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**The Part D Experience: What are the Lessons for Broader
Medicare Reform?
Kaiser Family Foundation
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TRICIA NEUMAN: Good morning, welcome to the Barbara Jordan Conference Center here at the Kaiser Family Foundation. We are really pleased to be here for a briefing on the Part D experiences, what are the lesson for Medicare reform? It is hard for me and maybe some of you to believe that the Medicare Modernization Act of 2003 which actually authorized the drug benefit was enacted almost a decade ago. I don't know I mean I am allowing for a little bit of rounding but for me that seems quite a surprise.

The new law responded to decades of concerns about elderly and disabled people on Medicare who lacked prescription drug coverage. The new law also represented a major change in the way Medicare was about to deliver that benefit to people on Medicare. It represented the end of decades of debate about how best to provide coverage and made a huge difference in the lives of people who were on Medicare as we will hear in a minute.

Thinking back as the law being debated and enacted and implemented there were so many questions that we were all asking. For example, would insurers offer a prescription drug plan, a plan that only provided one benefit? Remember we weren't really sure, there were plenty of skeptics. What share of beneficiaries would sign up for a plan when it was voluntary

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and the only penalty - there was a penalty for late enrollment and that was the way it would be enforced?

How well would Part D work for Medicare beneficiaries with low incomes? You'll hear there are significant subsidies for people with low incomes, but how well does it work for them in practice? How many variations would there be in this new marketplace in terms of premiums, covered drugs, cost sharing requirements? How much would Part D plans charge and how much would plans change from year to year? All of these seemed like pretty basic questions and we really had no idea how it would play out.

And then we had questions about beneficiaries; how would they respond to this new market? The idea is that people would compare plans they would look - go to the Medicare plan finder, get help and compare plans not only when the drug benefit was first launched but year after year. And what do we know about what consumers are doing in this context?

And finally but not unimportantly, what's going on with Medicare spending, would Medicare spending for the drug benefit rise faster or slower than projected? I think we have the answer to that one. And what would it mean for out-of-pocket spending?

So now with several years of experience I hope we have several answers to these questions and then we can talk about

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some of the things that we'd still like to know. Some have proclaimed Part D a resounding success and see it as a model for Medicare reform. They talk about fairly robust plan participation, the fact that it has provided significant help to people who previously lacked drug coverage and note the good news that Medicare spending is lower than what was projected.

Others note that there are strengths of the program certainly but they are less sure about what this means for future Medicare reforms. So as Part D moves to its eighth open enrollment period, we thought it would be a great idea to bring together a panel of experts each of whom has studied the program a great deal and has thought a great deal about how it works. To talk about what Part D means today, how it works for beneficiaries, how it may evolve in the future and what it means for broader Medicare reforms.

We're going to start this morning with Juliette Cubanski who is sitting here to my right, who's an Associate Director on the program on Medicare Policy at the Kaiser Family Foundation and has studied Part D for many years. She's going to provide a brief overview of what's gone on in trends in the Part D program.

We are then going to move to our panel of experts beginning with Jack Hoadley, Jack is a research professor he's at The Health Policy Institute at Georgetown University and I'm

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happy to announce he's also a newly appointed member of MedPAC, a Commissioner I believe we can call him the Commissioner. He's also a noted expert on Part D.

We're then going to turn to Karen Ignagni who is going to fill the empty chair, we've learned that Karen had car problems and faces some of the real problems that the rest of us face and will be joining us as soon as she can. And she'll be offering her insights on the Part D Program, she's actually returning to this discussion because she was here several times when the program was debated in those early years of implementation.

We're very pleased to have Jim Capretta back at the Foundation, he is fellow at the Ethics and Public Policy Center. He was written and spoken extensively about the Part D Program and issues related to the future of Medicare Reform.

And finally Marilyn Moon who's the Senior Vice President and Health Program Director at the American Institutes for Research. Marilyn is a former trustee, a Medicare and Social Security Trustee and she too has written quite a bit, maybe more than anybody and we welcome Karen. Karen I've introduced you but we're very happy to have you here.

KAREN IGNAGNI: Thank you and I'm terribly sorry.

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TRICIA NEUMAN: We understand, everybody understands car troubles.

KAREN IGNAGNI: Well then the Metro broke down, I can't make this up.

TRICIA NEUMAN: And the Metro broke down, well it all happens. Anyway we're very happy to have Marilyn, so with that what I'm going to do is ask Juliette to come up and make some remarks. Then I'm going to ask each of the panelists to say a few words and then begin a conversation and include you in that conversation with questions for the panelists, thank you.

JULIETTE CUBANSKI: Thanks Tricia. Good morning everyone, thank you very much for joining us this morning. I'm Juliette Cubanski, as Trish said I'm Associate Director Kaiser's program on Medicare Policy. In conjunction with our colleagues at Georgetown and NORC Kaiser has been actively tracking trends in the Part D marketplace since the inception of the program in 2006. And in my remarks this morning I'd like to give you an overview of what the marketplace looks like in 2012 and discuss some of the key trends that we have observed over time.

So starting with enrollment, according to the Medicare Trustees in 2012 two-thirds of people on Medicare, more than 30 million beneficiaries are enrolled in a Part D plan and another 10-percent are enrolled in employer plans receiving a federal

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subsidy for providing drug coverage that's as good as what Part D offers. Of the remaining 26-percent data in the Trustee's report don't indicate what share of beneficiaries have other sources of drug coverage and what share have none whatsoever. But previous estimates from CMS indicate that in 2012 about 10-percent of beneficiaries had no known source of drug coverage.

Of those with Part D, roughly two-thirds are enrolled in a standalone prescription drug plan and about one-third are enrolled in a Medicare Advantage drug plan. And roughly one-third of all Part D enrollees are receiving the so-called extra help, these are the additional subsidies that low income people with incomes less than 150-percent of poverty and low assets have which helps to pay their Part D premiums and cost sharing.

Since 2006 the number of people with - beneficiaries with Part D coverage as well as those with the low income subsidy has increased somewhat, while the number with subsidized retiree drug coverage has decreased somewhat. The share with no drug coverage fell between 2005 and 2006 when the drug benefit launched but as far as we can tell the share with no drug coverage has remained roughly constant at about 10-percent since then. And there are also several million people who are estimated to be eligible for the low income subsidies but as far as we know are not receiving it.

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As you can see here beneficiaries in every state have at least two dozen plans to choose from in 2012. Before Part D got off the ground as Trish just said, many people wondered whether this marketplace for stand-alone drug coverage would be viable and whether any plans would participate. And while total Part D plan availability has fluctuated over the years and is lower now than it was in the early years of the program I think it's pretty safe to conclude that with at least 25 plans to choose from in every state, the Part D marketplace really does appear to be thriving.

As to what beneficiaries pay for Part D, the average monthly premium weighted by actual plan enrollment has increased every year between 2006 and 2011 but it fell back slightly in 2012. Across the life of the program the weighted average monthly premium has increased by nearly 15-percent but as I said, this year we saw a one-percent decrease. We don't really have a definitive answer as to why the average premium fell but it could be a function of current enrollees switching to cheaper plans or new enrollees signing up for cheaper plans. But it could also be related to an actual decrease in plan bids in anticipation of lower drug costs due to greater use of generics and in particular the availability this year of a generic alternative to Lipitor, which is one of the most commonly used brand name drugs in recent years.

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But this average premium storyline doesn't really tell us much about what's happening at the individual plan level. So when you look at the most popular standalone prescription drug plans in 2012 we see quite a bit of variation in the monthly premium amount as well as variation in the amounts by which these premiums have changed across the years. So for example, the monthly premium for the most popular PDP, the AARP Medicare RX Preferred plan which has nearly one quarter of all standalone PDP enrollees in 2012. This plan's premium has increased by just over 50-percent since 2006 and 15-percent between 2011 and 2012 alone.

In contrast premiums for the second most popular PDP; the CCRX Basic Plan have decreased slightly since 2006 and only increased by three-percent between 2011 and 2012. The third most popular plan, the Humana/Wal-Mart Preferred Plan is relatively new and by far the cheapest of the most popular plans available in every region for just over \$15. So I want to quickly walk you through an example that a real beneficiary might face in deciding which plan to enroll in with all of this variation that you see here.

So let's imagine an older woman here in Washington D.C. who takes just two brand name drugs, she takes Lipitor for high cholesterol and Actonel for osteoporosis. Lipitor has a generic equivalent and Actonel has a therapeutic substitute

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available in generic form but she wants to stick with the brands and she read our Kaiser study that told her what the most plans are. And so she figured if it's good enough for all those other people then she will limit her choice to just one of these five PDP's. So she goes online to the Medicare Plan Finder and she sees that this Humana/Wal-Mart plan is by far the cheapest when it comes to the monthly premium but it also has a \$320 deductible as do two of the other popular PDPs.

