

**Briefing: Medicare Drug Discount Cards:
A Work in Progress
July 28, 2004**

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DIANE ROWLAND, ScD.: ...and Beth Fuchs, Mike Hash and Julia James are all going to take turns sharing some of the key issues and findings from the report with you and have a handout in your folder that I know they'll walk you through. And then we're going to turn and ask Mark McCullen, who I know you all know, to make a few comments from his perspective at CMS, and then really open it up to questions. I know many of you have the recent [inaudible] on your mind, but we'd like to at least suspend the first portion of our discussion, talking about the discount card program, and I want this to just be a very informal briefing. We're not issuing press releases or trying to make a lot of news today, we're just trying to bring you up to speed on what we see going on with the discount card program. Then please join in, we'll have a few callers coming in on telephone lines that'll probably dominate us and come in over the loudspeakers, but we'll give preference to the people in the room for the first round of questions and just identify yourself. We won't go around and identify ourselves now, but just identify yourself when you get to the question period. Let's start off with Beth and the report.

BETH C. FUCHS, Ph.D: Thank you very much and thank you to the Kaiser family foundation and Diane and Tricia Newman for asking us to do this and in various ways helping us out as well. We take responsible for the findings here [inaudible]. We were asked to sort of take a first look at how the discount card program was doing, mostly from a beneficiary perspective. In doing this, basically we're looking at sort of the role and characteristics of

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the major discount card programs out there, taking a look at beneficiary enrollment and outreach, primarily by CMS, and then the prices, what's happening in terms of the discounts themselves. Do they deliver any savings to beneficiaries? Does the choice of a particular card matter to the beneficiary? And are prices changing or have they changed over time?

What we ideally as researchers would have liked to have done was to get the entire underlying database that CMS has for the discount card program with all the drugs, all the cards, all the sponsors, and all the areas of the country. But they consider that proprietary, so we were sort of left to do what beneficiaries do, and that's use the publicly available resources. So we used the same websites that the beneficiaries are using as well as CMS's more detailed information. We went to the discount card sponsors' own websites when they had them, and not all of them were operational at the time we started. Even a couple at the end were not fully operational at the end of our study. We also looked at the various things that CMS has done to try to educate and to outreach the beneficiaries. I should say that the CMS [inaudible] and sales are very helpful in answering a whole slew of questions that we had trying to keep on top of the program.

I'm just going to touch on some of the major findings we had about the features, characteristics of the card program, and then my colleagues will join in with some additional findings, including what happens with prices.

One of the things that most intrigued us was, who are the people who are sponsoring these cards? Who are these guys, anyway?

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The first thing I think I want to clarify for you is that we're largely talking about—although the report does talk about the [inaudible] cards that are provided by the Medicare Advantage plan—the information I'm providing right now is entirely valid, they call the general [inaudible, audio fades out]. They're both that national, nationwide card programs that are out there, and ones that are in state specific areas, and they're referred to as the regional cards. So everything that I say just about has to do with these national and regional cards and not the MA exclusive plans.

If you look at these card sponsors and ask who they are, I think one of the things that makes [inaudible] if somebody is looking out for the beneficiary is that you really have to ask an awful lot of questions and there isn't a whole lot of transparency in trying to figure out who the card sponsors are. While CMS has obviously required these sponsors to meet a variety of regulatory and statutory requirements, including things like their business background, how long they've been in existence, how many covered lines they had previously in dealing with pharmacy management, for somebody who is simply trying to understand who are they, it is very difficult to find out that information. There's very little information on the CMS website. If you look to the sponsors' websites and their brochures, it's not consistent, it's not terribly informative. So I would say that there isn't much transparency there. Now this is the problem, not as much of an issue for program [inaudible, audio fades out], but it is something I would suggest to you [inaudible], it would be nice to know a lot more about who it is that is offering the particular benefits.

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If you look at the types of people who are out there offering, the so-called sponsors of these cards, not surprisingly the majority of them are the pharmacy benefit managers, about 53%. These include some of the names you're all familiar with, like Advanced PCS Care, [inaudible]. Then there are a whole lot of card programs that seem to be described as third party administrators, and then other kinds of categories. Some of them were actually discount card vendors in the commercial role and then switched over to doing this.

There are, as you all know from lots of reporting of your own and others, that the beneficiaries apparently are very confused by the "bewildering array of choices out there". It is certainly the case that when you look at the original announcements from CMS-- there were 73 or 72 of these general cards available out there, depending on where you are as a beneficiary in what region--there could be as many as 64 at one point that hits you when you go out to the CMS website. So if you're a beneficiary that means you have to look through a lot of information, at least initially, to figure out which card program may be best for you.

CMS approved essentially every applicant, as far as we know, that came in that could meet the various program qualifications. So it's not sort of a prudent purchaser approach so much as we have all these requirements in place and if these particular folks can meet these requirements then we're going to approve them. And so you've got that large array of cards.

When you look at them more carefully, though, it does appear that there are fewer card choices than terms of prices

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offered, pharmacy network, mail order, and the other kinds of features that go along with these card programs than meets the eye.

First of all, of the original 39 national card programs that were out there—and there were about 33 regional—there were about five I believe that dropped out from the initial [inaudible]. And then when you look at the card pricing and all the other features very carefully, you find out that a number of them have the same prices, the same discounted drugs, the same pharmacy network, and then maybe slight variations on the mail order options. Sometimes there are enrollment fee differences. But in general you can say that there are fewer choices [inaudible, audio fades out.] Also if you're using a website, a couple of the [inaudible] falling off for a variety of reasons. [Inaudible] some of it has to do with pricing and some of it has to do with other practices.

So as a beneficiary you have this bewildering array of choices, but maybe it shouldn't be quite so bewildering if there was more information available on these cards. Just take a quick example, if you look at the number of cards available slide, take for example the [inaudible], just using one week in July, three drugs, asking for pharmacies within a seven mile radius on the left side. When you look at Medicare.gov you initially get 33 card options. When you looked at the cards specifically by prices, by pharmacy network, by [inaudible], it really was six cards were offered by Advanced PCS were all the same. Then there were four additional sets of two cards each that were the same. So the choices are actually down to 24. Now for beneficiaries that's still probably quite a lot. But it does suggest that the choices and the

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confusion could have been somewhat less if there had been sort of more information about what these cards were offering to the beneficiaries themselves.

One thing I should note is that you probably know, Dr. McClellan has mentioned that they recently changed the website so that there are fewer card options that come up initially [inaudible, audio fades out]. There are possibly some other issues involved there, though, but apparently it's a lot more simple process now after we've finished this initial look.

Just quickly going in to more [inaudible] on who these card sponsors are and their partners or co-branders, the next slide simply says that if you look at what they call the PBA's, they're actually the pharmacy benefit managers as well as the card administrators, that have connected with contracts or other relationships with these cards, that [inaudible] is obviously linked to [inaudible] general cards and you go through them as slides. And so we also asked the question, is it really just the PBA or the PBM that determines what the key features are? Prices, pharmacy networks, etc. And I wish I could say yes, [inaudible], but there's actually enough variation that you can't make that simple generalization. It clearly is a major influence, the PBM, the PBA, [inaudible]. But the configuration of sponsors may actually have different features in there. And these guys, as you may know, they co-brand, there's different folks who will join together with a specific PBM, so the cards actually look a little different.

The next thing we asked was what are the covered drugs? In other words, which drugs are being discounted by these various card

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programs? It would have been lovely if I could report to you that we could figure this out, but if we could we had to do it on a basically drug-by-drug basis, just like the beneficiaries do. It's really impossible for us to give you anything conclusive about the nature of the so-called formulary's drug lists that are available for these card options. [Inaudible] that it promotes the card, promotes beneficiaries, they will list most of their drugs. Now that the so-called drug dictionary that is available on the website is more complete for the beneficiary, it's more likely to be a satisfactory enterprise to figure out whether the card program is offering those drugs. However, if you go to the card sponsors' website, the range of information is very variable and it's very hard to use those websites often to figure out which drugs are covered.

