



**Medicare Open Enrollment Preview
Kaiser Family Foundation
Alliance for Health Reform
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Ed Howard: My name is Ed Howard, I'm with the Alliance for Health Reform and on behalf of Senator Cardin and Senator Blunt, and our board, we want to welcome you to today's program on the open enrollment season for Medicare. Open enrollment for 2016 will begin on October 15, in case you hadn't noticed- that's tomorrow- and it runs until December 7. During that period you can switch – and I put this in the second person but I could put it in the first person, one can switch from original Medicare to one of the privately run Medicare Advantage plans or vice versa. You can switch from one Medicare drug part D plan to another or drop your part D coverage all together or find a Medicare Advantage plan that has it included. There are important and sometimes confusing choices that are facing more than 50 million Medicare beneficiaries and it affects their healthcare spending, it affects the costs to the program overall. It affects access to the services that are needed. And the point of today's program is to educate ourselves on the basics of this open enrollment process and learn about the trends in this growing segment of the Medicare enrollment.

We're joined in bringing this program by the Kaiser Family Foundation, one of America's most trusted voices on health policy issues, source for more good information about Medicare than almost anywhere else. A lot of it you'll find in your packets and in a couple of items that were so fresh they didn't even make it into the packets. We've got one of America's most distinguished Medicare experts, the foundation's Senior Vice President Tricia Neuman here to help referee discussion this afternoon. Tricia glad to have you back in the co-moderator chair. And why don't you start us off with a little scene setting.

Tricia Neuman: All right, well thank you Ed, thanks everybody for being here for the open enrollment period discussion. We are particularly happy to be here talking because so few people are really focused on the Medicare open enrollment period. There's been a lot of discussion about the ACA open enrollment period and that's obviously very important, but for the 55 million people who are on Medicare, this open enrollment period deserves our attention. And I'm saying this based on a very personal experience because I've been helping my favorite Medicare beneficiary, my mom, approach this open enrollment period. There are big differences across plans and people could leave real money on the table if they don't look and they don't think about their options and that's why we're here today, to talk about what the issues are. Why should people think about the plans that are out there, what choices are available and what they might do?

So, as background, and to save my fellow panelists some time: what are the options? Medicare Advantage are private plans that receive money from the Federal Government, from Medicare, to provide services under Medicare Parts A and B. Often these plans, mainly HMO's and PPO's, are also providing Medicare Part D coverage as well. Yet they vary in lots of different ways, including premiums, cost sharing, providers, drug benefits, and each can have important implications for consumers.

Another set of options for people during the Medicare open enrollment period are Medicare drug plans. These are stand-alone drug plans, prescription drug plans, that are generally for people in traditional Medicare. People sign up for a plan to supplement what they have under traditional Medicare. Part D is offered exclusively by private plans, which means it's not integrated in traditional Medicare. Seniors actually have to take action to enroll in another plan to get their Medicare coverage drug benefit. The Part D plans also differ in a number of different ways premiums, cost sharing, deductibles, what drugs are covered and on various tiers, and pharmacy networks.

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We're going to hear from Gretchen Jacobson on Medicare Advantage and we're going to hear from Jack Hoadley on Part D and we're all going to be a lot smarter in a few minutes. Each year during this open enrollment period, beneficiaries are encouraged to review their options but very few do. We know that switching rates are very low and we also have a good sense of why that's true. I think people have a sense that it doesn't make much of a difference, and it is too much trouble to compare plans. Our agenda is to talk about why it might make a difference.

So just to make it a little more personal, here are the basic set of choices. There are 39 million people in traditional Medicare, and 24 million of them are in PDP's or the stand-alone plans, they have some decisions, as Ed said. They can decide to choose among the various PDP's and there are 26 on average available. They can also decide to switch from traditional Medicare to Medicare Advantage plans. These are the decisions they can make during this open enrollment period. Or, they can make no change and that's typically what we see.

On the other side, there are some 17 million people in Medicare Advantage plans. Their first decision is, do they want to stick with their plan or switch to another one? There are 19 options available, on average. They can also decide to switch from Medicare Advantage to traditional Medicare, and if they do, they might want to choose a PDP although they might not be able to get a Medigap plan - a story for another day perhaps. Or they can make no change. Those are the basic options.

If you ask consumers what matters, they're going to say – they're actually going to say everything matters but in terms of what they can see initially, costs are obviously important -so premiums. This is an issue for traditional Medicare, Medicare Advantage and Part D. Premiums are very visible, very easy to compare but not the whole story. Deductibles and cost sharing also affect costs, and an issue for traditional Medicare, Medicare Advantage and Part D. Out of network charges, in network charges. Well traditional Medicare doesn't really have that situation but Medicare Advantage does and so does Part D. Access to providers, that's a big deal. Can consumers access to their physicians or hospitals or other providers? That's an issue for traditional Medicare and Medicare Advantage. Pharmacy access is an issue for Medicare Advantage plans that cover Part D and Part D plans. Which medications are in their formulary – affects both types of Part D plans? Quality matters, people say quality matters a lot and that's of course an issue in any type of plan.

But really what we hear is that people do value choice, but they also value simplicity, as you might hear as you talk to your friends and family and if you are helping people who you know. Simplicity is something that they think is a little bit far afield right now. With so many options, and differences across plans, it's a little bit more difficult to make decisions than some people might hope. So hopefully today we will make things more simple and help bring some light to the topic.

Ed Howard: Great thank you Tricia. Let me just do a little of our traditional housekeeping. I'll be as brief as I can. There are lots of important pieces of information in your packets. As I said a lot of them from Kaiser Family foundation and therefore top notch. There will be a video recording of this briefing available probably tomorrow, if not by Friday on the Kaiser website, KFF.org and thanks very much that the foundation arranging that. There will be a transcript on our website Allhealth.org in a few days. At the appropriate time you can ask our panel a question by filling out one of the green cards in your packets by coming to one of the microphones that you see or by tweeting if you

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will and the hashtag is Medicare OE, as in open enrollment. And if you need Wi-Fi the instructions on how to connect are on your table I believe and if you not they are user name house public, password house public.

So we do indeed, as Tricia said, have a lot of experts besides her on this panel. Let me just give the briefest of mentions to our panel and then let them go at it. We'll start with Sean Cavanaugh who is Deputy Administrator of CMS and Director of its Center for Medicare. He's going to give us the latest information about some trends in plan availability, in benefit design, in premiums and other costs. Then Gretchen Jacobson, Associate Director of the KFF program on Medicare policy is going to talk to us about the trends in the Medicare Advantage MA program. Factors like the stability of the number and quality of the plans available, changes in premiums and out of pocket limits, tendency of enrollees as Tricia mentioned to stick with their current MA plans. Then Jack Hoadley who is a Health Policy Analyst and researcher at Georgetown is going to discuss what to expect in Medicare Part D prescription drug open enrollment, particularly the number of plans available, the cost trends, the coverage gaps, low income subsidies that are available and then finally Mark Hamelburg is a Senior VP of federal programs at America's Health Insurance Plans, AHIP is going to address some of the successes and challenges that are facing MA plans including a high cost of drugs, the upcoming Medicare Part B premium changes and the star quality rating system. So we've got some really terrific stuff coming at you and we're going to start with Sean. Why don't I turn it over to you?