Two of these PDPs have no deductible but they're also the two most expensive plans when it comes to the premium and so it's hard for her to choose based on these two factors alone. So she types in her drugs into the plan finder to see what her costs would be and she realizes that while Lipitor is available for just \$2 in the CCRX PDP, but also could up to \$43 in one of the other plans and 20-percent in another and the plan finder tells her that that 20-percent equals about \$43 as well. So then she looks at what her costs for Actonel would be and she's kind of dismayed to see that two of the plans don't actually cover it on their formularies and the cheapest co-payment among the other plans is about \$43. She really, really likes this \$15 premium so she's pretty tempted, even though it doesn't really cover her drugs at the best price but the plan finder tells her that the AARP Plan is actually the cheapest

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for her when it comes to her total annual cost, though the Humana/Wal-Mart Plan is actually not that far behind.

So she signs up for AARP but in the back of her mind she really does wonder what will happen if her drugs needs change before the year is over and wonders whether this plan will still be the best for her. And she also knows there are utilization management restrictions that plans do impose so she knows that there is an open enrollment period available at the end of the year and thinks that she'll probably take advantage of that opportunity to compare her plan options then in case her needs change.

So this next exhibit illustrates the range of prices for the 10 most common brand name drugs as of 2011 and the three most popular PDPs. And it's plain to see that drugs will cost enrollees the most when they aren't covered on a plan's formulary, as in the case of Actonel in one plan and Nexium in another. But even when a drug is covered by all three plans cost sharing can vary dramatically, depending on a plan's benefit design and the formulary to your placement of the covered drugs. For example, for several of these drugs cost varies by roughly two-fold between the lowest and highest cost sharing amounts such as a low of \$43 to a high of nearly \$105 for Actos, which a diabetes medication. And what we've seen over time is that these cost sharing amounts have increased for

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all types of drugs from the cheaper generic drugs to the most expensive specialty drugs.

Here you can see the median cost sharing for generics increased by \$2 between 2006 and 2011, by \$14 for preferred brands and by \$23 for non-preferred brands and the median co-insurance rate for specialty drugs increased from 25-percent to 30-percent. And these amounts I should not for 2011 are actually pretty similar to the cost sharing amounts in employer plans last year.

And the last but not least important point I'd like to make relates to the availability of drug plans for enrollees who are receiving the Part D low income subsidy. The beneficiaries who receive the subsidy get the greatest help when they are enrolled in so-called benchmark plan. These are plans that have a monthly premium below a certain amount in each region and they are available to low income subsidies for no monthly premium. Those who receive the full premium subsidy but who are not enrolled in a benchmark plan have to pay the difference between the benchmark amount and the monthly premium amount that their plan charges.

So in light of these rules, a major concern for low income enrollees receiving the subsidy is that benchmark plan availability has been quite unstable over the years. To illustrate what this instability means from an enrollee's

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perspective, if you were enrolled in a benchmark plan from United Health in 2006 chances are you would not have been able to stay enrolled in that plan every year since then given the steep drop off in benchmark plan availability through United Health in 2008. And if you were enrolled in a Humana benchmark plan in 2006, you definitely would have had a change in coverage come 2009 when no Humana plans qualified as benchmark plans that year.

CMS does take responsibility for ensuring that LIS enrollees are enrolled in benchmark plans and will reassign them if their plan is losing benchmark status but only those LIS enrollees who have never switched themselves into a plan of their own choosing. So once you make an active choice to switch out of the PDP that CMS assigns you to you are thereafter responsible for getting yourself into a benchmark plan each year if you don't want to pay monthly premiums.

So the overall picture from an enrollee 's standpoint which is I think, really the most important perspective that there is on this marketplace, is robust plan choice with plans offered at a wide range of premiums to satisfy people at all different price ranges. But with cost sharing amounts that can vary dramatically from one plan to another for the very same drug, which makes the ability to compare plans across all of these different factors all the more necessary and the

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responsibility of doing so for the beneficiary and their caregivers, all the more important.

And so there's much more that can be said but we've got this great panel and I don't need to be the one to say it all so I'll turn it back to Tricia.

TRICIA NEUMAN: Okay Jack.

JACK HOADLEY: Great, thank you very much for setting up this session and inviting me to be part of it and my remarks are mostly based on a paper that Kaiser released that I wrote, it was released about a month ago and it's in your package. And really with that I want to take you back after this great introduction to sort of what we've seen in terms of the benefits and offerings of the program to what's been going on with the cost of the program. And like Tricia did, I want to take you back to when the benefit was passed into law in 2003 and if you remember that was also a fairly - not only was it a long time ago but it was a fairly controversial passage. It was the passage that took very close votes late into the night and so forth, lots of political wrangling to get this law enacted.

And from a cost point of view that context was that the pledge had been made that this drug benefit and the bill around it should not cost more than \$400 billion. And so that was the key criterion for getting this thing passed over the - this was

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the total cost over the 10 year period. And you know the cost of the benefit is made up both the cost for benefit payments, the cost for the low income subsidy, also the cost the cost for the subsidized employer sponsored retiree coverage that some people get. And then that's offset in turn with some of the enrollee premiums, the state payments as I call call-back payments, and then some of the savings from Medicaid as a result of moving the drug coverage for due eligibles from Medicaid to Medicare.

And so you had the - you have a complicated set of numbers and I'm not going to try to go into today but there's more details in the paper. But I want to do is sort of say well what's happened now we're in 2012 looking back at the spending pattern over that decade, we're almost through that decade so we almost have that entire experience to look at. And there's a chart in the paper in exhibit three that sort of shows the track of what's gone on from the time the projects were made and you've got to remember that CBO's responsibility in projecting the cost for this was to try to guess what it would cost, to project what it would cost for a very new kind of program that really had never existed before.

Not only the sort of private competition aspects of the program but just providing drug coverage in a standalone way to make it, there were a whole lot of elements that were

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different. And so this was really quite a challenge to try to come up with a reasonable cost estimate for the program. As we look back what we see is the cost estimates have turned out to be too high, a lot of that difference really showed up immediately in the first year when 2006 the program's cost was only about 74-percent of the projected amount. And when you look across the period from 2006 to 2011 the first six years of the program, the cost has been running at about 68-percent. So really the big gap starting showing up the first year and the trend really hasn't been that far off from what they projected, it's grown a little more slowly than the projected. But really the big difference starts to show up in that first year.

So what I'm going to talk is what are some of the factors that may drive that difference between projected costs and actual costs? And I want to start with enrollment and enrollment really was one of the big pictures that causes that difference in that first year. CBO thought that about 87-percent of all Medicare beneficiaries would participate in the drug benefit. That includes both the people enrolled in Part D Plans but also the people in that subsidized coverage through their former employers. In fact, the average enrollment has been about 73-percent so 73-percent versus 87-percent, it's a pretty big difference. Obviously fewer people in program means fewer dollars being spent in the program.

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Now some of that is because some of these people, a little than expected, ended up with some kind of other coverage outside of Part D. That's things like federal employees who don't get subsidized coverage through the Part D Program, people who found other sources of coverage that they wanted to stick with perhaps that they'd had before. But it also, as Juliette mentioned, a larger set of people who ended up outside the program with as best we know, no coverage at all, that 10-percent group was something that was not anticipated. It was really anticipated that most people would end up with some source of coverage at the end of the day. And so lower enrollment - and that really hasn't changed across the period so far so that lower enrollment started in the first year of the program, was one of the big factors in why costs have been lower than anticipated and why they've stayed lower throughout. But it's not the only reason.

Another part of this is just what's been happening with drug spending growth more generally in the system. So CBO projected, using the numbers that CMS actuaries create every year, that the overall trend of spending growth for drugs would be about 12-percent in the years leading up to the start of the benefit. And of course that affected where you go on the baseline for when the program started and then it would average about nine-percent over this period from 2006 to 2012. The

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reality, and this also in one of the exhibits in exhibit six in the paper, the reality is the growth has been lower, it's been more 10-percent and four-percent, these are per capita growth rates that I'm talking about here. And we'll talk later about some of why that's happened, a lot of that has to do with the generic drugs that Juliette already referred to. And it's been particularly low in the last couple years so we really have had very flat spending generally on drugs in the economy and again a lot of that has to do with the generics, and that's also why you see that flattening of the premium line in the last year or two. So the trends in the broader system have really been a lot of what's going on.

When you look at drug prices it's a little more complicated to look at. If you just purely - and I'm basing this here on analysis by MedPack, if you just look at purely the price of the same product from year to year, drug price inflation was about 18-percent across the first four years of the program. But then if you take into account the generic substitution that was going on and replacing some of the existing products with generics, prices have been pretty much flat over that period. So lower prices in the sense or less growth in prices has again been part of the story.

Rebates is something else that we want to look at. What are the rebates that manufacturers are providing to the

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plans to create discounted prices? The problem with the rebates is we can't look at them, we as researchers have no way to measure what's been going on there. The government researchers have a little bit of access to doing this and the actuaries have said that rebates may have been a bit above projections. On the other hand the Inspector General has looked at the Medicare drug rebates and compared them to the Medicaid rebates and said that the Medicaid rebates have averaged about three times the size of the Part D rebates. So you know, it's hard to get underneath these figures and make sure we're comparing apples to apples but you know, this has got to be part of that story too and perhaps the notion that the rebates have not matched what Medicaid gets.