One other thing I should point out is if you're a beneficiary, you have some of those really, really high cost drugs, you have to be very careful, and I would suggest that they check specifically with each card program to find out whether they can get a discount and how much.

Finally, just a very quick look at the state pharmacy assistance program and also the pharmaceutical manufacturers programs and how they coordinate with the discount card. I won't spend any time on this now because I think Mark McClellan may have a little bit more up-to-date information, but the big issue is that whether or not the state pharmaceutical programs can essentially auto-enroll, automatically enroll folks, people like low income folks, into these cards. Seven of the programs out there had

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already done so, a few more were essentially getting the beneficiaries to fill out applications. He may know of more, but it seems to be, from what we can hear in the field, that a number of states are still trying to figure this out, how to coordinate it with the program.

Finally, [inaudible], if you looked at the press releases from the pharmaceutical manufacturers since January, there's been a lot of announcements by the various companies—Pfizer, Navardis, [inaudible], etc.—that they will be essentially offering additional help to those beneficiaries who are on transitional assistance once they've got the \$600 credit. I would say until recently it's been very hard to pin down that information, the links on the Medicare website have not been complete in information. They seem to lag what the pharmaceutical companies are saying. I think part of that has to do with the fact that pharmaceutical companies have to negotiate contracts with each and every card, and those contracts have not kept up with their press releases. But now there's almost full information that's available when you click on the Medicare.com website.

With that, I'll turn it over to Mike.

MICHAEL M. HASH: Thanks, Beth. The report that you can see also took a look at the beneficiary enrollment process, the experiences in enrollment, and of course beneficiary education and outreach. It was an enormous challenge, given the 40 million beneficiaries in this program.

The first slide you have there just kind of recaps what the requirements are for the two types of enrollment. There's the

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general enrollment for the cards that are available to everybody except people who are not enrolled in the Medicaid program. And the actually enrollment process itself is handled by the card sponsors, they get the applications. Then for the verification of those applications for cards by CMS who determine whether or not individuals are enrolled in Medicaid or not. With respect to the transitional assistance program, which is the low income \$600 credit for individuals who have income less than 135% of poverty, that enrollment process requires a signed application in which the beneficiary or his or her legal representative is attesting to the fact that they meet the income requirements that are set forth and that they also don't have any other coverage, whether governmental or private coverage, with the exception of being enrolled in an MA plan or a Medigap plan.

That just alludes to--so I won't go over it--the issue of auto enrollment is an important one, primarily because in the case of low income beneficiaries it's well documented that this is a group of individuals that are often hard to reach. So the opportunity to auto enroll people who are eligible for the \$600 credit becomes a very important challenge to make sure that these individuals can take advantage of the \$600 credit and seven states with their state pharmacy assistance program has the authority to auto enroll their enrollees. There is a larger question looming out there about whether or not individuals in states who are involved in this so-called Medicare savings programs--these are the programs that provide protection from Medicare cost sharing--whether those individuals, all of them are 135% of poverty are lower, in terms of

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their income at least, but how to get them more rapidly and easily involved. That's a question which has not yet been resolved by CMS.

The fees for the cards, as you know the statute set a maximum of \$30 for an enrollment fee for each of the two years of the card program. Of course, there's no requirement to charge any enrollment fee at all. We've looked at sort of the distribution of enrollment fees that were established by the participating card programs, and you can see the table there that generally shows you that for the most part if there's any takeaway methods here, it's that the national programs, the majority, tended to be charging the full \$30 enrollment fee, whereas the regional programs by and large charged less than that amount. Only three of them actually charged the full \$30.

Again, the next slide's having to do with sort of the actual experience in terms of enrollment. These data I need to qualify because these are as of early July and I'm sure [inaudible] additional information that's more recent and complete. But the last information that we were able to access indicated that if you looked at all of the enrollment so far, it was in the neighborhood of \$3.9 million as of July. Of that number, CMS reported that about \$2.3 million were automatically enrolled or auto enrolled because they were members of Medicare Advantage plans that had exclusive drug discount cards. As we noted, some people—we don't know the number—had been enrolled automatically by the state pharmacy assistance programs in those seven states that have that authority. Beyond that it's not really known—at least not known to us, we were unable to determine the number that have actually voluntarily

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enrolled, that have initiated enrollment on their own, so that's a question that [inaudible]. Doing a little bit of rough math it looks like it probably couldn't exceed more than a million out of the 3.9 total. And then with respect to the low income transitional assistance enrollees, CMS estimates that within the Medicare beneficiary population there are about 7.6 million beneficiaries who would qualify based on the income requirements and again, CMS has reported somewhere between 900,000 and a million of those individuals eligible for the transitional assistance have actually enrolled.

Now, the whole matter and challenge and of beneficiary education and outreach is the next set of slides here because of course helping people to navigate the world of the discount card programs and to understand and use effectively the decisions, the four tools that were made available to them, it's really the hardest making this a successful program. What CMS has done, I'm sure all of you know, is there are several approaches they've taken, some of which are required by the statutes. They have, of course, the 1-800 Medicare number which has been significantly [inaudible]. I understand there are now about 3,000 customer service representatives or operators and the average wait time for a call is about down to two minutes now. There is, of course, the Medicare.gov internet site, which is the place that provides access to the prescription drugs [inaudible] which is the comparative information tool that is [inaudible] by beneficiaries when they enter certain information like their zip code and the basket of drugs that they may be taking or think they might need.

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Thirdly, CMS has expanded financial support to community-based organizations including the state health insurance programs, so-called CHIP's, as well as the triple AAA's, the area agencies on aging groups that are funded around the country, and finally some of you are familiar with the ABC coalition which is a partnership of a large number of community-based organizations. CMS is now making grant funds available to help support those organizations in helping to provide one-on-one counseling for Medicare beneficiaries.

Finally, there's been a significant investment in print and television and radio ads, up to \$18 million on TV ads alone as reported by CMS. Then there have been a number of direct mailings, particularly one by the social security administration to target low income individuals in April to alert them to the possibility of their eligibility for a \$600 credit.

Card sponsors are required to do a number of things to outreach and educate. They, too, have toll free numbers, they have internet sites, they have prepared various kinds of marketing materials. [Inaudible] alludes to our experience with those tools is that they vary quite a bit, there is no standard format for them, and some of them are more complete than others. The [inaudible] and the CMS regulations on the cards provide a number of beneficiary safeguards to make sure that the card programs that have been approved live up to their obligations under the program. That's summarized here by three types of oversight that are being conducted. One is a price change monitoring function to sort of examine the extent to which card programs are changing their policy to make sure that that volatility [inaudible] exists, is not

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something that's related to a kind of bait and switch tactic to get people enrolled with lower prices and then raise or lower the discount once they're locked into their card choice. CMS is doing that now but they're in the process of hiring a contractor to take over that responsibility. They're also doing unspecified mystery shopping, as it's referred to, which is basically calling in on a sponsor's 1-800 toll free number to determine that the answers and the information are reliable and correct. Of course they're monitoring complaints that come in, either through 1-800 Medicare, the OIG fraud hotline, and finally the grievance law that each of the card sponsors are required to maintain to get a handle on where complaints and what the nature of the complaints are so that there's a more careful monitoring of the performance of the card programs.