Sean Cavanaugh: Thank you Ed and Tricia, thank you both for inviting me here today. I just have a few brief remarks before I turn it over to our panelists who have done some more intensive look at the programs. I'd just like to take everybody back a couple years. This summer we celebrates the 50th anniversary of Medicare and Medicaid, but we're also celebrating the fifth anniversary of the Affordable Care Act. And if you recall during the Affordable Care Act a number of changes were made to the Medicare Advantage Program, particularly around the funding of the program. And at the time there was some controversy about what the effects would be and whether that was the end of Medicare Advantage as we know it.

I'd just like to say it's worth looking at what's happened since those changes were made because they contributed substantially to reducing the overall costs of the Medicare program. One thing we heard was that enrollment would drop, the plans would pull out. Well as you'll hear from other panelists enrollment and Medicare Advantage has grown every year since the Affordable Care Act has passed. Next year we'll have over 17 million beneficiaries, almost one-third of all Medicare beneficiaries will be enrolled in Medicare Advantage. We were told that access would be depleted, that certain areas of the country would not have access to Medicare Advantage, but in fact 99% of all Medicare beneficiaries have access to at least one plan and I think it's – don't quote me on this but I think it's very close to 97% or 98% have access to more than one plan.

There's also questions about what would happen to premiums and there's going to be a little bit of disagreement here today what's happened with premiums but essentially premiums are around at or below the levels they were prior to the Affordable Care Act; so premiums have remained affordable.

Probably the most promising news since the Affordable Care Act was what's happened to the quality of care and the patient experience in Medicare Advantage. So in 2009 we had about 17% of

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all Medicare beneficiaries who are in MA plans were in four and five star plans are estimates are that in 2016 we'll have 70% of all beneficiaries in four and five star plans. So these are beneficiaries you're getting measurably better care and also reporting measurably better experiences with their care, which has always been one of the promises of the Affordable Care Act and one of the goals of CMS.

So how do you achieve all this? Well it could have been achieved at the detriment of benefits? Well when we look at the supplemental benefits it looks as if plans are offering around the same level of vision, dental and other supplemental benefits. So in many ways the programs have been doing great, both Part D and Part C and the Affordable Care Act was able to generate significant savings and reduce significant over payments while improving the plan and the choices for beneficiaries.

But that does not mean all is well, both the Medicare Advantage and the prescription drug program face significant challenges. Despite the changes made in the Affordable Care Act we still believe that Medicare somewhat overpays Medicare Advantage plans. I think the latest estimate from Medpack was that there's about 3% extra payment due to coding intensity. So to the degree we over pay Medicare Advantage plans, when beneficiaries move from fee for service into Medicare Advantage it means it's increasing the costs to the federal government, it's increasing costs to the trust funds and interestingly also increasing part B premiums for all Medicare beneficiaries. So that's a challenge and one we've been trying to address by taking different strategies to reduce the overpayments due to coding intensity.

On the Part D side as I said the story on the beneficiary premiums is very good in that beneficiaries have face fairly stable premiums. I wish the same was true as the program as a whole. In fact, Medicare is paying more for the program because largely driven by very high cost specialty drugs. The per capita costs in a Part D program grew by 8% last year at a time when the total program costs of Medicare per capita were probably around 1%. In 2015 the actuaries are predicting the per capita expenditures for Part D will grow 15%. Now the actuaries in the out years have all this moderating somewhat, but clearly high cost, specialty drugs are a real challenge to the continued viability of the stability of the part D program.

So stepping back from those statistics I think a number of us are going to repeat similar things and I just want to repeat some of the things that Tricia said. One of the ways we make these programs work better is for beneficiaries to be engaged and to really understand their choices. There are many dimensions. The one that we like beneficiaries to focus on that often doesn't get the focus is the star ratings, the quality measures so they can choose plans according to that. There are many aspects as Tricia pointed out to the cost side, the premium is the easiest to quantify but there are significant out of pocket costs in both programs and beneficiaries should focus on that. The networks are important and understanding if your doctor is in. Networks have become important on the part D side as well as part D plans start creating preferred pharmacy networks; so beneficiaries out of pocket costs will vary significantly. What we see and what you'll hear is that shopping pays benefits, it pays benefits for the beneficiary and that they can significantly save money if they shop. But shopping by beneficiaries also helps the programs to the degree beneficiaries show they're willing to shop, willing to move based on costs, quality and access the more the plans in both programs will have to compete on all those measures. To the degree beneficiaries choose a plan and stay with it regardless of these changes, the less effective the competition is.

So as I said a lot of great news in both programs, a lot of things to celebrate and I think beneficiaries are celebrating it by increasingly choosing these programs but significant challenges ahead.

Gretchen Jacobson: It's terrific to be able to be here today, thank you. I will provide an overview of what people need to know about Medicare Advantage as we enter the Medicare open enrollment period. So enrollment in Medicare Advantage is at an all-time high. It has tripled over the past decade increasing from 5.6 million people in 2005 to 16.8 million in 2015. Today almost one-third, 31% of people on Medicare are enrolled in Medicare Advantage plans. This increase in enrollment as Sean said has been watched closely by many since 2010 because as a result of the Affordable Care Act payments were gradually reduced to plans over time. And as Sean mentioned, during the debate of the Affordable Care Act some speculated that plans might exit the market as a result of these reductions in payments and lead to reductions in enrollment over time. Instead to the surprise of many, enrollment has increased each year since the enactment of the ACA.

While almost one-third of people on Medicare are enrolled in Medicare Advantage plans as you can see here enrollment varies widely across the country. In some places such as Baltimore enrollment is far below the national average. However, in other places such as Portland, Oregon or Miami, Florida more than half of people on Medicare are enrolled in Medicare Advantage plans. The variation in enrollment reflects the diversity of the markets as well as the coverage decisions of people on Medicare. In 2016 the average person on Medicare will be able to choose from among 19 plans. This ranges from 21 plans on average in Metropolitan counties to 11 plans in more rural counties and is a slight increase from an average of 18 plans in 2015.

The number of plans available dropped between 2009 and 2011 because many private fee for service plans exited the market as a result of new regulations that required these plans to form provider networks. However, since that time period the number of plan choices available to beneficiaries has been relatively steady and this trend will continue in 2016.

A total of 2001 plans will be offered to people on Medicare in 2016. This includes 259 new plans that will be available for the first time. Some of these new plans are offered by long standing Medicare Advantage firms that are expanding their existing service areas. Other new plans will be offered by firms entering Medicare Advantage for the first time and includes some established healthcare systems such as Johns Hopkins that are expanding into insurance as well as some established insurance firms that have extensive experience with families and kids but less experience with seniors. Additionally 203 plans that were available in 2015 will be exiting the market in 2016, which you can see here in the gray bars. Many of these discontinued plans attracted relatively few enrollees and as a result only 3% of people in Medicare Advantage plans in 2015 will not be able to stay in the same plan in 2016.

As you can see in the light blue bars most of the plans available in 2015 will continue to be available in 2016. Overall Medicare Advantage markets and beneficiary choice appear to be relatively stable between 2015 and 2016.