But I've already eluded a couple times to generics and together with generics is also the slower pipeline for new brand drugs. A couple of the figures that sort of illustrate what's going on between 2006 and 2010, the rate of new drugs per year, there's only about one-third fewer drugs - new drugs issued each year in 2010 versus what was being issued and approved for the market in 2006. So the number of new drugs available is down and in fact, the new drugs that are available are smaller market drugs. The spending per product on those new drugs is only about half what it was by about the program started. So not only are there fewer new drugs joining the

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market with FDA approval but the drugs that are coming on tend to be drugs for indications that affect fewer people.

And then we talk about generics and that's really, I think is one of the biggest parts of this story. If you look at the top 75 brand drugs that were used in the Part D Program in 2006, more than half of them will have generic alternatives by the end of this year. And that's a pretty dramatic development and people have called it you know, now we're talking so much these days about fiscal cliffs, people talk about the patent cliff. We've really seen so many of the big blockbuster drugs you know Lipitor that's already been referred to, Plavix, lots of others, we could down the list, have had generic alternatives. We've not seen, going back to my prior point, we've not seen sort of the new blockbusters for treating cholesterol and blood pressure and osteoporosis and diabetes coming in. And so we've really seen therefore, the Medicare share of use of generics go from 60-percent in 2006 to 75-percent of utilization in 2010, obviously it's still a smaller share of costs. And this is something that's pretty well tracked the same way in the Medicare market that is tracked in the broader market.

And so I think that's the - to me is the set of factors; the lower enrollment, the lower overall spending growth in the system, the slower pipeline for new drugs and the

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greater use of generics are really the set of big drivers that I think has led to that gap between what was projected. A lot of things that CBO didn't have the ability to anticipate that would happen but in fact have happened and have caused costs to be lower.

And let's make a final point or so on sort of you know, how much we sort of attribute competition in all of this. And you know, it's true that there are lots of plans in the market so there is a lot of competition in this market but there's also a pretty good amount of market consolidation and market concentration like the mergers of a number of the big providers of the Part D benefits since 2006. And we're really in a situation now where a large share of all the market is just concentrated in a handful of the big firms that operate in this market. The other part we'd like to see if competition is really working and being robust, is that consumers are actively researching their choices and Juliette talked to you about sort of what's involved in looking at those choices. And it has gotten easier to make those choices, the plan finder's gotten better, CMS has taken steps to consolidate and make the options have more meaningful differences, but we still don't see a lot of evidence of people switching.

And you know, we've talked over the years to people in focus groups and they always tell us this is hard to do once

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I've a got a plan, I tend to stick with it even if I know the premium's going up. Now some of that's loyalty, they like what they're getting, some of it is just you know, an unwillingness to want to do the research to see if there's a better price out there. There's even some sense that people aren't even switching among the different plan offerings from the same plan sponsor. Unfortunately we don't know a lot about - there hasn't been a lot of research and we're going to try to undertake a study to try to look more at the dynamics of switching and try to see what's going on there. But we do think that the absence of sort of robust switching and robust research really is a limit on what competition can do in this market.

And the other point is really just to go back to what I said before which is, that the underlying drug growth, switch to generics, drugs in the pipeline is something that's affected private sector, Medicare, Medicaid, everything and so there's really not a good sense as I look at the numbers that the Medicare plans have been doing particularly better than any other sector of trying to manage the drug benefits. And I think as we look into the future some of the issues that are going to come up are the ability to manage some of the high cost drugs, the biologicals and some of those things but can more about the in the discussion. With that I'll stop.

TRICIA NEUMAN: Great, thank you Jack. Karen.

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KAREN IGNAGNI: Thank you, good morning everyone. I want to thank Jack and Juliette for really making me turn back to Part D after spending a year or so imbedded in commercial issues and regulations, so thank you for that. And I read Jack's paper before I read yours so I started thinking about my remarks through the prism of your paper first and then I read your great paper. And I think you said it Jack, in terms of how you ended but the research question I took away from your paper that was embedded in it; are there exogenous things going on or is the success due to planned performance, I mean reducing to the lowest common denominator?

So I started thinking about that in my few minutes, wanted to give you a window how the plans are thinking about this, how they used to think about it, how they're thinking about it today, what's changing and so on. First thing is there's a triangle of thought going on, if you just picture a triangle in your mind for simplicity's sake. And when you're designing a benefit package you're thinking about how do you maximize access? And I'll come back to that. How do you provide access to benefits at the lowest possible costs and how do you demonstrate that you're providing high performance and quality? So that's the triangle.

And how you think about benefit structures really is directly as a result of those three factors and you look at the

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three on an equal plain. And beneficiaries are obviously looking both at quality, they're looking at price and they're looking at access. So from the standpoint of what's the big deal about the tools, when this program started there was something that was done that I think had a material difference and it relates directly to what you said.

There was no tiering in the market prior to Part D. The putting benefits together in a tiering way, meaning that the plans weren't making decisions to say you can't have X. But there are incentives for people when their doctors found it appropriate to use generic drugs. Without those benefit structures we could've had all the generic drugs in the marketplace but nobody necessarily would've had an incentive to use them. So I think that was a very significant development from a plan perspective.

Second, there's a great deal of work going on in pharmacy and therapy, we call them P&T Committees on how do you do formulary management and therapeutic substitution? Juliette talked about therapeutic substitution. If a person is on a drug where there isn't a generic but there is potentially another where there is, you know how do you work with physicians to think about that and suggest alternatives and so on?

Third, adherence MTM, Medication Management Therapy, making sure that people - I have asthma, my plan is always

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bugging me, are you filling your prescriptions and perhaps I'm a little delinquent sometimes and that's why they do but they call me. And that's just a simple example of adherence and focus on adherence. In the beginning of D what we heard from the plans were people were presenting in their doctors' offices with shopping bags full of drugs. Marilyn always talked about this, many of us know these stories and part of this is to work with physicians and assign people case managers to just sort out what made sense, what didn't, how does A go with B go with C? Because we're talking about population with a number of comorbidities, so that's the bucket of plan tools, again oversimplifying in terms of time.

Two in terms of the cost, I thought you made a really compelling case about well there could be other reasons, we ought to look at the fact that there are fewer people coming through D. We know that people are in Tricare, we know that they're in FEHBP, we know they're in the employer sector and so on and so forth. But that doesn't explain the difference in terms of the monthly premium, monthly premium projection was, it was supposed to be over 50 something dollars, it's 30 something now so it's more than \$23 in terms of the difference in projection. And that is because of I think the investment in the tools in the benefit structures that rewarded people for purchasing generics but at the same time made sure they had

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access all the way down the line so people weren't forced. This is by the way, a direct result from quite a lot of the benefit structures that the plan developed in the 90s which didn't have those kinds of choices, it was more yes no.

Now back in 2003 when this benefit - 2006 sorry, this benefit structure began to go into effect people in the plan community said how can we really look at that triangle and make sure people have access and they're making their own decisions? The other thing that I would say that's really striking about the CMS data here is that satisfaction, overall satisfaction but if you look and get in under satisfaction by LIS category, duels, disabled and so on and so forth.

Final thing I want to say is in the bucket of innovation and I'm sure we're going to come back to all talking about these things. There are a couple of striking things going on in the plan community that we're very excited about. First the bucket of clinical pathways, plans are working with specialty societies and specialists to develop bundling and we're not talking now simply joints and things of that sort. But in cancer therapy, using oncology drugs, working with oncologists to bundle set goals, quality goals, I think there's tremendous potential in this regard. We talked a little bit about value based benefits but it started in the commercial market now migrating to Part D that a number of structures

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people are actually paying very, very little for their drugs if like me, they have asthma, cholesterol drugs and so on and so forth where there's just documented evidence that it makes sense to encourage this.

And in areas where there isn't much competition in the specialty area it's harder to do that but we know now we're seeing it in MS, we're seeing it in Hepatitis and I think we'll see it in others. Some plans bring back the farm benefit and reintegrating it in, we've also seen that there are some very compelling studies that look now at pre Part D, after Part D, what are the hospital savings, what are the nursing home savings? So the fact that people have drugs that's a possibility or that's definitely a direct by-product. We're looking at distribution channels, how do you think about when things should be distributed in doctors' offices, on an outpatient basis, in home and there's going to be much more activity around there.

And finally in terms of specialty drugs, I think the brave new world is - and I think we're seeing already evidence of this - and Mark McClellan wrote about this I think either in The Lancet, the British Medical Journal not sure exactly, I think that was where it was a while ago. But this whole concept of gain sharing where there isn't competition, incenting pharmaceutical companies to work with health plans to share

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risk. And I think in the area of specialty drugs there'll be a great deal more conversation to be had about do we have the intellectual base to actually evaluate all of the drugs and therapies? And I think we're just at the beginning of those conversations now.

