at the outset. And one of the things you might want to do if you've got a plan that's been operating in your area that's contracted to provide the Medicare benefit, see if you can find out anything about their record in handling appeals in other settings that might be somewhat informative. There are some special problems that are very predictable given the benefit and its structure. I'm not going to dwell on those. They've been covered through a lot of sessions during this conference, but this does represent a major change for dual eligibles. And even with CMS automatically enrolling dual eligibles in plans, this is going to be incredibly disruptive. And many will likely go without the medicines necessary to treat the conditions they have. There is going to be very predictable confusion.

You need to work with your states and push them to educate early often and provide adequate funding to the state health insurance programs and work with the cross section of groups to ensure that there's adequate outreach or at least as much out reach as you can possibly manager. I think - I remember someone refused to talk to me about marketing hospitals and saying the same message over and over again, you can never say it too much, I think that may be the case with this. And this is also a huge change for long-term care. The final regulations require plans to contract with long-term care

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pharmacies, but this is really a fundamental change for nursing home operations and other long-term care facilities and a lot isn't really well suited to anything other than out-patient prescription drugs. So working with nursing homes and nursing home associations in your area to see what problems they anticipate and do anything that you can to help them would be something that would be very helpful.

So, you know, this was my good news. It may seem like there's just too much to do and too little time to do it. While that's probably true, I think it's starting now, even though I know you've got a lot of Medicaid fights and other things on your hands, it's certainly not too soon to start it all. To work with a broad base of groups to make sure that this goes as smoothly as it possibly can, providers, pharmacists, long-term care facilities, like I mentioned, and other advocates. To anticipate problems, educate as much as you can, and use a broad coalition to advocate at the state level to have pharmacy assistance programs, make sure any pharmacy assistance programs you've got keep operating and can provide added funding and fill gaps in coverage because that's something that they can do. Families USA is going to be looking at the health plans when the information comes out and we're going to be putting a lot of information up on our website about changes in Medicare and having conference calls on a monthly basis and developing a Medicare resource center

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that we hope will be helpful to you as well. And we'd like to hear from all of you in terms of your experience so that we can set up some sort of network for information sharing. Okay. I was just told something wasn't applicable. I'm sorry.

The last slide I'm going to leave you with is a quote from the California Health Advocates website that just talks about what a huge challenge this is ahead, and it really is. I would like to have brought you the really good news but I think that if we work together, we can make it as good as it can possibly be and that's really something we should strive for. We do have to work with what we got in front of us in the immediate term and with that I'm going to turn it over to Bill who will talk to you about opportunities to change it.

BILL VAUGHAN: Thank you very much. Given the chaos that Dee described, particularly for the dual eligibles that's coming forth, is there any chance of delaying the implementation of this provision for them and perhaps delaying the fall back collection of money from the states? Right now that is not on the radar scope. Members aren't talking about that. But there are a group of consumer activists here in town that are trying to think through some legislation that might delay or extend the current Medicaid program or give everybody a couple of free chances to make an error and not turn them away without getting their prescriptions. That is not on the radar scope yet, but then most members aren't yet aware of how

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confusing and how disruptive this law is going to be for the dual eligibles. And I would urge - keep track of horror stories in the early fall as they start to develop. For example, a dual eligible in the early fall will be assigned a drug plan. And say they're taking 10, 15 different prescriptions and that drug plan they're assigned to covers seven of them, but the other choices in the area only cover five or eight or something, that there's no combination of plans this person could possibly get into that will cover all the prescriptions they're taking. If we can begin to document that, there is a chance, it's a long shot, but there is a chance we could develop a head of steam for some emergency corrective legislation this fall or next winter. It is something to watch for and to keep track of.

The other thing that Dee stressed is education. The 1-800 number, the mailings aren't quite what we need. What we need is face-to-face, one-one-one counseling, and the State Health Insurance Assistance and Counseling Programs called SHIPS, need help. Two years ago they were funded at about \$12 million a year. Last year at about 22. This year at 32. A great increase. But folks there's 41 million going on 42 million beneficiaries. That works out to about .75 cents a head for education. Heck, that's mailings and a penny change. We need substantially more money and steady funding for these SHIPS. I put out at the tables, and if anybody in the back

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would like it, we'll get it to you, lists of the appropriators. If any of you live in an appropriator's house or senate, district or state, I would urge you, if you have the time, to put in a good word for better funding for SHIPS and for making it permanent. And another education tool is every ten years there's a White House Conference on Aging. Expectations for this one that's going to happen this coming October are pretty low because there's no money to basically take all the [inaudible] recommendations that get developed and fund them. But this would be the kind of small change of, gee, let's get some more money to SHIPS, maybe lets put them into the Medicare Trust Fund so there is steady source funding. When they come up with these recommendations, congressman then like to say, oh, we implemented 65 percent of them or something. If we could get this idea of better education and steady funding of it into the mix, it has a chance of going somewhere over the next year, year and a half.

There's going to be lots of hearings, listening sessions all over the country for this White House Conference between now and June, now and July, and if you see one in your area, don't be bashful. This would be a good place to vent, let people know what you think about some of the complexity of the new law but also the need for education.