And finally, if this area of beneficiary experience, beneficiary education enrollment outreach, you think there are some lessons learned, at least from our preliminary [inaudible] program. Obviously there are many choices, the question of course is are there too many choices? Choice is clearly a value for beneficiaries, but I think what we've learned from this experience so far is that accepted choice is confusing and it's probably a [inaudible] sore on the slow list of enrollment beneficiaries into this program. The [inaudible] compare the PD, PDAP, which helps beneficiaries shop for the appropriate and highest value card for themselves, has really gotten much better. It was a huge undertaking to begin with, but it's been improved clearly over time. Again, the sponsor's websites and other data by them is much more uneven and certainly not as accessible as Medicare.gov. The other

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thing about the internet tools for decision making is that a survey by the Kaiser Family Foundation earlier in April of this year found that fully 70% of the seniors who responded to that survey had never gone online. So that doesn't mean they don't have family members who can go online or friends that go online, but still obviously relying on the internet as a source for decision support has a significant limitation in the Medicare beneficiary population.

There are, as we said, about 4 million beneficiaries who have enrolled. The enrollment has lagged, and we talked about that. Finally, in that area, in some cases it's not totally sure that enrollment in the card has actually produced an increased benefit for the beneficiary. The reason I say that is for people who are already enrolled in state pharmacy assistance programs where they were receiving very comprehensive help with their drug expenditures, what may be actually happening to them is that their benefit protection hasn't really changed. The federal dollars are now substituting for state dollars and reducing the cost of those state pharmacy assistance programs.

Lastly, the whole matter of beneficiary education is a very expensive undertaking. Without me calculating [inaudible] all the data here, but about \$50 million has already been spent on these outreach and education activities. It's pretty clear from the evidence as talking to people in other studies have shown that one-on-one counseling by individuals who are trained and have expert information is the preferred route for education of Medicare beneficiaries. Julia?

JULIA A. JAMES: Thanks, Mike. I'm going to go over the

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pricing analysis, and it's going to be more important that you follow the slides on what I'm going to talk about. So we're going to start on page 11, so everybody turn to the handout and I'll try to [inaudible] where we are to make sure that you're on the right chart.

So far we've talked about the results of our [inaudible] analysis, obviously a key question that we wanted to answer was are there good prices here? Are these cards really offering value to Medicare beneficiaries? As Beth mentioned, we were hampered in trying to analyze that because we couldn't have the full database. And so we had to go in—I'm sure all of you have probably been on the internet and gone into the tool—you have to go in, you have to enter this code, then you have to enter specific drugs, and then you have to pick pharmacies. You have to look at whether or not all the drugs you entered are excluded or just some of the drugs. So it's cumbersome to try to do a comprehensive analysis when you have that kind of a limitation. But we had to try to define what was feasible for us to do, because we wanted to track prices over time, we wanted to look at prices every week to see if they were changing, we wanted to look at different areas of the country, we wanted to look at rural areas versus urban areas, the East and West, the Midwest, etc., to try to figure out where there were differences and where there weren't [inaudible]. Obviously we want to look at different types of drugs, generic, brand medications, expensive drugs, drugs that aren't so expensive, to see what was happening.

That was all very ambitious and given the limitations, even if we had had the database, it would have been hard to answer all

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those questions comprehensively. But we ended up trying to narrow it down, and we chose seven card programs. It was pretty much ad hoc the way we chose them. We went in and looked at the card program in May when the program was just getting up and running and we picked seven card programs that had the most comprehensive information. So we didn't base our selection on the card programs on their prices or anything else, we just sort of looked to see which ones were going to be useful to us in following.

We also chose ten of the most commonly prescribed drugs for Medicare beneficiaries and in our methodology it describes exactly how we went about doing that. Then we also developed four hypothetical beneficiaries with a basket of drugs because obviously if you look drug by drug you sort of don't get an insight for somebody who's taking multiple drugs, as most beneficiaries are. So we [inaudible] put together four hypothetical beneficiaries.

And then we looked at prices in both rural and urban areas. We chose, for our four beneficiaries, we looked at what spending on drugs for them would be in Kansas versus Maryland in Baltimore. And then also for the ten drugs we looked at an urban area and a rural area within Maryland.

All of that means that our findings can't really be generalized, we can't make blanket statements about all the cards or what the total ranges are or anything else, but we do think that we have a pretty comprehensive approach and we can definitely make a few statements about what we've found.

All of the studies that you've heard about—and there have been a number of them out, programs started—all have similar

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limitations. And when you look at how they compare percentage savings, most of them are using different basis for stating what that percentage savings is. So they're a little bit apples and oranges but in many ways the bottom line all turns out to be very close.

So going to page 12 now, the first chart, we did find that at least some of these cards do offer savings. And the reason I'm saying at least some is because we didn't look at each individual card and analyze them. We focused on the seven to track cards from week to week. Then also we looked at the highest priced card and the lowest priced card of all of the cards to do some of these analyses.

MALE SPEAKER: What do you mean highest price and lowest price?

JULIA A. JAMES: When we put in whatever we were asking for in terms of our ten drugs or whatever, it would come up and it gives you the total price for all of the drugs that you put in. So then you can scan through all of the cards and you can see which one will have the highest total price for all those drugs and which one had the lowest price. We looked at only the card—when I say highest and lowest—the card that had prices for all of the drugs that we entered. There's also a separate section that will tell you this card has two out of the three drugs you asked for, and we didn't select those. We only looked at the cards that had them all. So again, going back to the first chart, one of the biggest problems we're trying to assess is how much value there is here for beneficiaries. We don't know what people were spending before they

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got the card because you could have a private card, you could be just walking in off the street and paying cash. You can go into two or three different outlets because you're shopping for best prices. So for any individual, the savings are going to differ based on what they were paying and where they were getting their drugs before they started using a card.

What we did, we found a source, which is the Maryland Attorney General Public Pharmacy Prices on their website, their prices by pharmacy. So we took those prices as cash customer retail pharmacy prices in Maryland, took those prices and compared them to the prices you could get for the seven cards that we looked at. As you can see from the first chart on page 12, all of the cards had prices that were significantly less at the retail level than the Maryland cash customer prices. Also, we looked at what would happen if you used the mail order prices offered by these cards. Usually mail order requires that you get a 90 day supply, it's mostly for your long-term medication. So what we did is we took the 90 day price and divided it by three. So these are 30 day monthly prices for the drugs.

If you look at card "A", of our seven that was the highest priced card. If you picked that card as a beneficiary you would save a minimum of the retail price of 19% off of what the Maryland cash customer prices were. Or 27% if you used their mail order price. Now it so happens that card "A" had both the highest retail and mail order prices of our seven cards. The lowest price card differed among cards. Card "E" gave you the lowest price retail, and that was a 24\$ savings off of the Maryland retail prices. Card

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"B" gave you the best mail order price, which would be a 32%, or almost one-third, percent savings off of the Maryland retail price.

Going on to the next chart, we wanted to compare the different cards because that answered and tests the question of whether or not it really makes a difference which card you choose or whether they're all pretty much the same and it doesn't make that much difference. We found that there is definitely a difference, and depending on where you live, what pharmacy you want to use, how you want to buy your drugs, what drugs you take, there is a difference among the cards. So you do have to do some comparative shopping if you want to maximize your savings. If you look at this chart—now this chart used the card with the highest and lowest prices, we're not talking about our seven samples cards here, we're talking about of all the drugs we looked at for these people, the cards with the highest and lowest prices. Definitely there were some differences. I want to have you look at Mr. Miller, the first individual here. If he chose one card he would be paying more than twice as much for his drugs as if he chose the lowest cost card. He chose the highest cost card. So for Mr. Miller, obviously there's a huge difference in the card that you choose. But for all of them, as you can see, there is a significant dollar difference to the individual every month depending on the card that they choose.