So Tricia I'll leave that there but hopefully I said enough to spark discussion.

TRICIA NEUMAN: You did I'm sure we'll come back to a lot of those issues. Jim, thank you.

JIM CAPRETTA: Thank you. Well thanks to Kaiser and Tricia for inviting me, I'm very pleased to be here with this group it's a great group. I want to go back into the data you know, there's a lot of numbers being thrown here and I just want to step back and kind of put a couple things in context so that you understand at least my perspective how to interpret sort of what's going on.

First with respect to the average premium the beneficiary is paying as Juliette mentioned it's obviously important to weight it based on where they are but you have to also really include Medicare Advantage prescription drug plans to get a fair picture of what the beneficiaries are actually paying. Because a quarter of the Medicare population is now on Medicare Advantage and those plans are also providing prescription drugs and a separate drug benefit for which the

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beneficiaries pay a premium. So when you calculate that in, as the actuaries have done at CMS, the average beneficiary premium in 2012 is roughly \$30 for the MAPD plans and the stand alone PDP plans. In 2006 when the program started it was about in rough terms \$24. So it's gone up an average about one dollar a year so it's not only that people have a choice between standalone PDP plans, they also have a choice to go into Medicare Advantage PD plans and lots of them have done so.

So when you look at the together, it's been a pretty remarkable success. Remember at the time of enactment in 2003, an amendment was offered to say that the beneficiary should pay no more than \$35. If that had been locked in we probably would've locked it in and then indexed it something, they certainly would be paying closer to \$50 today instead of \$30 a month. So you know the performance of the plans when you include MAPD in the calculation has been quite good.

The second thing to note is that it's true that enrollment at the beginning was below both what the actuaries expected and what CBO expected. Joe Antos of the American Enterprise Institute went back and calculated okay when you do the math, how much is that of the differential and the CBO cost estimate? It's roughly one-fifth, 20-percent so about 80-percent of what's happened in terms of the spend below what CBO projected is due to factors other than enrollment.

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And a third thing to note is that CBO has been bringing down their estimates of what this benefit is going to cost pretty much every year, including this year, two months ago. Two months ago they lowered their future projection of what the Part D benefit's going to cost over the decade by \$100 billion and they did at the same time that they raised the cost of the rest of the Medicare program. So their expectation going forward is that Medicare Part D is coming down and moderating even more and they've done that frankly, pretty much every year since 2006 and the rest of the Medicare program they increased the estimate of the baseline. Now that's a projection, hasn't happened yet but I think it's an indication of where they see some of the signals occurring in the program.

Now in terms of what's going on inside Part D, why is this happening? Actually I need to do one more thing, which is on the aggregate data. When you look at the aggregate data it's quite true that when you go back to 2004 and say hey what was the national health expenditure projection for prescription drugs over the next decade? And it was actually quite inflated and we came in way below it, in other words at the same they were estimating the drug benefit for seniors, they were also estimating drugs spent across the whole country. Both were too high by an order of magnitude and things have come down quite below what was expected at that time.

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So one might then ask as Karen asked, you know what's going on here? Is it chicken or egg right? And one thing you need to though when you hear estimates then indicating that the national spend has come down, you have to also realize that includes the senior population so you're double counting the senior effect essentially in the two numbers. So when you pull that out it's quite true that the national spend has come down quite substantially but it's probably - and my calculations are that the senior population in Medicare Part D has come down even more. Slight more, not a huge amount more but slightly more when you correct for the fact that the nation numbers include seniors as well.

Finally let me get into the issue of what's happening inside the drug benefits, what's really going on? IMS is the company that tracks prescription issuance around the country, has an immense database of prescription fills. And they've done an interesting analysis of the top 10 therapeutic classes you know, things that people need therapy for in the senior population in Part D. And what they found is that starting in 2006, so the drug benefits started in 2006 and then going forward to 2010 the top 10 therapeutic classes on average had in terms of daily cost of therapy, a 30-percent reduction in the daily cost of therapy per beneficiary okay?

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So that's 30-percent reduction, why is that happening? Well there's price pressure on the branded drugs through the competition that's occurring from the PDP plans and the MAPD plans, they're putting pressure on the branded manufacturers so that includes the rebates. Secondly as noted already, there's huge generic substitution going on, it's gone from essentially 60-percent rate in 2006. When a generic is available the seniors have been filling it about 60-percent rate of generic going back to 2006, the actuaries now report in 2012 that's up to 77-percent okay?

Now why did that occur? Is it just a general national trend and seniors are just falling in line with everybody else? There's a little bit of that but you have to understand these plans are pushing seniors into generics as fast as they possibly can. The example that Juliette put up there, you know you have to ask the question, does she really need Lipitor right? Couldn't she have gotten the generic? She probably would've saved a huge amount of money if she went with generic. And you know obviously there are clinical things there you know, and you don't want to answer but the vast majority of people on Lipitor can go with the generic and save a huge amount of money and most of the plans are pushing them into that and they're saving huge amounts of money.

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Now imagine back in 2003 if there was an amendment offered during consideration, there probably was, I'm forgetting. To say you know what, let's forget all this business of trying to have competition and incent people and using financial incentives and so on, let's just make them go into generics right? If it's a generic available why should the government be paying for the non-generic branded drug? And an amendment is offered to you know essentially push people into generics, with all due respect to my branded drug friends, I'm sure there would've been a huge counter offensive. You know, with ads and you know well, you can't do it in all circumstances and there's clinical reasons not to do it for the exceptions and of course there are exceptions and there would've been a huge brew-ha-ha okay.

And my guess is maybe they would've won, maybe the branded team would've won and the amendment probably would've failed. Or if it passed it would've come with 55 exceptions that would've gutted the whole thing you know? And instead what's happened is it's happened naturally because people see, you know what if this is the same therapy why am I paying more? And most of the PDP plans and certainly the M.A. plans have you know, nudged maybe that's the nicest way to put it, slight more than nudged people into generics by saying look you can get the branded drug but it's going to cost you a lot more. And that's

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happened all over the country, it's the main reason why you know, people are paying \$30 today and were paying \$24 six years ago.

Finally the projections going forward from IMS are that based on trend and generics coming online and so on, is that they expect by 2015 the average daily cost of therapy for these top 10 therapeutic classes for seniors will be down about 60-percent relative to 2006 it's a huge drop. So I think all in all one has to compare where Part D versus the alternative. What would we have done if we were trying to run this ourselves, would it have worked out as well? I definitely say it would not have but you know that's subject to debate.

Finally let me just end, this is my third finally but let me just mention two quotes and you can guess who they were. A former Director of the Congressional Budget Office; "The bids are coming in and the pricing is coming in better than anticipated and that is likely a reflection of the competition that's occurring in the private market", Peter Orszag. Former CMS Director, guess who it is. "We can report that average premiums for a Part D plan will be the same in 2012 as in 2011". According to the Former Administrator Berwick, Part D is a competitive market and we're seeing the effect of good competition among Part D plans to take its effect. Thank you.

TRICIA NEUMAN: Thank you. Marilyn?

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MARILYN MOON: I have enormous respect today for Jack and Juliette for studying Medicare Part D because the more you get into it, the more complicated it is. Try to figure this program out, try to figure what's attributable to what, it is really difficult because it is a very complicated and lots of things are going on. And we've heard a range of discussion of this and I don't find I disagree with very much of what's been said even though some of it is contradictory and that's the nature of Part D.

When I was thinking about this last night, what I wanted to say I was thinking about in the 1990's a friend of mine who was on Capitol Hill came to me and we had a big chuckle over the fact that a reputable insurance company had come to people on the Hill and said we have the solution for high cost illness for people that otherwise go into high risk pools and so forth. And this is we will insure them, we will guarantee that we'll insure as long as you provide reinsurance for anything above \$10,000. And what a good deal for the insurance companies that they could coverage on the first \$10,000 and pretty much have a very good sense of what they should charge for that as long the government took the burden off of them.

Well cycle forward to the 2000's and in many that's what they got with a Medicare Part D program. I, like many

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other people, did not anticipate what a good deal this was going to be for insurance companies and why so many of them would go into the market. They're smarter than I am, they figured it out and they came. Remember that once you hit the doughnut hole, first of all the insurance plan does not have to pay anything and then when you come out of the donut hole into high cost area the insurance company pays very little. The Medicare Program pays 80-percent, individuals pay five-percent, that leaves a very small and very much less risky share for insurance plans to cover. They have a very good deal in terms of this insurance market and that's something we shouldn't forget.

On the other hand let's also give credit to the private insurers because they have done some things really well. I totally agree with Karen Ignagni and with Jim that pushing people into generics has been something that these plans really did in a very energetic way with the tiers, with making the cost of generics very low and really encouraging and providing very strong incentives to seniors to go into that. They were riding a wave there's no doubt that, that was going to happen everywhere else and they were helped a lot by the publicity that was going on that said look, you're not hurting yourself by doing this. But they provided the financial incentive and they got those results and that's a very important issue that

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one should recognize and give credit for in terms of these private plans.