But back to the bigger question of possible changes to the MMA, Medicare Modernization Act. And I say changes, I know

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some of you like repeal, but I urge you to think through some of the budget numbers you saw this week with Mr. Ross out of California and others. That if we talk too much about repeal, there's a whole bunch of folks who would love to take that money, and heck you could achieve the President's goal of cutting deficits in half over four years or you could pay for a tax cut or that money could disappear out of the healthcare system very, very quickly. And we'd still be stuck with a 25 percent, almost a third of seniors with no prescription drug coverage. In 2006, the Congressional Budget Office estimates that about one percent of seniors will be spending more than 12,000 a year on prescription drugs, truly a catastrophic cost. In 10 years, in just 10 years, they estimate that one percent will go to 11 percent. One in nine seniors using more than 12,000 a year in pills. So before we casually say, oh, heck, I don't like this law so much, let's repeal it, let's think how we help people. And so we're advocating for change and improvement. And of course the key change is to get a handle on cost. To stop this ridiculous drug inflation. And as former Governor of Oregon Kisshover I think has said, the whole Medicare prescription drug debate was silly. The real debate ought to be why pills cost so much.

And this donut that they talked about that starts in 2006, that \$2,850, because the new law does so little to control inflation in 2013, which is the last year that the

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Congressional Budget Office gave us estimates, that donut has grown to – anybody guess? \$5,066. We've got to find a new word. That's not a donut, that's pizza pie or black hole or something. I keep looking for a word that describes the magnitude of that where you're totally out of pocket all on your own. Ways to control drug course, of course, might be to get a world price or to allow importation. The new law didn't directly allow importation. It said, let's study it for a year and if that commission or that group of people studying think it can be done safely why, heck, maybe we'll do it. Well, that report came out just before Christmas and – I'm sorry. I skipped a slide. This one is hard to read but it makes the point that the rest of the world gets better prices. The VA price a lot lower than Walgreen's. The Canada price a lot lower. So that there are cheaper prices. And the issue of reimportation then is can it be done safely.

This report that came out is truly, truly a radical document. Basically it repudiates 72 years of U.S. political theory, redderick and economic theory. I don't know why we have any trade. Then I would guess given the – yeah, we have a 120 page report signed by the largest agency, the federal government, that says consumers don't save much, and this was the argument against NAFTA. And I assume the President, the state of the union, will pull us out of the WTO and suspend the [inaudible] World Trade Talks and repeal NAFTA and pull back

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the Caribbean Trade Agreement because it doesn't help anybody and of course it brings in unsafe products. So as you go home today check that you're not flying on an airbus or to have one and for gosh sakes, for gosh sakes, stay away from imported bananas. Wait a minute. You guys think that's funny. I was very traumatized as a kid by imported bananas. I loved them on my cereal and stuff. And then I heard this - when I was about eight, I heard this thing about there was this poor guy down in Mexico who was unloading a boxcar full of Guatemalan bananas and a little green viper bit him and he swelled up like double and almost died and was terrible sick. And I was so afraid my mother would get bit when she was getting bunches of bananas for me that I said that I didn't want to eat any more imported bananas and I didn't for years and years and years. We ought to grow them domestically because if we grow them domestically - my mother said that they'd cost \$5 apiece if we did that. I said, okay, mom, there won't be any green vipers in bananas grown in a greenhouse in Ohio. So this stuff is serious people.

This report is so amazing. Where's Johnnie Carson when you need him? Because it really is pretty outstanding. The joke though, I'm afraid, is on us because we pay for it with our own tax dollars. And fortunately, fortunately, there's a large group of members of Congress who didn't read the report, I guess, and are happy to proceed with efforts that were in the

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last Congress to get importation safely, if you can import drugs safely. And they would save some money. This is the number from the last Congress of the Senate Bill, and you can see it covers the full spectrum of Senate. Look at that, Kennedy and Locke on the same bill. The spectrum is not any wider than that in the Senate. And the good news is that while we've been here, if Pete Whitehouse is in the audience, we've been working very hard; he has been working very hard, on the introduction of this years bills.

Congressman Gil Goodneck of Minnesota with a whole bunch of house sponsors will probably have 200 very quickly and probably go over the 218 majority, has a new bill in HR328 if you'd like to lobby and urge your members to be supported. There were nine new senators elected this fall, most of them very conservative. Seven of them have introduced that Goodneck Bill this week. And either this week or the week after, soon, the new version of Dorgan Snow will go in. It has an excellent chance. A very senior republican senator said that if it got to the floor, there'd be about 75 votes for it. And this is probably the single best place where there's possible change.

Now that report that I was making fun of was accompanied by several statements that were basically threats veto. And if the President is really serious and, you know, this gets to his desk and makes a serious veto threat, he's not vetoed a bill yet in four years. This would be like one of the

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first tests of party loyalty, and that 75 votes that the senator was predicting could get a lot tighter, and it takes 67 to override a veto. So members, even though this is wildly popular, members need support and I hope you'll let them know.