On page 13, we wanted to look at mail order and the implications of using mail order in terms of savings. We wanted to test whether or not using a mail order through a card would really be much better than other mail order sources that are available out there to beneficiaries. So we chose two outlets that had readily

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available prices - Costco and Drugstore.com, which is an internet pharmacy. We compared the 90 day mail order prices for the card with the highest prices. Here what we did is we took the 10 drugs we were looking at and we looked at a basket price for all ten drugs. Now we recognize it's highly unlikely any one beneficiary would be taking those ten drugs, but we have that sample of drugs. So we looked at the total cost of those ten drugs and we found that all of the cards were significantly less than the Costco price. The Costco price here is the price you get if you belong to Costco, with their enrollment fee. If you don't, you're going to pay five percent more than that. But we did find that Drugstore.com was very competitive with the card, and in fact if you go on their website they advertise about that. Again, this is an internet pharmacy that you access through the internet which perhaps many beneficiaries don't even know about because they don't use the internet, but it was definitely competitive with the card.

Now on the next chart, the issue of whether or not prices are changing because of competition among the cards. As I said, we tracked the prices of the ten drugs, we tracked the prices for the individual baskets of drugs, we did a lot of tracking over the eight week period. We found, in the first two weeks that we started, I think it's two of the first three weeks that the information was even on the net, that the prices were so unreliable because they were missing data, there were prices that were just on there obviously wrong, and their midweek changes and things that it was so unreliable that we just dropped the data for the first two weeks. Then we took the information from the middle of May through the end

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of June and we looked at what was happening with the prices.

We have an example here in this chart that shows what's happened for the basket of drugs that we had assigned to Mrs. Roy. As you can see, almost all of the individuals and all of the ten drugs, every single chart that we put together looks like this. There's little blips up and down, but generally practically very stable over the period.

And so in summary, we can say that the cards do offer value, at least some of the cards offer value. We didn't look at the whole issue of how much value the card offered to the transitional assistance enrollees. Other people have looked at that, CMS has put out the findings there. Obviously if the government is giving these individuals \$1,200 over a two year period there's obvious savings to them, so we didn't focus on that. Another thing we looked at was of course mail order. We also looked at generic substitution. I should mention on all of our prices we chose the option—you have an option of choosing generic substitutes where they're available when you're getting your prices—and that's the option that we chose. We went for the generic substitutes. One thing that we found, obviously, you do get savings from generic substitution, you do get savings by using mail order. One thing that is probably significant for beneficiaries is that these card programs may facilitate beneficiaries learning about these options and actually using them, where they might not know about them now or they don't know how to go about doing mail order by enrolling in a card that actually could facilitate these savings for them.

As I said, we found choice of card really does matter, so

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it is important that the information that beneficiaries have to compare cards is accurate and easy for them to use. And again, prices have remained stable.

So in summary for the whole report, I think clearly everybody recognizes that this is really a heroic effort on the part of the administration to get this program up and running on schedule. [Inaudible] into law last December and they had it up and running May 1 like they said they were going to. Of course there were some bumps in the road, there still are some, they're working on those. I think there's a lot to be learned for implementation of the [inaudible] from the experience that everyone has had with these cards, including the beneficiaries. I think it will be very interesting--this is our first look at this card program--I think it will be very interesting in the fall to see what happens to prices, to see what happens to a number of sponsors, whether or not you still have them all around, to see what happens with beneficiaries and whether or not they're--first of all, to see how many people have enrolled, and then to see how much switching there is, because that will be the opportunity people have to switch from one card to another.

DIANE ROWLAND: Thank you Beth, Mike, and Julia. And now we're going to [inaudible] Mark [inaudible].

MARK B. McCLELLAN, M.D., PhD: That's right, we'll be passing around a handout right now. [Inaudible] make a few remarks to begin with. First I'd like to thank all of you for coming, and especially thank Diane and the Kaiser Foundation for doing this important work. There's not very many foundations that keep up as

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well as Kaiser does with the issues of the day and bring in as good academic expertise, as good [inaudible] expertise as this foundation does. That's why I especially appreciate the opportunity to be here and comment on what's basically an academic subject, something Diane used to call me up and do pretty regularly. [Inaudible], which was nice as well, not as nice as this. That's right, it really feels like the old days and Beth and Mike and Julia have done a lot of hard work and I just like all of the constructive input that we're getting on the card program right now is going to help us do a better job. So all around a lot of thanks is deserved to help us keep working to get the most out of this program for beneficiaries.

There are a number of important findings here that we've heard about towards the end of this presentation. I think one of the most important ones is that there are real price savings here for beneficiaries. The example that Julia talked about, \$150 a month [inaudible] or so for all of the cards they looked at in that particular example, more for mail order. You heard about the prices being stable to modestly declining since late May on most of these card programs. No price increases [inaudible] for beneficiaries. And we've heard a lot about how we can take steps to help make sure beneficiaries get these savings, that's really our goal now. So this is a work in progress in that we are working to make progress on what we're lowering Medicare beneficiaries' drug prices and drug costs right now. There's been a lot of talk about this issue for a very long time. The bill was just passed in December, we had this program up and running and delivering substantial savings just within six months of enactment of the law. And we're going to keep

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working to make sure we're doing all we can to get more beneficiaries more savings through this program ahead of the full drug benefit in 2006.

I'm also pleased to announce today that our enrollment, as Mike's number suggested, our enrollment is now over \$4 million in the card program. We're getting more than 100,000 people signing up almost entirely on an individual basis per week in the program, close to 25,000 every business day. That's putting us well over the 50% mark of what people thought was going to be the total enrollment in this program with about 7.3 million by the end of 2005. So well over 50% there if you all look at other programs, other federal benefit programs, health benefit programs, when they get up and running it just takes work to get people informed and to get them enrolled [inaudible]. In Medicaid in many states, enrollment rates are still hovering around 50%, [inaudible] for programs that are implemented. SCHIP, which is a very important program for health insurance for low income beneficiaries, took more than a year—at one year was only at about 1.2 million enrollees. And so we're going to keep trying to learn from those experiences as well as the feedback and suggestions we have here to find the most effective way of doing outreach. We're taking some unprecedented steps there in terms of collaboration and beneficiary education efforts as Mike talked about.

Everybody should have a handout at this point. Bear with me, I haven't done this academic kind of thing in quite a while so hopefully I can go through this smoothly. I wanted to start out by talking a little bit about savings on the drug program. The Kaiser

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site is a very good one for looking at particular detail in seven of the cards. Now there area larger array out there, and Julie's right, that our website and our program is not set up to do large scale studies of all cards. It's set up, and our first priority is making it possible to do the most important comparison, which is for beneficiaries comparing what they are paying now for their drugs and what they could pay at the pharmacy that they want to use in their neighborhood on the best drug card program for their needs. So that is the primary driving force in the way that we set up the whole website and our whole 800 number support, so it's designed to make comparisons for individual beneficiaries, not the overall program. There are proprietary data that underlies all this, we're not allowed to [inaudible] on a general basis, but I think it's still possible, and a lot of people have done the kinds of studies that Julia and her colleagues described here today to get at this issue of [inaudible]. We've done some of our own, I think they're in line with what you have heard today from this Kaiser study. You all have probably seen our report showing that as you look at the best card prices, and again, that's the way this program is set up so the beneficiary can hone in on exactly which cards offer the best deals for them, not just looking at a subset of seven or whatever number, we've seen savings of about 11 to 18% off prices for brand name drugs compared to typical prices at local pharmacies. It's always hard to know what to compare. Beneficiaries are pretty smart, and the ones that don't have coverage now have found ways to [inaudible]. Many of them have pharmacy discount cards, for example. Some of them have found other discount programs. Most of

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them don't have access to the significantly lower prices that you can in a health insurance plan, public insurance plan like Medicaid or private insurance plan that negotiates discounts on your behalf. Drug manufacturers give discounts at the pharmacy from the pharmacist, and then the pharmacist have to [inaudible], that's usually about five percent or so. And so the numbers that we seem to see pretty generally are savings compared to retail list prices, about 15 to 25 to 30%. But savings off of the prices that people typically pay, including Americans with insurance, of about 11 to 18%. This includes cash customer prices as well as the lower prices that you can get from insurance.