Premiums for Medicare Advantage plans have also been relatively stable since 2010. As you can see in the chart on the left the average premium for Medicare Advantage plans that include prescription drug coverage was \$44.00 per month in 2010, \$39.00 per month in 2011 and \$38.00 per month in 2015. Average premiums differ across the country and as you can see in the chart on

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the right while the average premium was \$38.00 per month in 2015 this ranges from an average of \$6.00 per month among enrollees in Florida to over \$100.00 per month among enrollees in Massachusetts and Minnesota. This variation in premiums again, reflects the diversity of the markets and also the variation in enrollment by plan type. Premiums also vary within a state because plans and the federal payments to plans vary by county. For example, in Los Angeles enrollees pay an average of \$2.00 per month whereas in San Francisco enrollees pay an average of \$65.00 per month. And similarly in New York City for example enrollees pay an average of \$18.00 per month whereas in Albany enrollees pay more than three times that amount.

Unlike premiums and plan availability, we have seen an increase in out of pocket limits from Medicare Advantage plans over the past few years. All Medicare Advantage plans are required to limit enrollees' out of pocket expenses for Part A and Part B in network services. Traditional Medicare on the other hand does not have an out of pocket limit. And for some people this out of pocket limit is a very attractive feature of Medicare Advantage plans. In 2015 the average out of pocket limit was over \$5,000.00 which is a \$700.00 increase from 2013. Importantly the out of pocket limit does not include many costs that Medicare enrollees may incur and these include cost sharing for Part D drugs, out of network care, extra benefits offered by the plan and costs for care that's not covered by the plan. So while the out of pocket limit provides some financial protection for Medicare Advantage enrollees it's important to remember that there are many costs that enrollees incur that are not included.

So during this time of open enrollment people have the opportunity to compare and switch plans. With Medicare Advantage plans there are many features that differ across plans which people should consider when choosing a plan. However this is often much easier said than done. Premiums like Sean said, are the easiest feature to compare and they're readily available to people who are shopping around. Similarly deductibles are relatively easy to compare. But as you can see at the other end of the spectrum in orange provider networks are often difficult, if not impossible to compare across plans. To do so one would need to download all of the provider directories for each plan available in their area, then thumb through them to manually compare each plan. And if you remember from earlier the average person on Medicare has access to 18 plans on average in 2015. So you can see how this would be quite a large task to undertake.

The complexity in comparing plans is likely one reason why few people ever change plans once they make an initial choice. We conducted focus groups with seniors to find out how they selected their plan initially and why they've never changed plans. Overall seniors told us that they found the process of choosing plans to be overwhelming, confusing and frustrating. And you can see some of that frustration reflected in the quotes here. Many seniors said that if their plan is working for them they are hesitant to try something new and would rather find workarounds for their current plan. However despite the frustration in comparing plans as will probably be reiterated by many people here it's important for beneficiaries to really take advantage of the open enrollment period and see how their plan is changing and whether it's still the best fit for their healthcare needs. Thank you.

Jack Hoadley: Thank you and thanks to the Alliance for inviting me to be part of this and thank you to the Kaiser Family Foundation for supporting my work on this and to my co-authors on this analysis Tricia, who you've already met and Juliette Cubanski of the foundation who is also here today; so it's really a team effort.

So the story on Medicare Part D is that beneficiaries have fewer drug plans to choose from in 2016 than in 2015 but still have a lot of choices. The average beneficiary has 26 stand-alone drug plans to pick from in 2016. That's down a little bit but as I say still a lot of choices and the average beneficiary also has 16 Medicare Advantage drug plans to look at as well if they're willing to go and shift to the Medicare Advantage size for all their benefits. The drop from 2015 to 2016 is mostly low enrollment plans; so there's not a lot of people affected by this change. Over the time there's been a pretty steady drop in the number of plans available and that's been a combination of mergers and acquisitions that have occurred in this business. Some dropping of low enrollment plans, as I said again for this most recent year and also the requirement of CMS imposed a few years back to make sure that the multiple offerings from a given company are meaningfully different from each other so that when you have two plans to pick from the same company they're actually something different to look at and there's a real reason to pick and so the market has been a bit consolidated on that basis.

The premium story is as Sean mentioned has been a story of pretty flat premiums over a period of years but we are projecting that the average Part D stand-alone drug plan if nobody makes switches this year will go up by 13%, 2015 to 2016. So we are potentially for the first time in a number of years looking at some higher premiums even if a bunch of people switch and we already discussed the fact that there's not a lot of switching in this market, it's still likely to be the biggest jump in premiums in quite a few years. Some of this is certainly the fact that there are no more, or very few now brand drugs, they're switching to generics has been one of the drivers of flat premiums over the last several years, certainly the rise of some of the new expensive drugs is a factor in this. But there's also factors that I won't go into here but we could come up in questions about higher cost to Medicare that's going along simultaneous with these premium trends.

But again as Gretchen mentioned on the Medicare Advantage side there's a lot of variation in part D premiums by region around the country and you can see here that the lowest premium in New Mexico is \$30.00 a month – this is again, an average across all the plans offered in New Mexico on a high end New Jersey at \$50.00 a month and Florida \$45.00 a month. We can't explain this very well. We tried to look at some of the reasons why there's so much variation; certainly some of it is probably due with usage, although the premiums – the payments of the plans are risk adjusted so that should be taken care of, some of the health differences. And of course the prices of drugs really don't vary across the country so this is not really being driven by the underlying cost of drugs that has to be driven more by usage patterns and that sort of thing.

So as you're seeing this increase this year and sort of how does it come down to the person there's a lot of people who are looking at \$60.00 premiums that a lot more than last year, but there is still is you can tell in this graphic on the right hand side for 2016 a lot of variation. There are still people who's premiums are projected to be under \$20.00 and there are others projected to be over \$60.00 so there's a lot of choice out there in this market that people can look at.

Looking specifically at the increases, and I did find a typo on this, that dark orange bar should say increase of more than \$10.00. We are seeing that 39% of beneficiaries if they don't make a switch are looking at \$10.00 a month increase in their premium and again, this to me is sort of that signal to the beneficiaries even though they shouldn't be focusing all on premiums it's kind of a signal that they should start to think about whether moving to a new plan might be a good thing to do this year. Again those increases vary a lot by region and you can see on the one hand the state of Arkansas

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where the average premium actually dropped by 1% from last year to the other extreme Florida and Arizona where premiums are up by more than 20% projected from what we're looking at.

But again it's really important not to just look at premiums and here I want to call your attention to some of the other features that are changing. Deductibles, plans have the option of including a drug deductible. The law specifies a maximum deductible and that amount is adjusted based on the underlying cost of drugs so there's an indexed increase and actually the biggest increase we've seen since the program started and what the maximum allowable deductible is from \$320.00 to \$360.00. It's also true that two-thirds of all the plans have deductibles and that's more plans than have ever had deductibles before and the vast majority of those plans use that maximum deductible. So there are going to be beneficiaries out there who didn't see a deductible before who are seeing a deductible for the first time if they stay in their current plan and most of them will at least see some increase in their deductible, although some will continue to be in plans without a deductible.

Cost sharing has also been evolving over the recent years unlike the private sector we really see more tiers, more cost sharing tiers in part D plans than you typically do in private sector plans. So today most plans use a five tier structure where they have a preferred and non-preferred generic tier. They have a preferred and non-preferred brand tier and then they have a specialty tier that for drugs under Medicare's rules have to cost at least \$600.00 a month. And so people can find that their formularies and their plans have changed, that the tiers on which drugs are placed have changed and they may also find some changes in the amount of cost sharing attached to those tiers because one of the trends we're also seeing is the trend towards more use of co-insurance instead of flat co-pays; so people are now paying a share of the cost to their drug, which if it's an inexpensive drug will end up cheaper. But for some of the more expensive drugs having to pay 25% or 40% of your particular drug is going to be more expensive than a flat co-pay. And a lot of beneficiaries like the flat co-pays because they're more predictable from month to month.