Other solutions, negotiation. Retiring secretary of HHS Thompson said, gee, I wish I had negotiating authority. He said it on his retirement press conference unfortunately and not earlier. But the new law, as you know, blocks - this is a section of the law - blocks the federal government from trying to negotiate and net a decent price. And so we don't get the VA kind of price. And that would be a nice section to change too. I think - I'd just like to make a point that where we get hung up, where we lose the public or editorial boards is when the drug industry says, my gosh, if you question our profits, we won't be able to research anymore. We'll curl up and suck our thumb and not make any new products. This is a serious issue that we need to find a way to address and they to answer, this thing about we'll dry up research. There's a lot of dead kittens out there. This was sent to me by a democratic friend. I'm sure there's things like this on the republican side, equally silly, like if you know you vote democratic, a wolf might eat you or something. And this is how the drug industry lobbies, if you question our profits, we will kill your child. We will not invent that medicine that will save your child. It's, you know, the school of lobbying. Give me all your money

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or we'll kill you. And we have to think through how to answer that. We ought to really be working as to how we really get new breakthrough life saving drugs. I don't think we need a fourth kind of Viagra. They make the Super Bowl ads more interesting but we probably don't need a fourth version. We need stuff that would truly save us from cancer and Alzheimer disease. And we ought to be thinking - we ought to be having the national debate on how to encourage or use Medicare and Medicaid's purchasing power to get breakthrough drugs.

Here's just one solution, it's a little complicated, but basically we'll pay more for breakthrough drugs and less for the old line product. You know, a buck a quart for amoxicillin, but we'll pay through the ceiling for something that really is a breakthrough product. When you think about it, the current patent system is an incredibly inefficient way. It's a 20 year monopoly that doesn't particularly help us in getting new product. I'd urge you to look at this website, cepr.net. They've done some interesting work on, gee, could the patent system be changed in ways that get rid of the incentive to sit on old product and instead make new products. And the report that I just showed the title page to lists four or five different ideas, but we've been brain dead on this. We've been brain dead. We've let the industry scare us all into saying we can't question them, and somehow as advocates we have to break through that.

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I don't know if anybody's read the Marshall Angel, the former editor of New England of Journal of Medicines new book, The Truth About the Drug Companies. Great ammo in there about how little research they do, how little it costs. Same with the book called the \$800 Million Dollar Pill by a guy named Merrill Goozner, G-O-O-Z-N-E-R. Both of them, good ammo for answering the stuff that you constantly see on op. eds and talk radio and stuff. At the table I put out, and there's a few left - I hope there are - in the chairs in the back, a list of all the bills introduced in the 108th Congress, basically during 2004. It's a little wonky and many of you may not particularly appreciate it, but it's a description of the bills introduced to make corrections to the MMA, mostly democratic sponsors but there's some interesting republican ones. You'll see they're concentrated in areas like giving the secretary authority to negotiate upon importation and on stopping overpayments to the HMOs. It's an interesting list. It gives you a kind of menu of all the places where people thought there were problems in the new law and if we run out of them, we'll get you copies.

As I said before, all of these are long shots. The majority does not want to open up this law. They know they'd get very difficult votes, not only from democrats but from some of the more conservative members would like to save some money in ways that the Congressional leadership doesn't like. But even though they're long shots, precious building, most seniors

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as Dee pointed out, are still confused, don't know the details of this law and aren't familiar with it. As they get familiar, as we approach the fall where they've got to really focus in on it, pressure is likely to build. And not only that but we've got a guaranteed debate coming up on Medicare. There is a strange section, a Title Eight, in this law. Did you all read that, seven years before 45 percent of Medicare's total spending comes from general treasury revenues. President must warn Congress of this terrible problem. This was added to the law for the House conservatives who were worried about an expansion of entitlement. And they said, oh, gee, don't worry. If this new program takes too much money from the general treasury, we'll do something about it.

I think that when they put this in, they thought this would happen in the next decade. Well, change the economic conditions - it happens in 14 months. This notice of seven years will probably come up next February. By the way, anybody know where the seven years and 45 percent comes from? I don't know. Several of you have heard me say this before, but do you remember the Groucho Marks quiz show where the magic word and the duck would come down with this word and you'd win \$100? There was this duck in the legislative drafting room that came down with a 45 and seven and it got into the law because it makes no sense. We don't do this in the Department of Defense. We don't do this to Congress. Nobody has this kind of

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craziness. And it continues, let me – the fifth year it gets serious. He submits legislation and that legislation is supposed to be fast track or special, sort of like the base close, military base closing legislation that they've done. Now I think there's – I think there's a lot of sound and fury in this thing. I'm not sure it's all on the up and up. I mean they could vote no and say we've changed our mind; we don't care if it's 45 percent. And there are some filibuster loop holes left in the Senate, so it can't get too wild and hairy. But what it does do is over the next year or into next year, which is an election year, we're going to have a pretty ferocious debate on Medicare and the thing for advocates to do is not only fix the current law but make sure we don't further use this thing about 45 percent to ship cost to beneficiaries.

This is one heck of a chart. It's worth spending a minute on. For a 65 year old, for a 65 year old having the average social security check and average illnesses, average use of Medicare, if you take the hospital deductible and the doctor co-pays and part beat premiums and the drug premiums, the drug co-pays, he'll use 37.2 percent of your average social security check just going for what – Medicare's little gaps. That grows rapidly. Look at 2026. In 20 years over half the check goes. If you're an 85 year old, add about 15 percent points to this chart. So you're looking more like 70. Well, in the first year not so much, but by 2026, add about 15

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points. This says some things, which is that Medicare, despite being one of the best programs out there, has some horrible gaps in it and is increasingly expensive for seniors. We've got to get a handle on cost, particularly drug cost and makes you question about whether social security benefits should be lower in 20, 30, 40 years from now. But that's an ominous chart and we should use it to fight further cost shifting to seniors.