And I agree also that it would have been difficult for the Federal Government to do it in a coercive way. In the same coercive way you can think about that private plans have done, we don't like government to do that particularly if there's no choice. But we also have to be very careful then in terms of thinking about that and what that means in terms of the great context for how successful Medicare Part D is and what will happen in the future. I think that it's important for example, to be very careful in terms of attributing and figuring out what was due to competition and what was due to other things. And you've heard people parsing this out a little bit, I've also been trying to do some of it and the further I get into it the harder it is to do.

2012 is not a very good year to look at the premiums or to look at the data because 2011 there were adjustments that were being made for the first of the rebates that were being given for filling the doughnut hole. And then there was going to be an adjustment being made in 2012 and if you look at the Trustee's Report it talks about that for example, so that 2011 and 2012 you really can't compare those numbers. 2006 everybody bid too high so 2007 the numbers came down, that's not because suddenly competition was working, that's because

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everybody got paid too much in 2006 and so there had to be an adjustment in 2007.

So maybe the cleanest period is 2007 and to 2011 but even then there were other changes that were occurring and adjustments that are occurring. So it's very difficult to sort this out and to parse it out. I think what we should say is everybody has some challenges in figuring this out and how much of was due to private competition. Let's give some credit, the private competition has helped in many ways, the private competition also creates some other challenges however. As Jack said only about six-percent of beneficiaries switch plans even when the data show that they would be much better off if they switched plans. Some recent research by health economists have been showing increasingly that folks don't make these choices very well in part because it is so complicated.

Juliette showed you what the smart person would do it terms of figuring it out but if that person in figuring out, then suddenly in the middle of the year had a whole different drug put on their plate they probably would have made the wrong choice. And not very many people do that, most people look at the premiums and they give much more weight to the premiums than to anything else. Even though as the data have shown the co-pays can be dramatically different, the level of control can be dramatically different, it's a very complicated and

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difficult thing to do, so in terms of people switching that's really difficult.

I hope that the benefit structure changes that are being made over time are being made for good reasons on the basis of evidence and I think that's true for some private plans. But there's always going to be a competition here in terms of attracting beneficiaries and if you want to attract a beneficiary. Are you going to make choices in your benefit structure as a private plan between what is really best for the individual in terms of what the evidence says in steering people to the right drugs or the basis of the fact that everybody wants to have access to certain kinds of drugs?

I always beat people up about Nexium my old favorite where Nexium is no different than Prilosec once it gets into the body but look at the difference in prices between the two. And look at the number of people who demand that purple pill which used to be Prilosec but now it's Nexium, go back and look at the ads, the purple pill was Prilosec in the past not anymore. And so it's difficult for private plans to always do the best thing also because they have to meet the demands of consumers and they have to balance that off. So we have to be very careful in thinking about competition and how it gets uses.

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And I will finally say that going forward, the real challenge is I agree, going to be what's going to happen to the biologicals in some of the really expensive drugs and other drugs that come on board? It's not really the problem of the private plans, it's going to Medicare's problem because it's the one bearing the cost for anything about a little over \$3,000. The beneficiaries and Medicare have more of that stake in the game essentially than do private plans in terms of looking at their risks. So this is something we're going to continue to talk about and hear about, it's full employment for - I always like to end my talks about talking about full employment for analysts because that's what I am, it's full employment for analysts who are interested in trying to understand it. Understanding hospitals, piece of cake compared to Medicare Part D, understand physician services, piece of cake in terms of what are the costs? What's attributable to what, what's driving what? This is a very complicated, complex program.

TRICIA NEUMAN: Okay well thank you all for your comments, they were really insightful and I'm sure each of you would like to respond to each on a number of fronts. I think what I will do is throw out just a few questions, this is going to give you all time to think about the questions that you want to ask. I'm going to follow-up - begin by kind of getting back

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to the people thing and several of you have mentioned this idea and stickiness and where people do compare plans and how much they and when they do. And you know we do a lot of research here but of course the people who really make an impression on you are people like your mother and your mother's friends who say to me I don't really want to compare. Tell me it's going to make a huge difference and then I'll do it but I don't want to it unless you do it for me.

We really don't have a lot of data, I haven't seen a lot of data that tells whether people - how many people really compared plans in the first year that they become entitled to Part D. Whether they do it annually, whether they compare plans each year, when they think about switching are they really motivated by premiums, are they motivated by - is it that they want to move from a standalone to a Medicare Advantage plan? And I think I'm looking at Karen to start off to say you know, what do you know in terms of what consumers are doing? What's the perspective from the industry, what are they seeing, how much movement is there and from where to where and why?

KAREN IGNANGI: In the beginning of the program it was a baseline question to customer service and all of our plans have very well trained customer service folks who deal with a variety of questions. We also work very closely with SCHIPS

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and other beneficiary advocacy organizations. Originally the question was well how do I compare Part D versus as Jim said, MAPD, Medicare Advantage prescription drug plans and they were looking at price, they were looking at their drugs and that was the original kind of series of questions that were coming in.

As both the folks got a little more experience in the plans still looking at price but also beginning to ask their drugs, what drugs they might need in the future, both questions coming from caregivers, questions coming from beneficiaries themselves and it's very interesting. And then our plans also routinely refer people to the plan finder and so on and so forth and we've worked closely with CMS on Scripps to actually do that so we're seeing a much more significant number of calls coming in with very - and I don't want to say complicated questions meaning that they can't be answered. But complicated in a relative sense compared to where they were in the past which was more of a threshold baseline but as people get more experience they really are using these tools.

All the plans have cost calculators, they have comparison tools as well and that's developed frankly, as a result of this competition in the market, which we're seeing on the commercial side as well as Part D and on M.A.

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TRICIA NEUMAN: But not to push you a little bit further or anybody else, but do we know you know, each year what share part the enrollee 's are switching?

KAREN IGNAGNI: Oh sure we do yes. I mean CMS knows that and plans know that. I should've come with some of those data, I didn't I apologize for that, yes, people look at that. If you're running a plan you want to know are individuals satisfied with your plan, are they leaving?

TRICIA NEUMAN: Is it hard to keep people, are they leaving, where are they going?

KAREN IGNAGNI: Yes we're absolutely tuning into that and paying dramatic attention to that so you're really looking at this triangle and you can't really meet beneficiary expectations unless you're really doing the job on the access front. Giving people the choices, making it transparent, making sure the price point is correct and the that quality is there. That you're offering the kinds of tools to help people navigate.

JIM CAPRETTA: Just you know I don't have the data right in front of me but the CMS actuary Rick Foster, did testify that there has been movement from high cost plans toward lower cost plans every year. Has it been as much as people would've wanted to see? No, perhaps not but he's testified there has migration every year and that is one of the

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reasons you initially see a premium you know, a standard premium people think it's going to be above something and then they say well when you wait for the migration it's going to come in lower right, and that includes this year.

So there's been migration from higher cost plans to lower cost plans every year, hasn't been as much maybe as people would have thought. But you know it's important to realize that when you have a market it's this sort of game theory right? The people that are offering the plans, they don't know exactly how much people are going to switch and they don't know exactly where their competitors are going to come in okay? So you know, having seen a little bit of this on the inside, not much but a little bit, I know that they have - the competition puts a check on them you know? That they can't go - they can't do very much in a certain direction because they're worried about well you know, if we go too far we lose market share.

So you know even without huge amounts of switching that pressure still is enough to influence a market place.

JACK HOADLEY: And you know the problem is that the tendency of people not to switch and still most people don't switch you know, means the plans don't have to be as responsive to that potential threat as the other ones. I mean I looked at a data point two of the largest plans last year, the AARP plan

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offered by United, it's premium was up 15-percent and they average across the regions, enrollment up two-percent. Humana's largest plan, the Enhanced Plan or what was its largest plan, premium down nine-percent 2012 versus 2011, enrollment up one-percent. So basically they got the same output in terms of enrollment change with very different premium stories behind it.

So you know it's the stickiness and we need to understand better you know, sort of what goes on. One anecdote I'll throw out again, you said you know, we know a lot of these the anecdotes of people's parents and friends and so forth. A parent of a friend of mine you know, the friend did the looking obviously this is the way it tends to work, said we could save you know, mom several hundred dollars by switching plans. But started to look underneath that, realized the issue was as people have talked about, their still stuck on some of the old brands that they didn't need to be on. The solution was keep the same plan change the doctor because the doctor had been resistant to switching to the generic drug.