There's another [inaudible] compared the prices on the drug card to the prices in Medical, the California Medicaid program. It showed that the drug cards very generally had consistently better prices than Medical in California. As you heard from the Kaiser report, the prices are stable and the [inaudible]. Questions about are the drugs covered in these programs, there's simply no change. All the drugs that have been on the formularies included for coverage at the beginning of the program are all still there now, so it's consistent in staying savings.

There also are savings on generic [inaudible]. A very much less costly approach. It's a low rate, [inaudible], and we put that information right in front of beneficiaries when they go to the website or call us up. If you compare the generic drug prices with the card you can get to the prices that people are typically paying. Again, this includes the discounts they get through their insurance or pharmacy cards or whatever. It's about 38 to 50%--actually 37 to

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55%--and then on top of that if you were on a brand name drug now and switched to--if you pay retailer price for a brand name drug and you're paying for a discount or generic drug on the card, it's huge amounts of savings. We've talked to a lot of beneficiaries who have done that. That's why you see people talking about getting 40%, 50% reduction in their drug costs just with the discount. Part of that comes from finding out about generic and switching over to them. So that's just a specific set of comparisons. We've done a number of these and it's like what Julia described where we look at the prices of the card compared to the prices that people are actually paying in general in the United States for their drugs and for generics. So there's no question but huge savings on here.

Mail order savings are there as well. If you look at the mail order prices like Julia talked about, the mail order prices consistently are better than retail prices. That's not particularly surprising that they're lower, but for the mail order as well what we're seeing for the best cards at least is that the prices are [inaudible] better than online. The next page shows savings on mail order for a recent analysis that we did comparing Medicare cards to Drugstore.com prices for people who don't have a card and Costo.com prices for members. The brand name drugs are generally lower on the best card. That's not to say that all the cards, but if you're a mail order shopper, if you're going on the internet and go to Medicare website and sign up for a card, you can get prices that are consistently better than the mail order prices that are available from these very reliable, high quality internet pharmacies. Even retail prices that you can get on the best cards are better than the

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prices that these pharmacies generally make available online.

[Inaudible] Drugstore.com has started taking further steps, they're actually working with the card programs in some ways. They will match the card prices for people who have Medicare cards. Those cards are even lower than the Drugstore.com prices, like in all of these cases. And so that's another way in which discount price competition is a transparency that your price information available is driving the price up to get lower drug prices.

Julia and the gang didn't talk much about the low income benefits for beneficiaries with limited means. Just to reiterate the obvious, there are big savings off retail prices for people who have been without drug coverage who have been struggling with drugs [inaudible]. Big savings compared to what they have been paying before when you take in the \$600 credit, when you take in the fact that enrollment in any of the cards is free. Also we take into account some of the increasing number of manufacturer wrap around programs that are available through the card. This next page shows some examples of some widely used fairly [inaudible] prescription drugs that are covered by a manufacturer wrap around program on the card program. And so to remind you, the way these wrap around programs work is if you use up your full \$600, these programs allow you to get your prescription—they're covered for \$5 to \$15 per prescription. No more than \$15 in any case. We've got all this information on our website, and when you call 1-800-Medicare now you can find out about all the drugs where these additional savings are offered for people with limited income and which cards have them. There are an increasing number of cards that are—just saying this,

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Pfizer has just been one card now that they've announced recently that they're planning on getting contracts in place with a large number of other card sponsors and so these wrap arounds cover, at this point, six out of the top ten drugs in terms of drug spending by beneficiary. Drugs like Fosamax and Lipitor and Glucatorol [phonetic] for diabetes, Celebrex, other lipid lowering drugs, drugs that account for a very large part of Medicare beneficiaries' costs. So you put all that together for [inaudible] beneficiaries, it is obvious savings. The discount of \$600, it's literally thousands of dollars in help altogether for people who are on any of these commonly used medications.

So the important question is how do we get people as informed about this as possible, as quickly and effectively as possible, and through comments back and forth with Beth and Mike and Julia in this study, with comments that we've gotten from other experts on websites, from other experts on working with beneficiaries, and from the beneficiaries themselves, we've been trying to take a steady set of steps to keep improving how easy it is to get information about savings and to enroll and start getting those savings yourself. So again, when you go to our website or call 1-800-Medicare we're trying to let people know that there are three pieces of information that they need going in to help find out what this program means for them. Remember the price comparison—we're focused on the price comparison for beneficiaries, what they're paying today versus what they can pay with the card. So if they know their zip code, if they know the prescriptions and their doses by having the pill bottles in front of them, if they know

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their income for persons qualifying for low income benefits as well as those signing up for a state program or other manufacturer program, we can get them going pretty quickly. To make that happen faster we have made a number of improvements in the website recently to address some of those concerns that Beth and Mike raised earlier. Now when you go to the website—and some of you have tried this out—you very quickly get the three different approaches to searching for drugs. You can either enter the whole or partial name, and this can be done very quickly now because we've gotten a standard drug dictionary there that lists not only the commonly used drugs but basically everything. Before when people on Medicare came to the website they would type in the name of a drug that wouldn't be recognized [inaudible], but that was an extra burden for them. Now it shows up right away, you start typing in the name and it will go right to the drug, however uncommon it is. We also have a list of the most commonly prescribed drugs, you can just click on those if you're taking a drug that is commonly used, and there's now [inaudible], if you're not quite sure how to spell the drug. Go to the alphabetical list and you'll see a scroll down to find your particular medicine. Again, this is a much more comprehensive drug dictionary than we were able to get in place at the very beginning of the program back in May and June. This also includes all kinds of non-oral medicine for people who have had a little bit of trouble matching up what they took every day to what a 30 day supply was or a 90 day supply was. Now all this clicks up in a screen where you can check off the doses for each of your medicines.

Other things that we've done, fitting in with what Mike

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said about choices, valuable in terms of getting a product that really works for you but instead of that choice being confusing, we want you to get to the best choices for your needs fast. The way that the website works now when you go in, you don't get the list of all of the cards that are out there and all of the pharmacies and so forth, we default you to Google or any of the other popular web tools and we default you to a limited number of choices. We show the five best deals for you based on your drug and the prices you can get on them and it generally includes all of the drugs that you take and your particular pharmacy that you're interested in. So just one screen, you can get to that information you need really fast when you go online.

We also have added an online link to drug card enrollment for all the card sponsors that offer online enrollment. It's just click, click, click straight from our website to the program that you want to sign up for. As I mentioned before we've got information built in on the wrap around programs from drug manufacturers and we're taking some more steps to make it easier in the near future. Many people who are working with low income beneficiaries have said that it would be easier if they could just sign those people up online without having to send them out forms for a signature. As Mike mentioned, we are in the process of implementing an electronic signature process for all the cards that are able to support it in the coming weeks so that people will be able to sign up not just for the card completely online, but also when they're getting help from an advocate or a beneficiary assistance or themselves if they go online. They can sign up

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themselves for the \$600 through an electronic signature process.