Peggy, is this on our website? I believe it's on our website. FamiliesUSA.org under Medicare. If it isn't there today, it will be tomorrow. In sum, and I'll basically go back, if I could to one kind of chart that Dee had. I'm sorry. The next one please. It's on polling. Well, I'm sorry. Never mind. Never mind. In Dee's polling about confusing and stuff, there was one question that was asked, how angry - are you excited and really like this or does this law make you angry? And we're spending \$530 billion on a new law that had three percent enthusiastically excited and 10 percent angry. Now anger is kind of unusual in a poll and it shows great discontent. And this anger will be rising as people learn more. And our goal as activists is to channel that anger into constructive change so that we can achieve savings and drug pricing, not only for seniors not only for the disabled on Medicare, but for younger people. And in this new law it seems to me that we've been handled really an amazing organizing

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tool, a chance to educate on alternatives, a chance to build a case for change, a chance to work for drug pricing transparency, it shouldn't be such a great secret, a chance to lobby drug companies to continue the low income programs they currently offer.

Many of you, I think, have looked at this new law as a lemon. This is a great case to make lemonade. And with that I'll quit. So thank you.

MALE SPEAKER: Our table mics don't seem to work. Before we go to questions, I want to make sure we hone in on Bill's message. The headline here, I think, is nations leading consumer advocates convene and vote for boycott bananas in order to save kittens. Is that - messaging is critical and I guess you've got to stick with that. Let's turn to questions. Where are the microphones? A gentleman is coming up here, terrific. And in the back, go ahead, sir.

DON LEARY: I'd like - oh, my goodness gracious. Alright, if I can, let me vent my frustrations here along with, I'm sure; a lot of other people are frustrated about the situation. Let me first say this has been one hell of a conference and I've enjoyed every single minute of it. I have great, great respect, of course, for everybody that's out here doing this kind of work and in this particular case this subject matter needs a lot of work. I had the good - I had the wonderful opportunity to hang around with Walter Cronkite while

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I traveled with his tape all through New Hampshire during the campaign, three or four months. I met hundreds and hundreds of seniors at various meetings all over New Hampshire. By the way, my name is Don Leary and I'm with the Alliance for Retired Americans and I have the greatest respect for Bill's comments about repeal and the necessity to have something in place. I would say to you that there is - what I found is that throughout the trips that I took, shock and awe was the only real good descriptive of people looking at me saying why would my government do this to me. New Hampshire seniors in New Hampshire believe that the social security fight and the Medicare fight are one.

What they have done in New Hampshire is New Hampshire seniors have filed a resolution, have voted on a resolution before we come here this week to ask to see if we couldn't fight the good fight to repeal this law and get rid of it. The two things that need to be done is to repeal the law and to replace it. And the other thing - replace it with something decent. If we can't come up with something decent, then we're in the wrong business. But we need to replace it, there's no question about that and we need to be ready to do that. But if seniors are strong enough throughout this country, if seniors stand tall - and by the way, wasn't it the seniors we're talking about right now that had - that were named as the greatest generation. Well, by God, the greatest generation, if

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we wake them up and educate them to the points of this bill, which are absolutely ridiculous, they will, in fact, stand tall and save this country again, and we need to give them that opportunity.

MALE SPEAKER: Thank you, sir.

DON LEARY: Seniors will be, no doubt, outraged. This is so egregious. So egregious to the American spirit that we need to stand on top of this until it is gone. Importation, why I am supporting, the Alliance for Retired American in New Hampshire are supporting the importation bill that we've filed in the New Hampshire House. But the question needs to be asked why are we doing importation when this is our country and we have the right to get the drugs here. Why the hell are we driving buses to Canada to get drugs that were manufactured in Virginia? It makes no sense. Over 65. There is no politics involved here with regard to republicans and democrats. Do we really want to get away from politics? We can do that. The bottom line of the political question here is seniors over 65 have a primary concern and that is their health. And they don't care if they're republicans or democrats. They want to — before they leave this world, they want to live a good life. Now, we have friends in this fight. We have friends in Congress in this fight. We have people in Congress that have called for repeal. We need to get the job done.

The New England states, by the way, are right now

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setting up to follow New Hampshire's example to reach for a poll. The facts out here - who would, if we got the facts on the table about how ridiculous this drug is, who would listen to somebody to try to sell them a social security package? Nobody. Nobody with common sense. And I'll close with this, this is 700 pages of garbage written by the pharmaceutical companies and handed to representatives that have been bought and paid for. We have a right as seniors in this country over 65, 41, 42 million, over 65 can file, we're going to find this out, a class action suit against the Congress and the United States for fraud and embezzlement. Now -

MALE SPEAKER: Sir, we need to make sure we get on with other questions.

DON LEARY: Alright. One more comment. The fraud and embezzlement question is that they needed to get the money in their coppers, in their campaign coppers, money, lots of it. They needed to get that money in their coppers before they went and voted, and that has nothing to say about what the oath of office they took to vote for us and not the drug companies. These guys are ripping us off over here on the hill and we need to nail them down. In 2006, once the drug companies get their teeth into this, skip it. We're dead in the water. 2006 is too late. God bless. I'm catching a plane so I'm out of here.

MALE SPEAKER: Thank you very much. Good. We'll start in the front of the room.