TRICIA NEUMAN: Oh that's interesting. Alright everybody's been really good on this panel keeping to Part D and we wanted to keep mainly to Part D. And we do but I think we want to go a little bit further and say now sort of move to the other part of the title of our briefing which is what are

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the implications for Medicare reforms? And you know a lot of people are saying well there's something here and maybe this should be the model for Medicare reform and this obviously sort of conceptually a part of premium support. And I guess I'd to ask anybody who wants to answer, you know how far does the analogy go, what are the ways in which this could be a useful way to think about approaching broader Medicare reforms? What are the cautionary tales here, what lessons can be applied and perhaps which lessons learned to not go in that direction? A broad question for anybody who wants to take it.

JIM CAPRETTA: I supposed it aimed at me, I don't know.

TRICIA NEUMAN: Well at least you're helping everybody by starting.

JIM CAPRETTA: Yes I'll go first. Well look I mean I'm an advocate of premium support and I do think that Part D should serve as somewhat of model. Look, I don't claim that the prescription benefit with is largely a commodity than be mailed you know, is the same as delivering services in the you know, inpatient setting or in physician's office or you know et cetera, et cetera. So there's much more - even though this is a complex benefit, there's more complexity to delivery system reform so to speak in the you know, non-drugs part of Medicare than there is in the drug part of Medicare. It's actually fairly straightforward to get to an efficient mail order system

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with generic substitution and lots of pressure on manufacturers and pushing down the price points you know, that's a relatively straightforward exercise. And obviously in the Medicare benefit there's much more complexity.

Now having said that, one has to then sort of understand Part D in a political economy sense. Which is why do I think it is the model? I think it's the model because it sort of gets the relationships roughly right in terms of who should do what. That is, the government is not trying to figure out the right price for every drug, every pill out there okay? There's a real temptation to have the government try to do that okay? And I think that would be a disaster and all you need to do is look at the rest of Medicare to see why okay? When you have regulated prices, the government in the role of being the price regulator of everything in such a micromanaged way, it leads to pernicious lobbying of the government. It locks in things, it makes it very difficult to change, it has a lot of perverse and unintended consequences. We see that all throughout the Medicare/FIFA Service world.

So in the Medicare Part D context the government isn't trying to do that, what it is doing is it's overseeing the marketplace and it's providing you know, I think very well actually, fair rules for the bidding process and oversees that. And then it says the beneficiary we are going to give you an

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entitlement toward that coverage, the entitlement ensures you guaranteed coverage through a Medicare benefit. But if you want a more expensive plan, you'll pay more out of your own pocket, if you pick a less expensive plan you'll save some money. And so I think that roughly gets the relationships right, puts huge incentive on those delivering the services to try to figure out ways to save money and correction can be made, innovation can come into the program, it can evolve and change over time. It's all not locked into stone.

And so anyway I think that's the main reason why I think it is the model. It understands also the way our political system operates, it's the kind of program that you can't micromanage through Congress all the time and that's a good thing.

MARILYN MOON: I'd jump in a little bit and say I think Jim has given a very much more reasoned discussion than I've often heard when people say 40-percent savings in Medicare Part D over what was predicted and therefore obviously premium support would be just as successful. I think we've heard today a couple of things that make it very different than a premium support approach that I'm hearing from people outside. And I'm glad to hear Jim underscore some of that.

One is Medicare Part D has a lot more controls and protections than people are talking about, has upside risk

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protection which may have some advantages and disadvantages at various points in time. It also has a lot of oversight in terms of how the competition occurs, much more so than some of the proponents of premium support are asking for. The other is in terms of the savings that you would expect and the complications then of, we've heard about, of the generics and the wave of generic changes. And the fact that this is something very standard that was happening is much easier to have happen and take credit for than some of the other changes that would have to occur. And I think that's something that's really important to keep in mind and that makes us very unique in this particular situation.

It also, again I would just stress that it's difficult to extrapolate for example, the example of MAPD plans, yes MAPD plans look really good and they have very low premiums but we don't know what's going to happen when the extra subsidies to M.A. plans go away. And the subsidy that was going on we think, for the prescription drug plans in many case also may go away as M.A. plans don't have the extra cash to hold those premiums down. So I think that there are a lot of way in which one would have to be very careful and simply extrapolating this to premium support.

JULIETTE CUBANSKI: Can make another -

TRICIA NEUMAN: Sure.

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JULIETTE CUBANSKI: - oh I'm sorry Karen go ahead.

KAREN IGNAGNI: Oh no, no I'll yield to you.

JULIETTE CUBANSKI: I think it's important in terms of thinking about the low income population in terms of how Part D and what we don't know about premium support in terms of how it would help provide additional assistance to people with low incomes. In the world of Part D you know, I think there are some real concerns about the transition of low income subsidies enrollees from one benchmark plan to another across the years. And you know there was a lot of concern at the beginning of the benefit about the switch from Medicaid drug coverage to Part D drug coverage and you know, a lot of people were kind of predicting that the sky would fall and I think for the most part you know, those predictions really didn't come to bear. But there's still you know, several million low income enrollees whose benchmark plan loses its benchmark status from one year to the next and they have to make a switch if they don't want to have to pay a premium.

And I think what we know from our research is that there are many low income enrollees who are paying an additional premium. Is it because they want to stay with their plan or is it because they simply don't know that they could switch to a plan that would be available to them for no additional cost? We don't - I haven't seen the information to

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suggest what's going on beneath those numbers but I think that's a real concern and think this is a sizeable enough population. You know research that we've done shows that half the Medicare population has annual incomes less than about \$20,000, that's not a lot of money and so you know these people are really vulnerable and I think it's important to make sure there are adequate protections in a premium support world for people with low incomes for whom this coverage is really important.

TRICIA NEUMAN: Karen?

KAREN IGNAGNI: I just make three quick points. I think that the plans have tools in the M.A. area that are very valuable for Medicare beneficiaries. My colleague Jeff Lemieux, has just published now in health affairs in the Journal of Managed Care in January and February respectively how M.A. is doing head to head on diabetes management in the first instance and also on readmissions in the second. He's been tracking this now for a number of years using government data and I think what it tells is that these kinds of tools, they're broader than the tiering in Part D that's one example of a bucket of tools. But readmissions, care coordination, disease management and so on which you can - it's very to do in an open ended fee for service system. In a managed care arena you can do that and I would say that it's important to look at

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those tools and the value number one, the satisfaction number two, the performance number three but primarily number four, how that incentivizes providers. If we really want to get to the triple aim and walk the walk we have to create incentives that are much more complicated than you know, tiering structures to encourage generics but incentives for the kinds of bundling; ACO's, integrated care, capitation, et cetera that really begin to blend risk, shift risk and give beneficiaries transparency. It's very, very difficult to do that in a fee for service structure.

So what I'm excited about is I get in under the hood and look at these structures I think there's a great deal to contribute to this dialogue and ultimately the design.

I think Juliette has made a very important point and just Trish, I know you want to move along but just to say really quickly that in the beginning of Part D we, in our industry spend a significant amount of time working with disability organizations, beneficiary groups, the AMA, provider specialty societies on what are the rules for transition? How do you protect people, how do you make sure that they understand their choices, they're well treated but they're not disrupted overnight? I mean all of that has to be baked in to this discussion so I'm glad you've started that and I think forum like this will allow these kinds of issues to come out.

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And I think they need to because it's not an either or, and it shouldn't be an either or discussion. But how do you actually accomplish what is better for beneficiaries?

JACK HOADLEY: I just want to make one really quick point. You think about the example that Juliette showed about using the plan finder to find a plan suitable for a person with two drugs, just try to expand that concept to an array of Medicare services. We start with the fact that drugs - you pretty much know what your drugs are going to be next year most of the time and yes, you worry about the fact that they may change. But if you're trying to pick a plan that will cover your potential therapy needs if something happens and you get sick and your hospital needs and what services you want lower co-pays on and where you want deductibles. The idea of sort of workin through a plan finder to make a rational choice, I think it's going to be even more of a case of people picking a plan based on reputation and then saying I'm not going to move ever again.

KAREN IGNAGNI: Although that's where we're headed with exchanges and people make the opposite point that having the transparency, having the information is positive for consumers, letting them make the decisions et cetera. It all depends on do you have the information you need - this is where I've been spending the last year of my life, do you have the information

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you need to actually properly be informed about all those decisions? And there's a lot of conversation about that that needs to occur.

JACK HOADLEY: And having the standardization of sort of a gold and silver kind of models is something that we would definitely need to bring in to a Medicare design, something we don't have today with Medicare Advantage.

KAREN IGNAGNI: I actually think that's another seminar but I actually think there are limits to that that I think should really be discussed more in the commercial space. I think actually the D model really allows a lot of innovation to develop that works for beneficiaries both on the price side as well as the access side. Another forum, I know.

TRICIA NEUMAN: Well we have a huge agenda as you can see. We would really like to bring you into the conversation now so rather than have me continue to ask questions and I have so many I could ask, are there people here who have questions? Yes, good alright so Tiffany I - could you introduce yourself before you ask your question?