But I think the most important thing to remember is this 1-800-Medicare. All the information that's available on the website, you can get when you call us up on the phone. So anybody who has any compunction, any problems with going on the internet either because they don't have a computer or they just don't understand how to use it in this particular case or they just don't want the hassle of typing in and pointing and clicking, call us. The longest wait times we have now are about two minutes, and that's at peak times earlier in the week. Most of the time there's no wait or a minimal wait at all, and with the improvements in the website, improvement in our protocol for our trained representatives to use, people can generally get through, sharing all their information about their particular needs, their pharmacy, their drugs, income and so forth, you get guidance from us as to which cards offer a good deal for them and what their savings could be in well under 15 minutes. So it doesn't have to be that much time, and we're also taking some new steps, as you heard from Mike, to make sure we've got people who can provide face-to-face assistance. This is a very important issue for the drug benefit. It's also a very important issue, even more broadly, for the future of Medicare. We are in a healthcare era and we're increasingly going to be in a healthcare era when the individual needs of our beneficiaries are going to be extremely diverse. Healthcare is becoming more complex, more individualized, and that's going to have more to offer than ever before with new progress in genomic, with new recommendations about which—more knowledge than ever about which products and which treatments work

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best in particular subgroups of patients and particular combinations, we'll need to have a way to support, as effectively as possible, each individual beneficiary getting matched up with the most that Medicare has to offer for them. So that's what we're coordinating now. Absolutely, as Julia said, a useful process ahead of the drug benefit but there's even more, an essential process ahead of where 21st century medicine is headed. So we need to be there to provide personal support and assistance to get an individual beneficiary matched up with the medical treatments, the doctors, the hospitals, the latest information and the benefits that can give them the most out of this program. That's why this is [inaudible] increasing the amount of information that we're providing and targeting on quality of care, on medical evidence and the like is so important and [inaudible] going forward.

This last slide, we're seeing steady growth in this program. We've exceeded the four million mark this past week and are still getting 20, 25,000 people a day. I think now that we've made some further improvements in the website, further improvements in 1-800-Medicare, got more people on the ground who can get the facts out about the program and how to start saving, it is really helping to reach beneficiaries who might otherwise have been hard to reach or early on in the program might not have been able to get good, accurate information about what the program means for them and how they can sign up. We have more coming, the Access and Benefits Coalition was mentioned earlier. We're going to be doing more of an outreach program with them during the coming weeks to make sure that we're reaching low income beneficiaries. There are about a million

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low income beneficiaries participating in transitional assistance already, the vast majority of which—all but 100,000 or so—are the result of people signing up in addition to the automatic enrollment through our work with the state prescription assistance program. We're trying to do more there as well. So we're working on making progress for getting drug prices down right now and I think the kind of suggestions that we've seen here are going to be very helpful, another step in the process, in making sure that we're getting these savings out to as many beneficiaries as possible. I hope that we can continue, as Beth mentioned and Julia mentioned, the possibility of follow up studies to see how things are developing in the fall. There may be some further changes, not sure all the cards are going to keep participating and the like, and I hope you all will continue to follow the program closely. It's very helpful for us to make sure it [inaudible] for beneficiaries.

DIANE ROWLAND: I think it's a real pleasure to have something called a work in progress and to report progress. Too often, after something is initially implemented we're only talking about the bumps in the road. I think the report we've had here, as well as Mark's comments, help us to really see that this program has gotten up and running in a very rapid way. But it's also amazing—two academic presentations that occur in real time—[inaudible]. With that I'll open it up to questions from the group.

FEMALE SPEAKER: [Inaudible], the question is can that \$600 be carried over from '04 to '05 and beyond '05?

MARK B. McCLELLAN, M.D., PhD: Yes, it can be carried over to '05 and '06. All the people who are eligible for the [inaudible]

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are going to be eligible for some very comprehensive drug benefits, so we're going to get them into the drug benefit where they will be paying \$1 to \$3 a prescription if they're below 100% poverty; \$2 to \$5 if they're below 135% poverty. That's an even better deal than \$600. Then it stops at the end of '05 because there's not much left for it to pay for.

FEMALE SPEAKER: [Inaudible].

MARK B. McCLELLAN, M.D., PhD: It's a five percent co-payment when they're using \$600.

FEMALE SPEAKER: Co-payment of what?

MARK B. McCLELLAN, M.D., PhD: Of the discounted price. The \$600, as the study pointed out, can be used even for drugs that aren't covered, so you just pay full list price for [inaudible].

FEMALE SPEAKER: Here's a non [inaudible] from an observation. Yesterday I [inaudible]. I waited an hour, never answered.

MARK B. McCLELLAN, M.D., PhD: That's very unusual.

FEMALE SPEAKER: I [inaudible] call me back and [inaudible].

MARK B. McCLELLAN, M.D., PhD: That's very unusual since you called the right number. We are doing pretty close monitoring of what our wait times are on an ongoing basis. We have a program in place with all of our call centers around the country that monitors, that keeps track of statistics. [Inaudible] telephone support system of how long it is between the time a person calls in and the time that somebody picks up the call, and that's where we get our statistics on wait times and it's from hour to hour. We

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actually keep these on an hourly basis. We also compute dropped calls, calls where somebody calls up and it doesn't get through. We did have some problems earlier on with not so much our call centers but with components of the phone networks. Such a large number of calls and they hadn't built up the support to us so that some calls just didn't reach the 800 number. But what you were describing is extraordinary. I'm not sure what could have happened but that's not the experience we're generally seeing with all of our monitoring of the 800 line now.

FEMALE SPEAKER: And so [inaudible]?

MARK B. McCLELLAN, M.D., PhD: Two minutes is the peak wait times that we're seeing. So early in the week we get the large number of calls on Mondays and Tuesdays, typically earlier in the morning, that's when the two minute wait time happen and other times it'll be lower than that. I'll find out what happened with your call.

MALE SPEAKER: [Inaudible] what type of data do you have about usage and how are you compiling that?

MARK B. McCLELLAN, M.D., PhD: Usage online and call in?

MALE SPEAKER: No, the card.

MARK B. McCLELLAN, M.D., PhD: We aren't tracking individual use by individual beneficiaries. We are tracking sign ups but again, this is a fast, temporary program which is a bridge to the drug benefit. The card sponsors themselves have statistics, I assume on their own card because they're doing all the electronic transactions, monitoring. We don't keep statistics on that, we make sure that the card sponsors are meeting our marketing and other

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requirements. We keep track of any kind of consumer complaints, when people don't get the discounts they were promised, but the card sponsors keep track of actual use.

MALE SPEAKER: So if you're not tracking [inaudible] but you must be tracking [inaudible].

MARK B. McCLELLAN, M.D., PhD: I don't think I have any statistics or a report on it at this point on how much we spent there, but that's a good thing for us to get out to you.

FEMALE SPEAKER: I'm Peggy Eastman, Washington Writers of Caring for the Ages, it's a Lippincott publication. Could you please address the issue of what CMS is doing about drug card scam?

MARK B. McCLELLAN, M.D., PhD: We made some—in this program and all the new programs—we're going to have a very aggressive approach to alerting people early, before the programs actually start, about what they should look for for a possible scam. That's what we've done in the case of the drug cards, we made a whole set of announcements back in April before anybody started any kind of marketing, before the program was going at all, we warned people about what to look for and we warned that there were Medicare cards coming but that no one would call them, no one would be coming to their door promoting this product. That was not part of our marketing approaches. We told people about these Medicare-approved drug card symbols and worked with a lot of consumer groups to try to get that message out. Hopefully in part because of that early response, we have not seen a whole lot of scams developing. There have been some isolated reports around the country, at this point probably 25, 30 calls in to us. When the program started we also

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reminded people that either local law enforcement [inaudible] protection officials they can go to, and if they have any questions at all to call us at 1-800-Medicare and get through quickly and we will help them sort out whether this is a real problem or not. There have been a few of these cases, well under 10, where people actually lost a little bit of money that are being investigated right now by local law enforcement officials with our support. We're going to be doing the same thing, getting out ahead of other new benefits that are coming along, the drug benefit in 2006, that will alert people about what to look for in terms of scams and what to look for in terms of a real, legitimate benefit that's coming.