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LOU ALBANO: Lou Albano, District Council 37,
[inaudible] retired. That was quite a lengthy statement. I
don't intend to make one as long. I wish to make a suggestion.
We need to change the direction obviously. This conference has
shown the ways of so many ethics by so many people in making
contributions to change. But we have a president that says we
have a crisis in social security, bullshit. We have to, lead
by this organization and other affiliate, take a 30 day effort
as a suggestion that we send letters to every editorial board,
every congressman, senator, state representative, city
representative, town representative in the next 30 days and say
where is the crisis, it's here, it's healthcare. Why fix
something that's not fixed - needs to be fixed? You want to
spend \$2 trillion, let's spend it here in the medical effort
that needs to be done to help people to save lives. We need to
have our own earthquake and a tidal wave to sweep across this
country to save lives. We are talking about a change in
direction and this president must here that message. Thank
you.

MALE SPEAKER: In the back of the room, ma'am.

MARGIE WARE: Yes, my name is Margie Ware and in my
private life I am a member of the Democratic State Committee in
Massachusetts, but in my public life I am a SHIP Director in a
rural county in western Massachusetts. I paid my own money to
come to this conference because SHIP programs can't use their

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funds to come to an advocacy organization, but this is important to me. As important as advocacy and the gentleman from New Hampshire and getting us all riled up, I want to remind you that at the end of the day, and I think Dee made this point very, very well, the people out there, very frankly, they don't know enough to be angry. They don't even know this is going to happen. This is all new information. I've spent the last four months asking people to please pick up a copy of our agency newspaper so that when we start writing articles, they'll know it. But I know from four years of working on prescription advantage, that, you know, people who read the New York Times everyday, they're not going to know anything because, you know, that's not where the information comes.

Most seniors that I deal with who are disabled or have a vision problem, even getting a recertification in the mail is something they can't handle and so it goes to family care givers. So number one, I want to say to all of you who have aging parents in this room, please be out there helping them and informing them about what's going on because they're going to expect that you know what's going on and guess what, nobody knows what's going on. And at the end of the day, remember, most of the people in the SHIP programs are volunteers. I'm the only paid person in my program. And in some states there's one person and it's a phone line. I've been thinking about this for six months, but if I don't know until next October

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what plans are there, how – you know, I can go sit down with nursing home administrators but I can't tell them well, what's it going to look like. So I would just encourage you all it's important to get hot and bothered and we need to do that on the legislative level, be sympathetic to those of us who need to face to face, sit down individually with confused people over 65 and somehow navigate this maze and make it okay for them at the end of the day.

BILL VAUGHAN: Thank you. And I hope that remakes the point how thin the resources are here and how we need more – there's just one of you as a paid and how many volunteers?

MARGIE WARE: About 30.

BILL VAUGHAN: About 30 for western Mass.?

MARGIE WARE: [inaudible].

BILL VAUGHAN: Okay. This is a program that's stretched very thin around the country and anybody who can help with appropriations, please.

MALE SPEAKER: In the front of the room.

RAMONA SHERGOFF: Ramona Shergoff from Florida. I would like to make a suggestion that when you send letters to the editors, the key thing that you put into those letters to the editor are the names of your elected officials to whom you're really addressing those letters. That the way that they will get the attention of these elected officials is by seeing their names in the newspaper written by people. So those names

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are the most important names you can put in. That's it.

MALE SPEAKER: Thank you. Let's go to the back of the room again.

MIKE OXFORD: Yeah, hi. My name is Mike Oxford. I'm the President of the National Council on Independent Living and I run an independent living center that serves people with disabilities younger as well as folks from the aging community in terms of long-term services and advocacy. And I just want to make a suggestion about strategy and rederrick. Kind of throughout this conference there's only been reference to aging, and at the same time we're talking about we need to build big coalitions, and a certainly realize that most of the folks we're dealing with are ageing. However, there's a significant subset of people who are dual eligible and social security disability income recipients who are working age, several million people, and it would be wise for all of, in terms of our coalition building to remember that. And as we do our reaching out if we only talk about this and think about this as an aging issue, I think we're going to miss some coalition partners and it's critical that we pull everybody together as much as possible and it misses the boat to only think this is an aging issue.

BILL VAUGHAN: I apologize for not using that word or people with disabilities more. You know you get wound up and I apologize because we do try to be sensitive to that and we've

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just got to try harder. It's an awful good point. Thank you.

MALE SPEAKER: The front of the room, sir.

JACK LIGHT: My name is Jack Light, L-I-G-H-T, and in 1966, I was a young kid involved very, very firmly in setting up the Medicare and Medicaid programs in California. I was responsible for the administration of these programs, the processing of claims, setting up the system, etc. And I had no intention of getting up here to tell you this, but you have a message, this program will not work. It absolutely won't work. It's not un-administrable. It's unexplainable and it's un-functional. All it's going to do is make some very major manufacturers very wealthy and it is going to destroy the lives of a lot of old people who have - who deserve better. Mechanically, if for no other reason, it has to be stopped. It is non-functional. You can't let it go. You've got to stop it. You cannot fix it. You have to stop it.

MALE SPEAKER: Let me stick on that point because Bill flagged this at the beginning a little bit. How does one in the community balance the advocacy for either sort of stopping repeal with the potential desire to, you know, make sure the duals default enrollment actually works and maybe find the \$5 million low income people for whom this is a very comprehensive benefit. How do you balance those two?