WOODY EISENBERG: Hi my name is Woody Eisenberg, thanks to the panel for this excellent - thank you to the panel for this excellent discussion. There's a couple of points that I would like to raise and maybe you'll feel that you'll want to discuss them further. One is that although the free market

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aspect of the Medicare Part D benefit has been something that all of you have included in your comments, I think it's important to recognize the role that CMS has played in the regulation of this market. Any of us who are involved in actually delivering this benefit know that this is a highly, highly regulated benefit.

Everything from the structure of the formulary to the content of the formulary to the structure of the bids, the submission of the bids, notification of the members, appeals, grievances, on and on and on and on and on. So I think that has to be recognized and the things that I've mentioned are things that could add to the costs of the benefit and probably have, so part of my appreciation of the fact that the costs are lower is that it's been done within this framework of heavy regulation.

Another that I'd like to make is that although when we think of Part D we really focus on the individual and that after all, is who the benefit was invented for. A significant part of this benefit is being delivered to groups and the greatest engine for growth of Part D right now is that conversion from employer primary insurance, the subsidy plans through group enrollment through a waiver into Part D plans. And now that the subsidies are going away for many of the four profit companies, what we're seeing and what I expect to see

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especially over the next three years is a tremendous influx of members from commercial Part D plans into Part D through group enrollment and it's something that we need to consider in terms of how we fashion our benefits. And something for you to consider in terms of how you appreciate these increases.

And then the third point and I'll just mention it briefly is quality. And that again is the result of what CMS has done with the star ratings which is having a big impact on how we put together these benefits.

TRICIA NEUMAN: Okay and when you next introduce yourself if you could say what organization you're from I think that would help everybody in the audience, thank you.

RAPHAEL SEMANSKY: My name is Raphael Semansky I'm an independent consultant. I wanted to kind of circle back to what Juliette started with. I know we talked about how much of the Medicare Part D actually reflects a larger pharmaceutical market, the commercial market as well. I'm curious, there's been a big effort in insurance in general to increase cost sharing for individuals and I'm just wondering you guys could comment on what the cost sharing looks like for individuals in Part D. In terms of you know it's not just the premium it's also there's a deductible as well as you know different drugs are covered or not covered. And I think you know, your example of two drugs you know, for my father who had 15 drugs you know

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looking at you know, these plans becomes extremely complicated and he actually wound up with a Part D plan as well as using the V.A, so it became even more complicated for him.

JULIETTE CUBANSKI: Well I would say the good news I think is that if you're able to or have a family member, caregiver who's able to type all those drugs into the plan finder, it does all the calculations for you. But as my slides showed you know, we have seen cost sharing increases over the years and I think of some concern is you know we've seen more plans using co-insurance so you're charged a percentage of the total cost of the drug as opposed to a flat copayment amount. Which makes it a little bit more difficult if you're just looking at that co-insurance rate and you don't know what the total price of the drug is, you don't know what you're actually going to be paying out of pocket when you go to the pharmacy counter.

So there again I think it places more emphasis on the importance of these types of tools that consumers are provided in the Part D marketplace to help them really make better choices for themselves. It doesn't necessarily help you when your costs or your drug need change during the middle of the year if you're in a plan that actually doesn't cover your drug on the formulary or it charges a high co-payment for a particular drug. And there you hope to have some flexibility

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in working with a pharmacist or your doctor to maybe get you onto a cheaper drug or a drug that'll work for you that is covered by your plan. So I think there has to be some flexibility on the part of consumers in that situation.

MARILYN MOON: I think the other issue is particularly for the folks who have modest incomes between 150-percent poverty and 250 or 300-percent of poverty, these cost sharing amounts can be substantial and can discourage use of drugs. We know during the donut hole that people stop using drugs that are important for them to take every day and I suspect that that may be true for some of the ones that are very expensive that are on the higher tiers. And which is also what I was getting at before when I said hopefully the higher tiers increasingly become things for which there are good alternatives and or that are really not being recommended as opposed to simply high cost drugs. And in some cases they are just the high cost drugs so that means that the individuals are being subject to 35, 40-percent cost sharing which can be really substantial for these modest income individuals.

MEGHAN KERNS: Good morning, my name is Meghan Kerns and I'm with the evaluation side of HHS Office of Inspector General. And as Jack mentioned we have slightly more access to data than private researchers and so given that, I'm wondering what research questions you all think still need to be answered

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to contribute to the conversation on Part D and broader for Medicare reform?

JACK HOADLEY: There's only one thing that comes to mind is one you've already worked on which is rebates. I mean really trying to understand more about the dynamics of what's gone on there, would be really important. I think another thing, although this is something I am trying to study but we're still running into some data issues although hopefully will get resolved, is the switching question we've been talking about and sort of the dynamics of what goes on. CMS has just not put out a lot of numbers and I know the plans internally have numbers at least for each individual plan but - and we're going to try to take a good look at this over the next six months to a year of what the dynamics I think but those are a couple of areas that come to mind.

You know actually I'll add one third one which is what we raised you know the employer plan, that's something that isn't very transparent to the public. We can't even look at that the benefit parameters are for a group employer plan, even the ones offer thorough Part D. We can tell how many people are in them but that's about it.

JULIETTE CUBANSKI: And can I throw in another one which is actually sort of building on this question of switching and what Karen mentioned about transitions is what's

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happening for the low income subsidy enrollees when they transition you know, perhaps inadvertently from one benchmark plan to another? And in terms of you know, what implications are there for their access to medications, are they switching medications? Those sorts of questions I think are really vital to understand more about it.

TRICIA NEUMAN: Another other research dreams?

LESLIE FRIED: I'm Leslie Fried of the AVA Commission on Law and Aging and thank you for your discussion. There wasn't much discussion actually about the Medicare population has multiple chronic conditions, many of them have cognitive impairments and actually the impact of that group and having a change in Medicare reform I know that I too, volunteer and help individuals in their Part D selections each year. And it's so complicated especially with folks who have so many needs and I am very concerned about the impact of a significant change in the Medicare program so that people may be having to change providers if their plans change. But that actually is not my question, actually my question goes to quality and quality ratings and while there are star ratings, my question is has there been any research at all as to whether individuals are really using the quality ratings to make choice regarding Part D plan? Because that can have an impact if there is significant Medicare reform.

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JACK HOADLEY: You know externally and it'd be interesting to know what people inside the industry are seeing, externally I mean the highest rated plans, there's not very many right now they're at the four and half, five star range. But they actually don't have a lot of enrollment and part of the problem right now and we look at it just sort of as researchers is that so many plans are clustered kind of at those same numbers of stars at least in the Part D ratings. They may be a little more spared in the Medicare Advantage ratings but it is something I think is an important question. Is there any sense A, that people are paying attention and B, that they are moving in any kind of numbers towards a more highly rated plan? Do they see that as a serious matter? I think you know, early on the ratings tended to pick up so many odd things I'm not sure I would've advised somebody to pay attention. Now the ratings at least are a lot stronger and more robust and you know, maybe a more appropriate measure of quality.

TRICIA NEUMAN: We have a question in the back from Phil?

PHIL GALEWITZ: Hi, Phil Galewitz with Kaiser Health News, two questions. Can you talk a little more about the 10-percent of seniors who are not in any drug plan, that's five million people. Are you bothered by that, do you think that

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percent has come down in the last couple years? Also can you talk about the question of, and I wonder if Marilyn can address, are health plans making too much money off the Medicare Part D program?

JACK HOADLEY: Let's speak really quickly to the 10-percent. I mean I think basically as far as we know it's been pretty flat, CMS - the last number that's been out on that is 2010 so don't have the most current numbers we'd like. And it's a real mystery you know, we know some of those people are people who are just making rational choices, I only used one drug, I didn't use any drugs, I'm willing to incur the penalty if I want the benefit later on. So for some it's probably a perfectly rational decision but our worry is that for a lot of others it's people who are just you know, somehow kind of off the grid in a sense or just not aware that this opportunity is out there, found it too complicated, didn't sign up, you know have the cognitive impairments, don't have a good helper. But we really just don't know it's something else, it's really tough because they're probably the people that are going to be the hard to find in a survey or any other kind of way to get at who these people are why are they making the decisions, or failing to make the decisions that they ought to be making?

MARILY MOON: The modest amount of research that I've seen on enrollment or lack of enrollment in part D has

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indicated to me anyway, that it's a knowledge that's really driving a lot of it as well as a fear of incurring an additional cost for population. Again we're talking about a large number of people between 150 and 250-percent of poverty which is where you should look. The notion that someone at 150-percent of poverty of about a \$16,500 a year has plenty of resources to pay all of their healthcare costs is kind of a joke in the United States but that's where we are. And Part D is actually more generous than some of our other support systems for low income seniors.

Are plans making too much money? I think that's a really loaded question. I think the answer would be - if I were going to do that kind of an analysis and taking it from sort of an analytical standpoint, is to say what do I think is the contribution that they're making over and above what a single system program would make and what the challenges would be? And you would have to then look at it both from satisfaction of patients, you'd look at it from whether or not the cost savings to the Medicare program would justify it et cetera. I think that in the United States we believe - and I'm not totally on board with this but we believe that health care is just like any other business and you're entitled to make as much money as the market will bear.