I would also remind you that the structure of part D has the infamous donut hole and then a catastrophic phase; so as people's drug use during the year moves on and their costs accumulate their cost sharing will actually vary as it goes through those different phases. We know that the donut hole is being phased out thanks to changes made in the Affordable Care Act but it won't be fully phased out until 2020.

The other trend we've seen recently is a trend, and I think this was already alluded to a couple times, towards tiered pharmacy networks. So where it used to be if your pharmacy was in the networks and most pharmacies are in the networks in most plans that was it, your cost sharing was going to be the same regardless of the pharmacy you went to. But starting around 2011 a lot of plans started instituting tiered pharmacy networks where there's one set of pharmacies where you pay lower cost sharing and a second set of pharmacies where your cost sharing is higher. Obviously incentive to go with those cost sharing's that have the lower preferred – those pharmacies that have the lower preferred cost sharing. But one of the question is do beneficiaries understand that distinction, do they have one of the pharmacies near them that offers that lower cost sharing, are they willing to switch pharmacies in order to get that. So again, it's one of the elements that is important as people shop for plan options. And the difference is in that cost sharing can vary a lot from plan to plan but one example is a brand drug that might have had a \$20.00 copay on the designated pharmacy might have a \$33.00 copay in any other network pharmacy or a generic that

might have been \$1.00 with one of the designated pharmacies may turn out to be \$10.00 in one of the other pharmacies.

So I wanted to briefly mention the low income subsidy beneficiaries that qualify through Medicaid or through low incomes and assets can get this kind of a subsidy and if they pick certain plans they're able to get a zero premium. And what this map shows is that the states vary in how many of those plans are available with zero premium from a low of two in Hawaii and three in Florida to 10 in a variety of other states, you can see on this map. And one of the things that we've looked at is how many of those low income subsidized beneficiaries are already in one of those zero premium benchmark plans and don't need to make any kind of change to maintain that zero premium and how many of them are in a plan that's scheduled not to have a zero premium and you can see the numbers here. Some of the people in this orange slice, the nearly two million LIS beneficiaries in this orange slice will be reassigned automatically by CMS to a zero premium plan. That's probably about one-fourth of the people in this group but as our numbers suggest there's another three-fourths of that group who have chosen their own plan in the past and so have to make a decision if they want to maintain paying a zero premium.

And finally and this really mostly repeats things we've already been hearing but people really can save money if they shop around. History says that they tend not to. Our analysis suggests that almost nine out of 10 stay with the same plan from year to year and even the ones facing large premiums, many of them stay put. Shoppers do need to look beyond the premiums at the drugs and what's covered on the plans formulary at the pharmacy networks, at the star ratings and there are resources to help people do this including the plan finder on Medicare.gov which really allows people to put in their drugs and find out exactly what their drugs will cost and which plan will end up being cheapest. And with that I'll stop.

Ed Howard: Go to Mark, we'll hear from him.

Mark Hamelburg: Thank you Ed and thanks to all for inviting me to be here. So what I thought I would do is start and echoing Sean's remarks. I think there's going to be a little bit of overlap here although a little bit different points of emphasis perhaps. But I would start by highlighting some of the specific aspects of MA plans that should be important to beneficiaries as they decide maybe not plan to plan so much but at least the larger question of whether to go into the MA program at all or go into the fee for service program or stay there. And it's critically important not just as an individual, from a total health policy perspective because CBO estimates that in another 10 years we'll have 30 million people in MA plans or around 40% of the population. So this is a big deal and it's important I think for people to understand what MA plans provide.

Now they have the flexibility to offer benefits that fee for service does not cover. And these benefits as a whole we believe help enrollees access care, better manage their illness and very importantly and sometimes not entirely focused on contribute to an overall better quality of life for people in these plans. I give some examples on these slides, things like extra skilled nursing coverage, vision, hearing and dental benefits, fitness benefits, there's a range of other services like in-home safety assessments, transport to physicians in non-emergency situations that fee for service covers. The list goes on and on.

They can also have different and often times lower cost sharing than original Medicare for services that are covered by the original Medicare program. And as Gretchen mentioned very importantly they can have or they are required to have annual out of pocket caps that fee for service does not have. And MA enrollees are mostly in plans where they're also getting their part D coverage and in many cases that coverage is at very little or no extra premium costs to these enrollees. And for anyone who has tried to navigate the healthcare system for themselves or a family member we know how complicated that can be and there's a lot of what MA plans offer that can really be helpful in these difficult situations whether it's care coordination disease and case management, nurse help lines, integrating prescription drugs, and medical benefits. These are some of the perhaps unsung things that you don't really think about until you're really need them and you see what kind of benefits they can offer. And also many plan have tools that address disparity and care for minorities, for low income beneficiaries and for other vulnerable populations. And they again, run the gamut. Health literacy programs, cultural competency initiatives with providers, outreach to community leaders, direct outreach to beneficiaries to encourage them to keep their medical appointments and again transport for non-emergency visits that some communications can really make the difference to make sure somebody gets their benefits. On part D of course, there's not a fee for service comparison. I think Jack obviously went through in great detail the sorts of trends and key choice issues. I think I included the slide. I'm not going to go through the list of things here. I just think it's important for us as we talk through this to remember that the part D program began 1/1/06, so 10 years ago. And for any of those like myself, I was CMS at the time who were involved in the implementation of this program to see that it is such a major success story at this point, 10 years later is really gratifying and I just wanted to remember as we focus on the details it's nice that we're – it's become such an accepted part of the Medicare program that we can have such a granular discussion but I don't want to miss the bigger picture there.

On quality echoing a point that Sean made it is – it's great to see that overall the enrollment of MA beneficiaries and plans that are earning at least four stars continues to increase. The additional point I just wanted to mention is that research, especially recent research does indicate that MA plans and their contracted providers are surpassing the fee for service program on several specific quality metrics and even more broadly and more importantly it's critical to remember that unlike the fee for service program MA plans are accountable for quality of care. That they are extensively measured and they're compared to each other on a wide range of metrics whether it's through accreditation, star rating. So there's an accountability there and an ability to assess the quality of care that you may be receiving that isn't present in fee for service. Sean hit on some of these challenges. I'd say we may have a slightly different perspective on some of these challenges and maybe our lists don't exactly overlap but on the rising drug price concept, I think many including AHIP and our members believe we really – if not already there we're just about at that critical point where we've got existing prescription drugs that are going up in price. We have products in the pipeline with really sky high launch prices and if you take into account the market exclusivity that many of these new products may have you can have medications coming to market very, very expensive without a therapeutic alternative and it just puts the program as a whole in a position where we're all very concerned that these trends are simply not sustainable over the long term.

Now at AHIP we've been advocating for a number of things including at least as a first start greater transparency around how prices are developed and continued enforcement against unwarranted patented extensions by drug makers. And happy to talk more about this but this is a huge, huge issue and something that requires – and fortunately I think it's reached a tipping point where it's

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getting the sort of attention that it really requires. Star ratings for low income beneficiaries we, despite the overall increases in star ratings, which of course we're very happy to see we have consistently raised concerns that the star rating system does systematically hurt and bias plans that focus on low income beneficiaries. And that has implications and implications for the benefits that enrollees in these plans can obtain and it also is important because in terms of sending market signals about the quality of care that somebody might be looking at as they're shopping for coverage it may not really tell the full story for the types of effort and successes that those plans are having and helping these vulnerable populations get access to care.