FEMALE SPEAKER: The problem is that seniors are already confused and some of them have some cognizant problems, and so when they get a call like this they don't know if it's--

MARK B. McCLELLAN, M.D., PhD: That's right, and that's happened. That's why seniors have always been such a popular target of scam artists and that's why we and our partners in local law enforcement and our partners in the federal government, we started a new joint effort with the Federal Trade Commission. That's why we all need to be visible to make sure that we're doing all we can to protect these, especially the ones that are vulnerable to this.

MALE SPEAKER: [Inaudible]. Could you tell me [inaudible]?

MARK B. McCLELLAN, M.D., PhD: First of all, in terms of numbers, it was as Mike said about 2.3 or so million auto enrollees in the Medicare Advantage program. But so far for the auto enrollment in the state prescription drug assistance program we've got probably between 100,000 and 200,000 auto enrolled there, so

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it's more than a million and a half who have signed up on their own. I mentioned it's 100,000 a week that's coming in, but more than 100,000 a week is almost entirely people signing up on their own. The Medicare Advantage plan, we have not done any comprehensive analysis. The ones that we have suggest that the prices of those cards are comparable to the good prices available for the general cards for people [inaudible] program. It's reasonable to conclude that the price discounts are on the same order as what we've seen here, so [inaudible] and [inaudible] for mail order.

[QUESTION FROM SOMEONE, CAN'T HEAR AUDIO]

MARK B. McCLELLAN, M.D., PhD: Not necessarily, many of the Medicare Advantage plans, at least prior to the improvements in payment, particularly this year, were not offering drug benefits. And those that are offering drug benefits now often don't have complete benefits. With the start of the card program, the requirement that these new cards has to have manufacturer discounts that are passed on to beneficiaries, those cards as well were [inaudible] in getting discounts from manufacturers that they're passing on. So some of them may have been getting savings before, but now they're more widely available and the people who were auto enrolled were generally not in a comprehensive benefit before.

MICHAEL M. HASH: Just a quick note to that, in the beginning CMS announced that they were going to put up on the PDAP, or on the web, information about the exclusive card program. But they decided for whatever reason not to do that, so you can't actually—at least from the outside—you can't go and scan the card options that are exclusive card options, which is why we didn't

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address that in our report.

MARK B. McCLELLAN, M.D., PhD: And we are addressing that, too. We are going to get some more information up on the website [inaudible] cards. For now, people find out about the discounts through their own Medicare Advantage card. We primarily refer them to their Medicare Advantage plan.

FEMALE SPEAKER: [Inaudible].

MARK B. McCLELLAN, M.D., PhD: No, I can't off the top of my head because I don't have it memorized [inaudible] that Medicare beneficiaries spend money on. The ones that are covered are listed on the handout, and if you go to our website it's a complete list of all the drugs that the manufacturers are covering now. [Inaudible].

FEMALE SPEAKER: [Inaudible].

MARK B. McCLELLAN, M.D., PhD: Yeah, we are doing all we can to publicize these programs and expand it. I mean, [inaudible] I think we're up to eight manufacturer programs now because these have come online. The Pfizer one was a very recent edition and others have come online last month. [Inaudible] more manufacturers participate and [inaudible] all we can to [inaudible] information about those too. I think it's a very important step to add to the \$600 credit and existing discounts to make sure that low income people can get a tremendous amount of [inaudible].

DIANE ROWLAND, ScD: I need to remind callers on the phone that if you press star 1 you can get in a queue to ask questions.

FEMALE SPEAKER: Mike, I have a question for you. You said it's unclear about whether there are real increased savings for beneficiaries, especially those in state programs. But then you

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said that [inaudible].

MICHAEL M. HASH: Well, in general the people who are enrolled in the card programs, there are savings from what we used as a reference for retail prices, and that's pretty clear. But for individuals who previously or currently have some kind of coverage through a state pharmacy assistance program, many of those programs are quite generous in their assistance drug protection. The issue there would be the individual might not actually experience any real change in the coverage they have, but the state that has been paying on them in the past and helped them with their drug costs now gets in effect the use of the \$600. So you sort of have federal dollars that are substituting for—and lowering the cost of the state pharmacy issue.

FEMALE SPEAKER: [Inaudible] really not any better off.

MICHAEL M. HASH: As an individual you might not have any change. Your coverage is as good as it was before but it hasn't changed.

MARK B. McCLELLAN, M.D., PhD: You might want to call the New Jersey and New York programs, but this has provided a lot of financial help to those state assistance programs which are completely paid by state dollars. The federal government has not helped them at all in the past until now, and they've been struggling, too, like everybody else this rising cost of being able to continue those benefits is very important to them for low income seniors. It does provide a financial [inaudible] for them. Some of the state's wrap around programs are not quite so generous. [Inaudible]'s pretty good and at least for very low income people

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they have very low out of pocket payments. Others have significant co-pays, 15%, 20%, and in those cases this wrap around money helps directly. But I think Mike's right, that the state programs are already very generous. This is a [inaudible] as well as cost.

DIANE ROWLAND, ScD: We're going to take our next question from a phone in caller. [Inaudible] of Drug Topics magazine.

FEMALE SPEAKER: I have a question for the Kaiser folks. I wanted to know whether your pricing analysis factors in senior discounts given by many retail pharmacies?

FEMALE SPEAKER: No, as I said, we had trouble trying to figure out what kind of prices to use and we were able to get these prices in Maryland that the attorney general puts up, but as I mentioned for seniors there are all sorts of discounts and ways that you can save money out there and we didn't have any way—actually I think some of the maybe the CMS source compared them to prices sort of generalized across all types of discounts and got more of an average. The prices that we used were the cash customer, you walk in off the street and buy your drug at the pharmacy price. And so to that extent they're probably among the highest that you would see.

FEMALE SPEAKER: [Inaudible].

MARK B. McCLELLAN, M.D., PhD: As you probably saw in the reading from our new regulation [laughter], we absolutely intend to build on this transparency and the benefit in 2006. I've heard from a lot of seniors about the program, and while they do want to make it as easy possible to find out about the savings and sign up, they also really like having information on what the actual prices

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they're paying for their drugs are and which drugs are covered. So we make very clear in the regulations we intend to build off this new transparency in pharmaceutical pricing and in drug benefits with the benefit in 2006. [Inaudible] that's what we want comments on, the way to do it the most effectively, but I think it could include things like continuing to make available the price that you pay when you sign up for a drug card program, definitely making available information on what drugs are on formulary when you sign up for the program so you can compare what your needs are, what the benefit actually provides. We'll keep listening to beneficiaries and others to tell us about what information it is that they want that would be most useful. We absolutely [inaudible].

MALE SPEAKER: Beth, you've mentioned one of the lessons from the card program that might be a [inaudible]. What other lesson did you all see from your study in the drug card program that could be transferable to '06, and to what extent should the experience of getting this program up and running in such a short time frame with the heroic efforts of [inaudible], to what extent should that make us nervous or confident about the ability of [inaudible] the much more complicated '06 program up and running, given all the personnel shortages and retirements and price hikes and all that.

BETH C. FUCHS, PhD: I want to say that I think one of the biggest benefits will be the infrastructure, not only from having the website, the tools for great prices and everything, but for the administrators out there. I mean, huge amounts of infrastructure is being developed to be able to handle all of this that will be

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essential for the new benefit. I think Mike could talk about the obvious which is the communication [inaudible].