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If I were Queen I probably wouldn't have it operate quite that way but I don't - I haven't seen anything that indicates that these profits are outrageous. Although I do understand that a lot of these plans see their Medicare operations now as a very positive aspect of their business and they are making good profits now.

KAREN IGNAGNI: Alright I'm going to take the bait.

TRICIA NEUMAN: I'm so glad.

KAREN IGNAGNI: Much to the dismay probably of any of my colleagues sitting in the audience. Phil, do you ask this question to other stake holder groups that have 25 to 30-percent profits or those that have 15-percent profits? Because we've had a debate for the last several years, I'm not picking on you now but we've had a debate for the last several years about health insurance reform and about health plan profits. The health profits, the average profits in a good year are between three and four percent, we have many companies down at two as you very well know. And we've never really had a discussion about profits in the rest of the healthcare stake sector. And in the United States to be able to be in a business whether people like the word or not, you have to be in the black rather than the red. And I think the proof is in the pudding here in terms of Part D, our members have come in well under expectations, have very high satisfaction from the people

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who count. Those people who use and buy our products and we've worked very hard to balance this access and quality and price but I hope we can actually get beyond this issue of what's going on simply in the health insurance sector.

If we want to have a discussion about profits and administrative costs we should widen the lens so that we are talking through the healthcare sector because there's lots more to cover from many, many people and many entities that are up at the 20 to 25 to 30-percent level. So I hope we widen that lens, I hope you're the leader in that.

TRICIA NEUMAN: And that's a whole other topic for a conversation.

KAREN IGNAGNI: Indeed it is.

TRICIA NEUMAN: I think we have a question in the back and then we may time for one more and then I think we may be wrapping up.

BOB HELMS: Okay I'm Bob Helms from AEI, that's the American Enterprise Institute. I want to ask the panel to comment on what may be - I know this is a program about Medicare Part D but I want to ask about if we have - what you think about what may be another natural experiment going on in state Medicaid drug programs. It seems to me that there's a lot of interest in moving to managed care for these plans where the managed care plans are able to use all the tools that Karen

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talked about to push generic substitute and so on and consumer choice. Yet the fee for service side off the Medicaid program just takes a percent off of a published price, something that's highly influenced by politics and the state legislature. So I've never seen the sort of the effects of the managed care programs, maybe I missed one but one small study I have seen, but if you use the smoking gun theory just the noise that's coming from the pharmacy groups of the states you would think that something is going on here. So I wanted to ask you what do you think of this natural experiment?

KAREN IGNAGNI: Actually if Bob, the question is to me, we actually had Lewin look at this a while ago and we're hanging the data now and studies rerun and updated but if you look at the states the ability - what they're doing in terms of rebates and then you look at the plan's ability to do rebates plus use the tools, on the latter side you have more penetration and more effectiveness in terms of leveraging the full arsenal of things that can be done. So we feel we're very excited about both the old research and what we're seeing in terms of new research because you're coming at the problems from a variety of perspectives. And I think that's what the design of D has really encouraged people to be very active in creating tools and techniques.

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But I want to say, because Juliette's point is really correct, we've tried to do it in a way that gives people choices, gives them transparency, doesn't you know force them into one route or another but puts the choice in their hands. And again, that's very different than the kinds of strategies that were being used in the '90's they've been tremendously updated and modernized. And you're seeing - that's why at the end of my remarks I wanted to highlight some of the newer trends we're seeing and that's going to continue that modernization which I think is very exciting in terms of the potential particularly in the area of specialty drugs.

JACK HOADLEY: I'll make a quick comment that takes it actually back to the Medicare side. I mean one of the things we don't understand very well is how low income people respond to some of the co-pay and financial incentives and we know from MedPack's research it's the low income subsidized population that don't use generics at as high a rate as the higher income population. And we just don't know, when you've only got a small range of co-pay to work with and yet small incomes where those small dollars matter a lot, sort of how well those tools work. So whether we're talking about the Medicaid or the low income part of the Medicare benefit I think this is an area where research is really needed to try and understand what tools work for this population, and knowing that it's not going

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to be the same tools most like, that work for the higher income population.

KAREN IGNAGNI: But can I just come behind you? It's really interesting, low income as you know are very high utilizers on specialty drugs in Part D, they're protected, LIS folks are protected in terms of the cost sharing there. But one of the things I can share from the perspective of our members and hearing quite a lot anecdotally where low income individuals, particularly prior to Part D, a number of them, a very high proportion were coming in with those shopping bags full of drugs and they had never been managed, coordinated or anything of that sort. So these - although you're right the tools are not the same but how you think about the problem is very different depending upon the population, the needs. But those kinds management, care coordination, drug coordination, formulary management, that can be very helpful for the low income population.

JIM CAPRETTA: I just want - I just agree with you I think there's - I've had opportunity to hear about this recently, I hadn't focused on it much recently but I think this is an untapped opportunity at the state level to do things differently. I think the rebate program that was instituted, states just sort of got used to it and became kind of this sort of guaranteed way of doing business and subject to all the

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pressures that you indicated and they've been slow to move away from it. But I think there's probably dawning on more and more people that there's a better way.

TRICIA NEUMAN: Okay I understand we have two quick questions, I have - I thought I promised that we'd be out of here on time but let's have just two questions and maybe some brief answers.

LEE RUCKER: Hello Lee Rucker, AARP Public Policy Institute, thank you so much for the wonderful discussion. Jack, a minute ago you mentioned the word mystery and that certainly pertains to a component of Part D that I've been looking at which is the medication therapy management programs. I'll have a paper coming out on the through the AARP Public Policy Institute in about a week or two, it's just being formatted. But the comment is that I was glad there was some questions about the quality of the benefit or the quality of the plans pertaining to the star ratings. But we're trying to get a better handle on the quality of the pharmaceutical care that people are receiving and how they're actually managing on those medicines. The medication therapy management benefit thus far, I believe has been underpowered and undersubscribed if you will, by the people who are the targeted beneficiaries who are entitled to special hands on services that must be provided at no charge through the plans. CMS set some of the

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criteria for the MTM, primarily the dollar threshold plans have leeway in other components and thus far at year seven we don't really have a good understanding yet of how people are responding other than much below expectation, but how this component is really helping. I believe it needs to be much more incentivized and please give me your card, if you're interested I can make sure you get my paper but I think it also goes to the benefit of the pharmaceutical - the value of the drugs if you will to ensure that the utilization is appropriate and we are preventing downstream cost to the rest of the Medicare system so that this MTM component really needs to be powered up.

TRICIA NEUMAN: Thank you. And I think we have a last question coming somewhere.

SUSAN JAFFE: Hi I'm Susan Jaffe, I'd like to know -

TRICIA NEUMAN: Can you -

SUSAN JAFFE: I'm Susan Jaffe I'm a reporter with various places, I have just two quick questions. Do you know how much of the Part D is due to increase plan use of restrictions such as prior authorization, using co-insurance, requiring preferred pharmacies, new higher pricing tiers, and as Marilyn mentioned, seniors who can't afford to fill prescriptions in the donut hole? And number two, have you

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compared the savings to other government health programs where the government negotiates drug prices?

TRICIA NEUMAN: Should we start with number one?

Anybody know the answer to number one?

MARILYN MOON: No.

JACK HOADLEY: I mean it really is very hard to parse out any of those factors.

JIM CAPRETTA: Well the donut hole, you know that the donut hole is not a factor because that's in the baseline. The donut hole was there when it was enacted so the fact that the donut hole exists is not related to the fact that the cost estimates have come down, so it's always been there.

MARILYN MOON: Although it could be to the extent to which people stop taking drugs during the donut hole and then don't start them again.

JIM CAPRETTA: Well that doesn't affect the government's costs.

MARILYN MOON: Sure it does if they don't -

JACK HOADLEY: It does if they don't resume the use which we have evidence that it happens.

KAREN IGNAGNI: Now a number of M.A. plans have always had coverage in the donut hole.

JACK HOADLEY: Exactly.

TRICIA NEUMAN: And number two?

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JACK HOADLEY: I mean I think number two you know, was a little bit of - you know I tried to cover a little bit of that in paper. But again it's very hard to do a clean apples to apples comparisons of these things. You know you've heard at the beginning of the discussion on our prepared comments you know, some of the different ways that we look at the same numbers and get to different places with them and that's the challenge with this kind of stuff. There's a lot of things out there that depending on both some mythological assumptions and you know sort of how you go about doing the analysis that can get you to different places. And again, that's just within looking at the one program and when you try to compare across programs it gets very difficult to make clean comparisons.

TRICIA NEUMAN: Alright well I hope you will thank me in joining the panelists, we're sorry we've kept you so long but there is obviously a lot of interest in this issue that we haven't examined in too long. And we thank you all for coming, thank you so much.

[END RECORDING]

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