And our research has shown that there's some bias and I think some research that CMS very recently released on this, in our perspective confirms that this is the case. At least for the specific adherence and other measures that they looked at and we think it's really important that something be done to address these concerns. Lastly on the question of ACA cuts and health insurance tax. As I said I think Sean and I might have a slightly different perspective on this. We believe that the data does show that there has been an effect from the cuts in the ACA. Now we know that the cuts are almost fully phased in. We have another year to go for part of the counties but it's also important to note that averages mask many of the variation that occurs in different location, different geographies, different counties. I think Gretchen may have touched on that. So it's really critical when you're assessing the impact of these sets of policy choices that given the way that the MA program is designed that you don't just look nationally, don't just look at averages, you need to look at particular areas where people live. And on the health insurance tax that isn't something that's phasing out. That's something that continues to grow and will be with us and AHIP did analysis a few years ago through the firm Oliver Wineman and they found that there was a – by 2023 we're expecting a very significant impact. I'm not seeing it right in my notes here but it's something like as high as \$42.00 per member per month impact from the health insurance tax low and MA plans. So we're very, very concerned about the long term implications of health insurance tax. I think it needs to be something that's addressed, put together both the insurance tax and the ACA cuts collectively. MA plans are doing many of the sorts of things that as a policy matter the secretary and others have been pushing and it's critically important that policies that are considered now and in the future be designed to try to encourage those activities and not discourage them. Thank you.

Ed Howard: That's great, thank you very much Mark. As we mentioned there are a number of different ways you can now join the conversation. There are the microphones here and I apologize to you folks way down in the corner. One of the ways to get a better view is to come to the microphone and ask your question. You can also put – write your question on a green card or you can tweet to Medicare OE, hashtag.

And can I start us off – I think well I guess it was no more than four panelists and a co-moderator who mentioned this business of trying to induce beneficiaries to look more closely at the choices that are available to them through the changing circumstances. Now two things occurred to me, first in the more general market as affected by the ACA you've got navigators and application assistants and agents. Are there parallel mechanisms for Medicare beneficiaries and what are they and how effective are they? And second one of the answers might be the answer to the first question but how do we get people out of the mindset that shows up on Gretchen's slide of those quotes from the focus groups where and understandably they say "We've done all this work enough" so how do we get them – how do we make it easier to come to a rational conclusion on these issues?

Tricia Neuman: I started us off so I'll put my finger in it again. Yes there are – there are health insurance counselors in every state that can help people if people know to go to them. But I would imagine and I don't have the numbers but I would imagine many people are unaware of state health insurance programs and fewer people use them. I think one of the issues is that people do find this overwhelming and they find it complicated and they get their Medicare and You book and they go "Wow that's a lot of information" and what they tell us is they keep it because they think it looks really important but they don't want to open it because it looks so boring. And so then they start to get stuff from all the plans but they're already in a plan and what they told us in the focus groups is they sort of think the plans are basically the same. They think they might end up worse off if they make a change. One – I know they do get an annual so I'm going to turn an answer into a question which is such a nice way of pushing it down the table. I know there's an annual notice of change. But my question is how patient – how customer specific is it because so for example my mom gets told there's an annual notice of change and she can go look for it if she goes online. But I don't think she gets "Hey your drug number one is going to be shifted to tier 3 and that means instead of paying this, this year, this next year" because that would shake her up. And if it were patient specific or customer specific I think that might motivate action more than "We're changing our tier structure" and you know you might go online and find out which pharmacies are in our network, which just seems vague and not motivational.

Sean Cavanaugh: So it's true all the information is tailored individually as it could be. I wanted to make a different point though. So I took over the current – my current position about a year and a half ago when we were going through this process and people were saying "Oh the number of MA plans by community is down from 35 to 30, what's wrong with the program"? And I was new to it. I was like 30 seems like a lot, I can't imagine choosing among 30 anything much less things that vary on all the parameters that we've just walked through. So I think one of the questions that I get from beneficiaries is you know "Can't you simplify this" or "Why are there so many plans, can't you simplify it"? And one of it was referenced which is if a company is going to offer multiple plans they have to be meaningfully different because I do think we had plans out there that didn't add a lot of value and just made the choices much more harder.

The answer I give and I – I mean we all fall back on anecdotes about our parents is I point out to my father the great lengths he goes to to save \$.30 per gallon on gas. I was like you can spare two hours to save several hundred dollars on your health insurance and when you frame it like that and then you show up and help you can get them to do it.

Jack Hoadley: I was just going to add I think it's a challenge really to all of us to figure out how to make the notices that go out, specifically the annual notice of change which is a particular document that plans have to send out to say what's changed that Tricia was referring to. But even more generally the kinds of notices that go out how to put them in a language and a form while obviously having to conform with all the legal necessities that CMS has to do, they'll make people notice that hey there's a reason to do that. I'll give a brief plug to a stakeholder group that the National Council on Aging has convened with stakeholders ranging from beneficiaries to drug manufacturers to plan. We've been focusing particularly on the part of D side to try to think about a number of issues including how to get the notices better. And of course one of the things we discovered was it's hard; so but I think it's something that a lot of people need to give attention to you know, what are the ways we can get people's attention to really get them to start thinking about these things.

Mark Hamelburg: And I'll just add that you know, over the course of the years it's not just the Medicare program but it plays out over and over and over again there's always attention between how much information is necessary versus how much information is too much information and if everything is important than nothing is important. And that sort of ability to focus on what is critically important to most people is something that I think the government has struggled with for many, many years and I think this is just a function of that.

Ed Howard: Can I just ask as a follow up, nobody in this course mentioned the plan finder and I wonder if that is – if somebody could explain what it is first of all and assess whether it's really something that can be of any help.

Tricia Neuman: All right, I'm going to give a plug to the plan finder even though there are issues with it but it is the only place where you can go to compare all the Medicare Part D plans based on the specific drugs that you take, the dose levels, your pharmacy preference so it is sort of an awesome resource and the only one like it that I know of that is available to people on Medicare who want to compare and choose their plans. Can it be improved? Sure, definitely but it's a pretty great resource. The problem is I don't know how many of our moms, grandmom's, aunts and uncles want to go on and spend the time to do it even though Sean is right, they're clipping coupons for other things but this isn't that much fun. It's hard to do.

Gretchen Jacobson: I would just also add that it's unfortunately not very useful for comparing Medicare Advantage plans because it's missing a lot of those really difficult features that are different across Medicare Advantage plans like provider networks and – it's just not feasible at this point to include that in the Medicare plan finder.

Sean Cavanaugh: Yeah I would do two things. One to say put a plug in for plan finder and as Tricia said or the panelist said it's much stronger on the Part D side than the Part C side, though it's still a really good place to start for any of this. The other thing I'd say is typically and it happened today when I come to meetings like this people come up to me with ideas on how to improve plan finder and typically – and it happened today I say "Great can you give me the money to do it"? We've got a long list of improvements, it's a really good tool that could be much, much better and we hope to get the funds to invest in it some day because I do think it could enhance what I said, which is I think beneficiaries shopping intelligently making better choices for themselves is actually not just good for them, it's better for the program as well.