MICHAEL M. HASH: Yeah, I think it's clear to everybody, and I'm sure at CMS as well, that the business of trying to figure out what information and in what format is sufficient to help people make informed decisions but it's not overwhelming. That balance is what this experience, I'm sure, is helping them to find out. I would say that the law [inaudible] require them in the discount card program to accept, as Beth described, all of the qualified applicants. They did. I think the likelihood seems to be—who knows?—but the likelihood is that the number of choices of prescription drug plans is likely not to be as many as there are drug discount card sponsors or programs. That might make the handling of the information easier, but if you've got 70 some-odd choices with 50-some odd thousand pharmacies and 60-some odd thousand drug products, trying to figure out how to process that information and present it in a form that's acceptable and useful but not overwhelming is a real challenge.

FEMALE SPEAKER: I'd like to say about function [inaudible], I think there are certain things that are coming—are being exposed now—about problems that hopefully can be addressed before '06, like the nursing home population. I don't even know yet what the timing is on getting the cards up that are specifically targeted to that population. But right now, if you're in a nursing home, and of course a lot of the low income are, there are certain things like the fact that you have to have unit dosing and the way you'd have to have your drug packaged and the fact that a lot of

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nursing home residents don't have a choice of pharmacy. Those things all have to be dealt with.

MARK B. McCLELLAN, M.D., PhD: Yeah, those cards are up and being marketed now. The \$600 is available to them for those cards now. We made very clear that the \$600 doesn't count against benefits or eligibility for any federal program, Medicaid or otherwise, as a result of their enrollment so they can use the card in the nursing home population. So they are up, but Beth's right, that it is a very different pharmacy environment in nursing homes where typically it's just one long-term care pharmacy in the nursing home and we are touring right now, seeking comments and [inaudible] on how we can best bring price competition and get lower prices into those sets. The long-term care pharmacies do negotiate discounts now from the drug manufacturers. We want to try to build on that, the same kind of transparency and pressure to get prices down that we would find in all the other concepts. So that is an area where we're going to do [inaudible] work, but for now the cards are available in nursing homes and they do provide the \$600 assistance as well. And in terms of workload and so forth at the agency, you heard me talk about this earlier this week but maybe I'll add to that. We can hire Beth and Julia and hire back Mike and get even more work done.

FEMALE SPEAKER: I just want to add one thing to all this. I think it would be very helpful, and it would probably be a very different environment [inaudible], but because there was such a number of sponsors and because there are these sort of arrangements between the same guys, probably to position themselves for card "D",

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that I would hope that when we go into the card "D" environment that there would be [inaudible] instead of some of these sort of "me too" cards out there. This doesn't really do the beneficiary any good.

MARK B. McCLELLAN, M.D., PhD: Yeah, I expect that there will be, as Mike was saying, fewer choices. This is a trial run for [inaudible] and so forth. Some of them are offering very good deals and attracting a lot of beneficiaries, others may decide that this isn't the market for them, they're not able to get as good of prices and they're not providing good pharmacy access and services. We may even see there will be fewer cards marketed next year, [inaudible] waiting till 2006. We're going to keep working off what we've learned here to make sure we're giving beneficiaries the best voices. Steps we've taken about limiting the information to five choices helps with that and help make sure it's the best five choices.

FEMALE SPEAKER: And we'll keep studying it.

ROBERT JOSH: I'm Robert Josh from the Ellison [inaudible]. Are you seeing any evidence of any sort of price shifting or pharmacies are shifting, what they're giving up on the Medicare end to other pharmacies that are raising prices from other pharmacy customers? And two, are you seeing any evidence, even anecdotal, where non-Medicare, younger people are checking these prices out on your website and they're going in to pharmacies and saying hey, can I get a better deal?

MARK B. McCLELLAN, M.D., PhD: I'm sure some of that is going on, we don't have any way to quantify it. Our main focus has been on what's going on for our beneficiaries in terms of the prices

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that they're getting and the Kaiser study shows you can't track prices over time. If they're not increasing, people have heard about [inaudible] relative in comparison to the price that's on the card now to the retail list prices back in 2003, and they are significantly lower, too. But we haven't done a whole lot of detailed comparisons outside of Medicare. Our main focus has been on getting transparency in Medicare. Until now, it's been very hard to find out about prices at your local pharmacy for anybody. You heard the troubles that the folks doing this study had in getting good, comprehensive retail price information. There's not [inaudible] price competition in the whole drug industry and [inaudible]. They're changing that, I think that is going to happen, spillover facts on other people asking about this kind of price information or people trying to make it available. But we're just a couple months in, I think definitely the changes will take a little longer to happen.

MALE SPEAKER: [Inaudible]. What additional types of information [inaudible]?

FEMALE SPEAKER: Yeah, and for some of the—when the information was first put on the website you could see who were the co-branders, who were the participants in the [inaudible] program. But for the most part that information was not available. But even that information is generally not sufficient. I mean, your average beneficiary or counselor is not going to go and know what FXC Corporation, so then I had to do basically an SEC file and [inaudible] figured it out. So there's obviously a limit on the beneficiaries needs. It would be nice to have enough information,

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links [inaudible], that you could readily figure out what the corporate enterprise [inaudible].

MARK B. McCLELLAN, M.D., PhD: And we'd be interested in hearing about these specific suggestions, too. We do make sure that all the card sponsors meet all of our marketing, financial, and security requirements. So if there is more information that people want, we'll try to provide it.

MALE SPEAKER: Dr. McClellan, did you ever get the names of those five national cards that don't charge an enrollment fee?

MARK B. McCLELLAN, M.D., PhD: Yes, you can. I don't have them right now but we'll follow up with you on that.

MALE SPEAKER: Okay, and I wanted to ask you a little bit about the enrollment just to make sure. I thought you said at one point you had about one million people who had signed up [inaudible]-

MARK B. McCLELLAN, M.D., PhD: No, one million people enrolled in the transitional assistance, that's the \$600 benefit. What we want to make sure all beneficiaries understand is that this is a program is open to everybody who's struggling with drug costs and none of them have good drug coverage now. But there are two parts to it. There's a discount program available to everyone, and then there's this additional \$600 in so-called transitional assistance for the low income beneficiaries, people with income below \$16,800 for a couple. You've got about a million people signed up for that, for the discount cards, with the \$600 assistance and then another three million plus in the drug card program itself.

MALE SPEAKER: Okay, and of that one million that gets that

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\$600 assistance, all but 100,000 did so voluntarily?

MARK B. McCLELLAN, M.D., PhD: About 100,000 to 200,000 were auto enrolled through their FTAP [phonetic] program or their Medicare Advantage program.

MALE SPEAKER: And you said 20 to 25,000 calls or actual—

MARK B. McCLELLAN, M.D., PhD: Twenty to 25,000 people signing up every business day. Signing up, actual enrollment coming in.

MALE SPEAKER: And what exactly was the [inaudible] for the number of people [inaudible]?

MARK B. McCLELLAN, M.D., PhD: I want to get this to as many people as possible. As Mike pointed out, there are about seven million or so people eligible for this credit, people with low incomes who don't have good coverage now. We're going to try to get as many as we can. In projections that were done for this program suggests that in total, about 7.3 million people would sign up and maybe about half or so of those would be low income and half would be people who qualify for the discount part of the program. That's why we're doing a lot more outreach, to reach that number. We're more than 50% to the overall goal, and we've got the new campaigns coming up soon for low income enrollment. We're continuing to work on [inaudible] enrollment as well.

DIANE ROWLAND, ScD: We're sort of running substantially over and I think that Mark probably has a number of other things on his schedule, so unfortunately I think I'm going to have to bring this to an end. But I want to thank you all for staying on the discount card today and for coming and I think this is clearly an

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area where continuing to look at the experience can both help inform this process and get more people enrolled, but also help inform the future of the Medicare drug benefit. So thank you all for coming and we'll have you back often, I hope.

[END RECORDING]