DEE MAHAN: And it's something that I was handed a note to remind people of. Is you delay enrollment. The law as it

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is right now has late enrollment penalties. So that's - there are some low income individuals who have no healthcare, no drug insurance right now, no drug coverage who could be helped, as Jack had mentioned, and they do need to go and sign up and get access to the benefit and don't overlook that. And it's certainly understandable, the benefit is very confusing. And being angry about it is certainly understandable. But, Bill, why don't you talk a little bit about the point that you'd make.

BILL VAUGHAN: The - it's going to be awful for dual eligibles, but then you look at where Medicaid in a bunch of states is heading. So if this is repealed, as much as we're all standing for Medicaid and against block granting, against cutting it back, some states have already to limited to what, four scripts in Tennessee, three in Texas and the Medicaid benefit is getting pretty shabby. So before we repeal Medicare let's think about where Medicaid is heading and if we can win that Medicaid fight. But I'm back to - it's worth maybe half a minute, I was on staff of really the authors of Medicare Catastrophic and, boy, there's some strong odor, but I was on committee staff of Catastrophic, and when it was repealed, the only thing that survived was the Quimby Slimby Program really of paying apart the Quimby program of paying the part the premiums deductibles and co-pays, but nothing else basically survived. And for years, literally, for several years after

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when as a staffer you kind of move behind the members and you pick up the buzz and – well, I don't want to offend anybody but the G.D. Greggy Geezers, that's the last time we do anything. The members were so upset at the reaction and they said well, they didn't listen well, but that was their reaction, was well, we're not going to touch this area again. We're not going to come back and help seniors because all they do is bite you in the hand. And it was years, it was '96 before the next real Medicare drug benefit was put back in. and all I'm saying is given the budget situation that's been described to us and how many people want to spend this 530 billion that's been committed to this part of the world over the next 10 years, I don't think it will stay and I don't think there will be anything there. Now we can say, well, the heck with it let's just get cheap pills, back to [inaudible] quote, If we just got cheap pills, that would be good enough. I'm telling you, when you got 11 percent of people taking more than 12,000 a year in pills, maybe that isn't good enough. Sure you can get those pills cost down to two or three thousand, but what's the average social security check.

I'd just be very, very careful because this money will not come back easily. And as much as we dislike this, I urge you to think of ways to work it to help those people who aren't able to come here to this conference because they're already so sick and so low income. And there are some of those who are

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helped by this, folks.

MALE SPEAKER: Let's go to the back of the room.

FEMALE SPEAKER: I have some questions about the nursing home situation. I have a concern and maybe you can address this as to whether nursing homes will be able to simply contract with one plan and basically say to the individuals that are in that nursing home, this is the plan that we're going to work with. If you don't except this plan, you'll have to go to another nursing home. Is this a real possibility? And if so, what would you suggest that advocates do?

DEE MAHAN: I'm going to answer this as best I can, the final regs just came out last Friday and we've been reading as fast as we can and trying to remember as much as we can. And also perhaps if you can come up afterwards and give me your name and I can just go back and make sure that the answer that I give you right now is correct. But the regulations indicate that plans have to contract with any pharmacy that will accept their standard contract, and that applies also to long-term care pharmacies. So there is a lot of rederrick in the preamble of the final regulations talking about increased competition among long-term care pharmacies, that that's going to bring prices down and that will be a very good thing and that nursing homes will want to go out and contract with as many long-term care pharmacies that are connected with plans as they can.

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Every plan that participates in the program has to have what right now in the regulations is defined as convenient access for long-term care facilities that – there’s an indication that convenience is going to be spelled out a little more specifically in terms of future guidance. But in terms of contracting with just one, I know the plans cannot do that. A nursing home, I don’t know if there’s anything in the regulations specifically addressing what a nursing home does itself, but I would think that the facility would want to look at the plans that the residents are participating in and try to work it that way. I’m not sure what it would look like. Do you have anything to add?

BILL VAUGHAN: No, other than this is the kind of example, in September, October, when we actually have the hard examples to document. You know, there’s 100 people in this nursing home and 50 of them have less of than half of their drugs covered under a possible combination of plans available in that nursing home, members of Congress might act. I mean that’s pretty overwhelming documentation, but we need hard facts.

MALE SPEAKER: Sir, in the front again.

TIM MILLER: Thank you. My name is Tim Miller. I’m from the Oregon Health Action Campaign. What I’m about to say is not endorsed by the Oregon Health Action Campaign. This conference has been great. It’s been very stimulating. It’s

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been very encouraging; at the same time in some ways it's depressing. I believe in the work that we can do and the work that Families USA and all of us have been doing, but let's face it, we've only had limited success. And if we look on the other side, if we think the other side is not using similar tactics, organizing themselves, writing letters, all this kind of stuff, then we're fooled. Jerry Follow has come out and said he's going to mobilize 40 million for 2008, right? So I believe it's time to start looking at the possibility of upping the stakes.

If you look at this country, there's never been a progressive social movement, whether it's women suffrage, civil rights, labor, anything that hasn't come to a point where there's been civil disobedience in the street, blood flowing. I believe it's time that we at least look to the possibility of linking with other organizations who have experience and dedication and the balls to defy the law, to go to jail if that's what it takes. I think we have an obligation to at least link, maybe not directly supporting, but working in coordination. And this is a comment, an idea, just a suggestion, food for thought, maybe I'm crazy, maybe I'm not.

DEE MAHAN: Thank you. You're right when you talk about the rederrick and good messaging, and I suggest that you come to hear our lunch speaker, if you'll be around, Joe Trippi who is going to talk about getting messages across.