Mark Hamelburg: I'll just make a plug also you've got 100 Medicare, you've got plan call centers, there are lots of places it may not provide the full panoply of every choice in one place but it could be an iterative process and also as somebody again, as Sean mentioned and Tricia as well who has done this for parents you can window a list and then use other ways whether it's through call center, plan finder or other places to find the choice that you think is best for you.

Ed Howard: Yes John – John you want to identify yourself and –

John Green: I'm John Green [Inaudible 00:58:10]

Ed Howard: Hang on just a second. Is there any way to make that microphone work?

John Green: Okay is this better?

Ed Howard: Much better.

John Green: Okay.

Ed Howard: You sound terrific.

John Green: Thank you. So again John Green, National Association of Health Underwriters represent health insurance agents and brokers. Not mentioned among the panelists is a resource we are trained and certified to sell these plans, our people are local, they're kitchen table people. They know what the networks are. I put in a plug for the drug finder too; my members use it extensively for Part D. There are some problems with C, but again they know what the networks are like and they always re-evaluate all their clients' plans each year because health status change, incomes change, medications change, the tiering issues – they're looking to put them – place them properly in a plan that you know is efficient but costs less. So I just want to put in a plug for us; we signed up 40% of all enrollees in the private exchanges; so we've been doing this for many decades. Our senior agents are actually older themselves and very experience; so I put in a plug for using an agent. It doesn't cost the consumer anything. The carriers pay us a commission to do it and that book of business has value so providing good service is important from year to year. Thanks.

Ed Howard: Okay. Pick up some of the many questions that have come in.

Tricia Neuman: There are several questions about switching. One is, if only about 10% switch plans on an annual basis who are they, what's their motivation? Can we get more information about who switches and why, to encourage more of it? Do we know how many people switch Medicare Advantage plans each year? And I think those are our – I think those are all I can batch together on the issue of switching. Anybody can take those.

Jack Hoadley: I can talk a little bit about the switching. You know the study that we've done on the part D side can identify how many switched were using Medicare administrative data to do that analysis, so we don't have information on their motivations. We know some of that from other sources. I mean we can see that when the premium increase from one year to the next is greater, more people switched than when they don't see a lot of change in premiums. So clearly some of it is motivated by those kinds of things, but it's a lot harder to know what really convinces people to start the process. I think once they start the process they're going to be driven to move by premiums and all these other kinds of things. I think it's what gets them past the – all the things you've heard which is "Oh this is complicated, too confusing, leave well enough alone. Everything is probably about the same and it's – I think the thing we're really struggling with is how to get people's attention.

Sean Cavanaugh: The only thing I would add to that is and I apologize I don't have the number of switchers but Jack's slide presented 13% increase in the part D premium and he I think accurately portrayed that if no one switched. The fact is not enough people switch but people do switch and so the reason Medicare – well there's a couple differences between the number CMS released this year and Jack's. One of which is we base it on historical experience of how many and who switches and so that premium increase in actuality we think will be much, much lower. So there is some

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switching but it shows you how powerful switching can be because it would bring that 13% number down into the 3 and 4%. And that's with an inadequate number of people switching so imagine the power of many, many more people voting.

Ed Howard: Sean is that – somehow the idea that if I'm remembering the statistic quoted by our panelists is accurate, 10% switch and that's going to make that big of a difference in that – in that increase?

Sean Cavanaugh: Yes because it's a very skewed 10%. It's not a representative sample. It's mostly as Jack said people who see a very significant premium increase. Not everybody sees a significant premium increase, too many of them stay put but the ones who do move tend to be at that high end of the spectrum.

Jack Hoadley: Certainly the potential – I mean some of those people in my slide that are projecting a \$60.00 or higher premium they've also got a \$20.00, under \$20.00 plan. If we have a lot of people switching from a \$60.00 to a \$20.00 even a relatively small number of people switching to \$20.00 that's sort of a leverage that you talk about and it's also, and I think Sean alluded to this earlier it's an important signal to that market because to the extent that people don't switch those plans that are at the high premium levels are going to tend to go ahead and raise their premium. If they think they're at risk for losing people when they raise their premium they're going to think harder about how to set their premium, what they need to do to manage their cost in order to offer a lower premium product; so it's a signal to the market as well.

Gretchen Jacobson: I would also add some information that we got from our focus groups. Many of the people that were in our focus groups that had switched plans were people who had friends, families, agents, brokers, people that actually helped them to switch plans and to look at all the various plans. So it seemed that sort of having that help really motivated people to switch. And then additionally we also heard from many people that they assumed that if their plan was increasing prices that was just part of a general trend and that all plans were increasing prices; so it really took a big change to get people to stop and look and see if there was something else.

Ed Howard: There's a study and I'm not sure who would respond to this first but there's a study in the October issue of health affairs that concludes the Medicare beneficiaries tend to leave private MA plans for traditional Medicare when their health declines. If that's true why do you think it happens and what are the implications for both the program and patients? Mark do you want to take a crack at that first?

Mark Hamelburg: Sure I'm happy to start. Yeah we did take a look at that study and I have a couple of thoughts both a little bit more technical and a little bit broader. Starting with the technical as I understand it the study was looking at a very specific point in time, one year. People from 2010 to 2011 and seeing where they started and where they ended up. And really most of the change that they were noting dealt with duals, dual eligible and specifically or primarily dual eligible going to nursing home care, okay? So it seems to me first and foremost what the article is sort of raising the question is there something intrinsically concerning about MA plans providing coverage to people when they are going to nursing homes or having these other conditions. And I think first and foremost you can easily see that there are lots of reasons why somebody is moved into a nursing home and particularly long term nursing home that they might dis-enroll from an MA plan, they

might move out of a service area. Sort of the last thing on people's minds especially because you have as a dual you have a lot of flexibility in your enrollment rights. It's sort of – there may be other things that are causing them at least given the particular points in time that they're looking at that might have shown why these statistics were what they were for that population.

Also as I said it's only one year of data, okay? So it seems to me you know before you have a trend that should be really concerning you need to look at more than one particular year. Also I think you know given some of the overall disenrollment rates as we said are very, very low so within a very specific sub population having you know sort of going in one direction being different than another it's still a very low disenrollment rate or from MA to fee for service. If this was really a significant issue I think you'd see much broader movement to people and you're not seeing it. And also even the study that they recognized there have been changes in the program since 2010 that aren't really reflected in the study and that might have an impact. And more broadly again, sort of the last broad point is that we have lots of studies that show that duals and others are getting good quality care and MA plans. And if there was something really problematic with this study or that this study was uncovering something really problematic you wouldn't be seeing those data. I guess I did take a look at it and so I hope that's helpful.

Ed Howard: Anyone else want to weigh in?

Sean Cavanaugh: Just briefly I would say we are continuing to look at it. Our fear though, not our conclusion is either the plans are doing something wrong you know, when someone gets sick they don't want to take care of them anymore or that we, the agency, are doing something wrong meaning we're not paying appropriately for sick beneficiaries. And so we've been re-examining our risk adjustment to make sure we're properly paying for high cost folks and we're trying to understand the study better to see if the plans are doing anything wrong but certainly haven't drawn any conclusions on either of those.

Jack Hoadley: The only thing I would add which isn't so much to the specifics of the study but to the extent as people you know accumulate illnesses and accumulate health conditions the health, the Medicare Advantage plans that have restrictive networks is more likely to bump into people's concerns; so if somebody is trying to as they accumulate more illnesses now needs a cardiologist and a rheumatologist and an allergist and several other kind of specialties, they could – not saying they do but they could run into more issues around network choices and that could lead some of them back to traditional Medicare and so that's maybe the one thing that's a little more systematic that this could be picking up.

Tricia Neuman: I'm just going to add one small point which is I think one of the populations we haven't talked about today are the people who are on Medicare, almost 10 million people on Medicare who are under 65 and have permanent disabilities. And I think that's a group whose experience is not well understood and Medicare Advantage plans and I think that is given their enrollment rates are a bit lower than people who are older but I think given their numbers and given the important role that Medicare Advantage plans are playing it's really important to understand how well these plans are serving this population because they're serving this population because their needs are not necessarily the same as those who are 65 and older.

Ed Howard: Mark you talked about – I don't mean to be picking on you but you put the stuff in your slide so why – how can I resist? You talked about the Part B premium increase for part of the population and I guess what maybe 15 million people, 30% of beneficiaries are facing the possibility of 50% or more increase in their Part B premium. And I wonder who these people are, why they're facing such a steep increase. I understand deductibles are going to go up about the same amount. State Medicaid programs are going to be effected. What are we to make of this and what should we be thinking about as options?

Mark Hamelburg: Well I'm happy to start. Sean might be the right person to really get the perspective on where the administration might be going with this –

Sean Cavanaugh: No it's all yours Mark.

Mark Hamelburg: If you're giving me your proxy as to what the solution is going to be. So I think it's worth raising just at least as a start because it could affect people's decision making now and possibly in the future and folks may have seen at least the Board of Trustees had previously estimated and we don't know for sure what they're going to decide to do. But the way that the law is written that there is a hold harmless provision essentially for beneficiaries that prevents part B premiums from going up and ties it to when Social Security payments aren't going up. But about 30% of the population is not protected by this hold harmless provision. And it includes newly eligible beneficiaries who haven't – or those who are otherwise haven't been paying premiums through Social Security withhold. You've got duals who are not protected and obviously duals themselves are typically not affected by it but state programs that would subsidize their coverage are affected by it. And this isn't just a premium issue; it's also a deductible issue as well. And but for the deductible it's not a hold harmless issue. I believe everybody is affected by the increase in deductible, the part B deductible.

Now for almost all people in MA plans they are paying the part B premium. Now for many of them they have what is known as zero premium plans, they're not paying anything extra but they still – they pay the part B premium and if you are deciding to go into original Medicare, you got to decide whether to get a Medigap policy, some of these changes especially the increase in deductible can effect that. So I'm not giving any particular solutions because Sean is the one to ask about that but I think people are very, very concerned that for this large group, 30% estimated of the population they could see a very significant monthly increase in the deductible, in the part B premium at an increase in the deductible and that obviously can have an impact as we're sitting here a day before open enrollment and impact on how people decide what program they want to go into.

Sean Cavanaugh: So I would just add Mark did a very good job explaining it. The one step before is actuaries found that Medicare Part B expenses are growing faster than they previously predicted. They're still growing very slowly by historical standards but they are growing more quickly than they had previously built into their estimates; therefore there's been the part B trust fund has what's called a margin, a surplus in it and there's been some erosion of that margin. So they need to – they identified the need to raise the premium in part to cover those higher costs, in part to rebuild the margin. When they did that it happened to be a year as Mark said where 70% of beneficiaries are protected from any part B premium increase. So if you need to raise a certain amount of money from 55 million beneficiaries but 70% of them are exempt from paying it, the amount you need to recap to collect from the others essentially almost quadruples. So whatever premium increase have

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otherwise been needed it needs to go up by much, much more. Mark correctly identified the populations – I would just point out the largest of the 16 million or so is the duals which who don't actually pay premium increases, it's the states. So it's a very significant probably unbudgeted expense that the states would have to come up with in the neighborhood of 2 to 3 billion dollars if something weren't fixed. So the populations are the duals – a number of people who don't qualify for Social Security benefits like if anybody probably no one here is old enough, but the old CSRS federal retiree system some other public retirees – anybody paying the income related premium and as Mark correctly pointed out the newly eligible beneficiaries.

Tricia Neuman: Another group are people who have been advised to delay Social Security; so people who are age 65 or older who are waiting to get their full retirement benefits and a lot of them get good financial advice that says "Hey wait as long as you can because this will increase your benefits over the rest of your life". They too will be affected and they're not necessarily a higher income group of people. So to sort of close the loop I think next step is Social Security is going to announce or schedule to announce no cost of living adjustment tomorrow. And then everybody kind of waits for the secretary to announce what her determination will be as to the premium increase and the deductible increase. She may have some flexibility in determining adequate contingency reserves but that still may result in a pretty big increase in the projected premium and the deductible which then brings the discussion back to this building and this part of town because any other way to – any other option for reducing the growth in premiums and deductibles for the 30% would require a change in law.

Sean Cavanaugh: Yeah I just want to accentuate that last point. So when the secretary makes her decision there's only two ways money really two ways money gets in the Part B trust fund. One is the secretary sets the premium and then that triggers 3 to 1 matching payments from the treasury. But if she gets it wrong meaning if she sets a premium too low and expenses exceed revenues next year there is no mechanism to fix that other than a change in law. So Congress would have to intervene, meaning secretary has to be very careful and wise when she sets the premium.

Jack Hoadley: The only other thing I would add in sort of putting this in a slightly longer term context you know the division of Medicare in a part A and part B you know which is a historical artifact in a sense of 50 years standing we're in a situation where a lot of care is shifting from the hospital part A to non-hospital part B services and so part A being funded by the payroll tax, part B being funded through this premium and general revenues means even if Medicare costs as a whole are being level, flat, low increases whatever there may be this shift in part B and that's something that a lot of people have said at some point down the line needs to be rethought and that sort of plays into this not for this year's particular problem but as we think about potential for this to reoccur in future years.

Ed Howard: We had a couple questions about low income program. Jack you touched on this and I wonder if you could take you know, 45 seconds to describe what the low income assistance really consists of and there's another question that – so few plans in Florida benchmark plans that qualify people for the best deal on the low income assistance.

Jack Hoadley: So the low income subsidy in part D and part D is unusual in Medicare in a number of ways that we've talked about being delivered only by private plans being the most obvious one but another one is that there is a subsidy built into the Medicare program for the drug benefit unlike

part A and part B benefits where the subsidies come through Medicaid not directly through Medicare. You get that subsidy in part D and it's about 11 million beneficiaries who are eligible for those or who get those subsidies either through already being a dual eligible or through applying based on income and asset levels. And what you get for that is a zero premium as long as you pick one of the benchmark plans in your region. You also get far reduced co-pays for most of them no deductibles and no donut hole and a true out of pocket cap. So there's a lot of good things that this creates for you and most of those good things don't matter what plan you're in. For the premium in particular there's a calculation CMS makes each year to set a benchmark at a region which is based on the average premium submitted and then it's sort of the arithmetic that leads to a situation like Florida that says where the benchmark landed and how many plans land above or below it. And so it's a little hard to do a why, we've seen different states be in that situation where they have fewer plans below the benchmark but the benchmark is set separately for each region; so it is a regionally specific benchmark.