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MALE SPEAKER: Let's go once more to the back.

MILDRED FRULING: My name is Mildred Fruling. And I'd like to ask a question. We've been speaking about the prescription drug aspects of this Medicare legislation and actually the focus of this legislation is privatization. Prior to 1965, when Medicare did not exist, private insurance were the only available sources of health insurance for seniors, and more than half of all seniors had no coverage because they either could not afford it or because of their chronic conditions which insurance companies were not to anxious to insure.

As I understand it, and perhaps I'm right, the demonstration projects, which have not been mentioned and I understand are still in the offering, are going to be a means to an end. Prescription drugs was the Trojan horse, privatization is the goal, what do we intend to do about that?

BILL VAUGHAN: Thank you, Mildred. There's this debate that we're going to have starting well in 14 months on the 45 percent thing will be a great chance to say, hey, if you worried about treasury money going into this program, how come we're over paying the HMOs compared to fee for service so much? How come we have this 10 - it's actually \$12 billion slush fund for these new preferred provider organizations? We can repeal that. That would be some of the first places we can save some money and we even have Senator Gregg, the conservative budget

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chairman from New Hampshire, talking about some of these perhaps overpayments. I believe it was Gregg. I better double check that.

But in the handout of corrective bills, you'll see favorite things to fix the bill. An awful lot of it deals with fixing the overpayments. And if I can have one minute, page three of those sheets, for people who have them, is a very inside the beltway joke. You'll see there's about 25 bills introduced to repeal the CCA, which is what Mildred was talking about. A six state demonstration to start in 2010 that would basically privatize Medicare and drastically drive up premiums for anybody who tries to stay in fee for service. You'll see a whole bunch of democrats in different states putting in NIMBY, Not In My Back Yard Bills, meaning this CCA can not appear in our state. Why did they do that? There was a lot of rumors, street talk, that several republicans who said that they were for this bill and actually conditioned their vote on passage of the drug bill on a commitment that the CCA not occur in their state. So there's some teasing going on here that nobody really wants to force fee for service people to pay much higher premiums. And you watch, over the next year or two of budget debates, I think we can strip some of this stuff out.

DEE MAHAN: I also think, and Bill you can tell me if you think this would work in terms of strategy. If you look at the drug benefit, it's delivered through private plans. And to

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the extent that it does create massive confusion, that people are dissatisfied, there is an opportunity to say, look, when you try going with the private sector for this and no other option, you know, it just doesn't work. And that's certainly something in terms of monitoring plans and what's going on in your area and laying the groundwork for future action because Mildred is absolutely correct.

BILL VAUGHAN: We're overpaying the private plans six to 20 percent compared to fee for service.

MALE SPEAKER: We'll go to the front of the word. Yes, ma'am.

LULA LUCKY: Hi. My name is Lula Lucky and I'm from Roanoke, Virginia. Okay. My name is Lula Lucky and I'm from Roanoke, Virginia. I was listening to them talking about seniors not knowing. Three days before I left Roanoke coming here I had a workshop with some seniors on Medicare and the new benefits that's coming out here. I ordered my books through CMS and they sent them and I had 23 seniors. They knew nothing about nothing. Their ages was running from 68 to 94. And only four out of the three - out of that bunch said that their daughters went on the internet and got the policies and all of the internet and they was the four that had gotten the \$600. And the rest of them were like saying, you know, I got \$240 where did that come from, you know? So right at that point I didn't get into it because I felt I don't want to say something

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I'd be sorry I said because senior's minds kind of get a little twisted off sometimes. And what I want to say to you privatization, as I said before this group three or four years ago, people don't understand what the word means. Seniors don't understand what the word means, and that I got from experience in Winchester, Norfolk, Richmond and a couple other places.

But what the seniors need to know is what's happening to them because a whole lot of them are afraid that they going to get cut off with the dual - with the dual process there because a whole lot of them, like they say, I don't get by \$521. If I didn't get Medi - what is it, Medicaid, to pay for my medicine, I couldn't make it. One of them said she only gets \$607 and if she didn't get Medicaid, she couldn't make it because she has to eat. And only one of them out of that whole group lived in a senior building. And what I'm trying to say now, and I go along with the lady that - whoever was speaking when I come in, we need to know what to say to the seniors and especially those young mothers that have those children that are CHIP and they are being cut off because they don't know where they going.

MALE SPEAKER: Thank you. Do you want to state a little bit more again about how information is going to be getting out to folks so that they do have a sense of what to say?

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LULA LUCKY: Well, we have a LOA organization in our area. And most - some of my workshops I do I go through them so it can get to the other part of the, you know, the older Americans in the area.

MALE SPEAKER: Alright, thank you.

BILL VAUGHAN: In terms of that information, I want to correct a misstatement. Senator Gregg has talked about getting rid of 89 billion in subsidies for corporations for providing retiree coverage of this drug benefit, not the HMOs. I misspoke and I know he's sensitive on those kind of issues.

DEE MAHAN: In terms of information that's going to be getting out to people about the plan, a lot is not finalized yet in terms of the regulations and requirements and marketing material. The plans are going to be expected to provide material. CMS will be doing an awful lot of marketing, whether it's any better than the discount card, I can't say. I can't make any guarantees.

LULA LUCKY: Well, how do you make seniors understand what they are doing? They don't have nothing to gain. They're losing.