And then what happens is if you happen to be in one of those plans and we have seen a lot of volatility from year to year and which plans qualify under the benchmark in a given region but if you're in one of those plans that qualified last year so you got your zero premium and it doesn't qualify anymore this year depending on your circumstances and this is more than 45 seconds already but depending on your circumstances CMS may reassign you. And that's basically if you were put in that plan in the first place by CMS. But if you took the trouble to pick a plan even though you may have done it with the help of somebody else then you're considered a chooser and you don't get reassigned. And so there's a lot of people now over the years who were in that category who don't automatically get reassigned, they get a letter that says "Hey here's a list of all the zero premium plans", but if you don't read that letter and you don't act on that letter you stay in that plan and we know there are some beneficiaries who are low income by definition because they're getting that subsidy who are paying premiums that are not as high. They still get some assistance with that premium but there are people who are paying \$50.00, \$60.00, \$80.00, \$100.00 a month for people that really shouldn't be able to afford that. And again it's like the question of getting people to switch. How do you get this particular population, who has the option for zero premium to pay attention and switch? The only other caveat I would add is for some of them like everybody else it may not always be that the zero premium plan is the best for them. In some cases it's worth them paying \$5.00 or \$10.00 in premium to get more of their drugs covered. So it doesn't necessarily mean because somebody is paying zero that's why we don't automatically switch those people or CMS doesn't automatically switch those people. So like everything else it's complicated but it does seem like there are people who could be better off and the question is how to get them there.

Ed Howard: Could I ask, we're down to less than 10 minutes of our scheduled time and if I could ask you to take a look at that blue evaluation form before – as we go through these last couple of questions and try to give us some feedback on how we can improve these programs. We're particularly interested in those of you who are congressional staff to give us the feedback about how you might be able to use the information.

I've got a couple of really straightforward questions not quite so philosophical. Nobody really talked – we were talking about a part D pharmacy networks and there are two aspects of that that triggered questions in my mind. One is no one talked about mail order which is daily fact of this Medicare beneficiaries life. And I wonder whether as people have constructed these networks,

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they've done it in a way that parallels the controversy that we've been seeing in health insurance of "narrow networks". Someone asked the question are you able to get to one of these network pharmacies and get the lower co-pay?

Jack Hoadley: So on the mail order side – mail order is used a lot less in Medicare part D than in commercial plans. There is some mail order used and people in most cases are able to get access to mail order but because of the way the rules around part B is structured there's more of a – there's less ability for a plan to create incentives to get people to use mail order and I think that's one of the reasons you haven't seen as much of the use. I think a lot of people you know are creatures of habit. For all the reasons we've been talking about so they've been using their community pharmacy they're going to stay there and if the plan isn't able to create some kind of incentive to move them to mail they can. There are good reasons on both sides of whether you should or shouldn't allow those kind of incentives. I think on the narrow pharmacy network if you look at the pharmacy networks as a whole there's a generally kind of any willing pharmacy rule that applies in Medicare; so the networks as a whole tend to have more pharmacies in most plans have most pharmacies in their network. And so consumers don't generally have a problem.

Where the problem has arisen is in the tiered networks and CMS has done some studies and put out some notices to the plans identifying that some plans seem to have so few pharmacies in that for a preferred tier of their pharmacy network that a lot of people may have trouble having one that's convenient to them and Sean may want to say more about this. But CMS has taken some efforts to try to both put plans on alert, to try to sort of make sure they're the preferred sector of their pharmacy network is more robust but also more information on the plan finder. Changes were made to the plan finder a while back to make sure people put their pharmacies in and so when they get a price it's based on their pharmacies price. But to try to flag these situations where maybe there isn't a convenient preferred pharmacy.

Sean Cavanaugh: Jack is correct that when we noticed the proliferation of these preferred networks our first concern was were there beneficiaries actually had access to them and so you can imagine a situation where they are enticed into a plan with promise of very low cost sharing and then find that the preferred pharmacies where that cost sharing is available is not available to them or is difficult to reach. We did a study and the findings were actually very reassuring which is that most of the preferred networks actually have very good availability, the vast majority of beneficiaries.

We did identify a few outliers where the opposite was true where very, very few beneficiaries had access. We've worked with a number of those plans to increase their networks. I would say there was one that was reluctant to increase their networks and we work with them instead to make sure they more fully disclose that to beneficiaries which is you know, just make sure they understood what they were getting into. That the network was very restricted but it is an interesting phenomenon. There's been a lot of controversy around this but our study did show that the networks were fairly available – fairly well available to most beneficiaries.

Mark Hamelburg: If I can just add. I think the plans and the – what they're seeing for the beneficiaries is the ability to use these preferred pharmacy networks to really offer cost effective coverage. And particularly with some of the other trends that we've talked about earlier it's just critically important that – and that's why you're seeing an increase in the use of these approaches.

Tricia Neuman: On the topic of networks, we seem to know a lot about the networks of the part D plans. What do we know about the Medicare Advantage networks? I'll just leave it at that, what do we know about Medicare Advantage networks?

Sean Cavanaugh: So in recent years some plans have moved to more of a narrow network approach which has caused some disruption for beneficiaries. We've tried to be even handed about this because we try to encourage things that improve quality and efficiency of the plans. But we're also interested in the beneficiary first. So we have regulations – we've done two things. One was make sure the plans know they need to notify us if they're making significant changes in their network particularly during the year; so we can determine whether beneficiaries are affected in a meaningful way and whether they need or should be entitled to a special enrollment period; so you can imagine you joined a plan because your doctor was in it, you got half way into the year and your doctor was no longer in it. So when we're aware of those situations we try to allow the beneficiary special enrollment plan.

The other thing we've done is we had really been only enforcing our network adequacy requirements when they were changes meaning plan wanted to expand into new counties or something. We are now moving towards more regularly checking the adequacy of networks. Having said that I think you know these automated network adequacy and network monitoring tools that we have are imperfect at best. And it's difficult to be sensitive to all the regional differences and what an adequate network is one of the things we've been working with both within CMS but the industry has been working with is making sure that provider directories for example are timely and accurate and up to date. It's very difficult but from the agency perspective it's absolutely essential because I've often said that's what they're selling. They're selling a network, that's the product and the beneficiary ought to know what the product is. Having said that I know the industry struggled working with physician offices about keeping the information up to date.

So that's a long answer to we know a lot but never enough about the networks it's an essential topic because I think that's an essential part of the product that the industry is selling and the beneficiary is buying.

Gretchen Jacobson: And I would add that there's just so much that we do not know about Medicare Advantage networks. We don't know how many of them are ultra-narrow networks, how many of them are broad, whether they're mostly broad, mostly narrow, whether they tend to include academic medical centers. We – there's just so much we just have no clue about with Medicare Advantage networks because it's really, really difficult to dig underneath and actually compare the networks.

Mark Hamelburg: I'll just add that I might quibble a little bit with the notion of an ultra-narrow because as Sean indicated there's still an overlaying network adequacy requirement; so it's really – there may be creations of breadth of networks but they still you know plans must comply with the overarching network adequacy requirements.

Ed Howard: We have come to the end of our time. And I don't know about you but I've learned an awful lot in the last hour and 45 minutes about these issues and I want to thank our friends at the Kaiser Family Foundation not just for joining us in putting this event together but contributing so

richly to the quality of the discourse. And I'd like to thank our panel and ask you to join me in helping to thank the panel for what I think was a very enlightening conversation.