DEE MAHAN: Well, and getting information out to seniors and others in Medicare is a huge issue and that's a lot of what I talked about. We need to do the best that we can. And has Bill mentioned, funding for SHIPS is going to be incredibly important. What CMS is finding information strategy

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looks like is not – not out there and known right at this point in time.

MALE SPEAKER: Let's go to the back. We have about eight minutes and I see about three more questioners there and one more in the front.

BECKY MARTIN: My name is Becky Martin and I live in Florida and I spent most of the last year working for the Florida U.S. Action Affiliate on the Medicare Education Project and as part of that I showed your fabulous video with Walter Cronkite to about 3,000 seniors across the state focusing a lot on getting into the more rural parts of the state. And it just had a wonderful effect and I really wanted to get up and thank you all for putting the effort and the money into doing that. And my question is when is the video that's going to explain about the dual eligibles cut going to come out? It's enormously helpful. I did probably talk to about 1,000 people before I had the video and then did the remaining 2,000 with the video and we're such a culture that is so used to accepting what comes out of the TV that that is a really enormously useful tool in explaining what is a very difficult to explain piece of legislation and this dual eligible part is even worse. So I really hope that you got that in the works.

DEE MAHAN: Well, we'll certainly take your request under advisement. And thank you very much for your comments on the video. And I know Bill got to see a lot of the country

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last year.

BILL VAUGHAN: And we have about 80 copies of the tape left over if folks haven't seen it or would be willing to show it. It's still relevant.

BECKY MARTIN: How many of you folks have seen that video? The woman who was just here at the mic is one of the stars. Well, the rest of you need to get it and see it and put it to use in your communities because it is still very relevant and it's an extremely useful tool.

DEE MAHAN: You can get access to it through our website, www.familiesusa.org. And also -

BILL VAUGHAN: I've got 80 hardcopies I'm trying to get rid of.

BECKY MARTIN: I'll take some more of them back with me.

DEE MAHAN: Or you can email directly to bill. And also, I mentioned earlier that we will be doing a lot of things on the web, have a resource center on Medicare and if you want to come get in the loop on that and send us thoughts, information on what's going on in your community, you can email to Medicare Action at familiesusa.org. That email address is, I believe, up and running right now. The other aspects of the resource venture will be developing, but we would like to hear from people.

BECKY MARTIN: Well, I asked at every meeting that I

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went to a show of hands from the seniors of who had computers and never did more of a third of hands go up and in the low income areas mostly nobody really had computers, so I really encourage you to make it available through video if you do something like that also.

DEE MAHAN: And I think - let me ask you, Peggy, if someone is doing a presentation can you do like - what do you call it - the video stream with what we've got on the web? Yeah. Okay. Also, as I'm being reminded, we send a copy of the video to every senior center in the country and then do contact us if you need a hardcopy or if you want to talk to someone about your technical assistance for doing a video presentation based on what we've got on the web because it can be done. I don't know the technical aspect of it.

BECKY MARTIN: Well, we need it for the dual eligibles. Thanks.

MALE SPEAKER: Let's come to the front.

TERRY GENDELL: A couple of comments. I'll try to be really quick. I'm Terry Gendell from the Chicago Area Agency on Aging and we are working in coalition with Centers for Independent Living, which address the disability folks who are in Medicare as well as some of the policy groups. I just wanted to suggest a language change and I know that I keep suggesting this and I don't see anywhere. We've started to use it and it started being pretty successful. Let's stop talking

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about Medicare beneficiaries, it seems especially inappropriate considering what we're talking about in the law here, and start talking about Medicare consumers. We're asking them to be super consumers, make choices beyond what anybody else in the country is being asked to do. It also is inclusive of all of the people in Medicare and it also addresses the issue that some of those Medicare consumers are the caregivers and professionals and others that are trying to understand this. So that's just a suggestion as we're all developing messages and materials to start changing the language across the country on that.

And just another quick point is beyond just SHIPS that need funding, there are in place trained folks who in community based organizations through all the coalitions that are being built that are ready to go or could easily be trained because they have 90 percent of the knowledge and we need to start seeing how collectively we can address getting some funding to those community-based organizations not just SHIP. So I'd like to expand that conversation as well.

DEE MAHAN: Okay. Thanks. That's a very good point and I think sometimes we spend too much time in Washington and using words like Medicare beneficiaries and it's nice to hear people out there who are listening.

MALE SPEAKER: A lot of pressure on you, sir. You're the last question at the back.

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HARVEY FERNBACK: Well, not a question. This is Harvey Fernback, Physicians for National Health Program. Obviously people know what our solution is but what I really want to offer is a quick face on this wonderful discussion. [inaudible] is that it's a great country, unfortunately, we can't get legal drugs to our people and we can't keep illegal drugs from our people. Thank you very much.

BILL VAUGHAN: It's like we're going to have an ownership society, but not ownership of cheap drugs.

MALE SPEAKER: I want to wrap this up and than folks. I think we, just sort of summary, if we could go back to where Dee started. The title of her presentation was, How to Help Consumers and Build Pressure for Change. She talked about educating, monitoring and advocating. In sessions like this we always want to thank the panel and we want to do that, but the session is really dependant on you all also so let's thank everybody in the room. There is now a 15 minute break to 10:45 and then you move to the workshop sessions at that point.

[END RECORDING]