Medicare 101:
What You Really Need to Know
Alliance for Health Reform
April 20, 2007

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ED HOWARD,J.D.: Good afternoon. My name is Ed Howard, I'm with the Alliance for Health Reform and on behalf of our chairman Jay Rockefeller, our co-chairman, Susan Collins and the rest of our board, I want to welcome you to this program on the basics of Medicare. Before we get started, this is a live webcast and so I'm able to say, at least for those of you in the room, and tuned in now that we want to recognize that there are a lot of things going on outside of the scope of Medicare, including a set of events in Blacksburg, Virginia that are being recognized with a statewide day of mourning in the Commonwealth of Virginia. It's a week when there have been a lot of sad happenings, and we want everyone to know that the families and friends and colleagues of those that have been so terribly adversely affected by the event at the Virginia Tech are in our thoughts and our prayers.

We're going to be talking today about Medicare in the most basic of terms. Medicare is not the most popular government program in America, it's awfully close, it's also the program that the federal government spends more on than almost any other, 374 billion dollars last year, or about one dollar and seven on ever dollar spent by the federal government. And it helps some 44 million beneficiaries and their families. And it's been the subject of great deal of high profile attention right here in congress over the last few

years. We've had a new prescription drug benefit added and brought online last year, there have been struggles with payments to physicians and other providers trying to preserve both access for beneficiaries and a level of budget disciple. There has been controversy over how much private health plans are paid by Medicare, there have been concerns over the long-term fiscal effects of health cost increases and the aging of baby boomers, this is a program with a lot of moving parts that touch a lot of people in this country and therefore is of great concern to the policy makers of this town.

We're particularly glad to have as our partner and co-sponsor in this briefing the Kaiser Family Foundation. Diane Rolland, on my left, whom you'll hear from presently, is here from the foundation. And we want to welcome not only those of you here in the room, but once again to the congressional staff to the state and district offices who have been alerted to this program, and select reporters across the country as well who are tuned in. We want you to understand the basics of this important program as well, and we want to thank you for being a part of the discussion.

Let me turn at this point to Diane Rowland from the Kaiser Family Foundation for her introductory remarks.

DIANE ROWLAND SC.D.: Thank you Ed and thank you all for coming to attend this briefing or for listening on the webcast from your offices across the country. Today is

Medicare on Monday we did Medicaid and I think one of the biggest issues in health policy is often the confusion between the Medicaid and the Medicare program. So today we're talking about the healthcare program for seniors and people with disabilities, as opposed to Medicaid which was the program for low income individuals. However, as I know you'll hear today, there's a lot of interaction and overlap, especially in the population on Medicare that is low income and also served by Medicaid.

And also today I think one of the things we want to stress, and get across to you is that while much of the discussion around Medicare in the last two years has been around an issue called the Medicare Drug Benefit, the program is actually much broader, does much more, covers many more services and has a lot of issues related to the provider community that receives payments from the program to the population served for medical care an to some of the gaps in the program. And so I hope that our discussion today will help you to have a good framework for future policy discussions and answering constituency issues on the Medicare program and we'll fill in some of the gaps in knowledge that you may have.

As Ed said, we do these 101s because we think the basics are the most important piece of understand where to move forward with programs and to answer questions about programs so there is no question that you will ask that is too simple or

unsophisticated, please let this session be one of a learning experience for you and education experience that can help to build a better knowledge base for the future and I'm really glad we have such a great panel to be able to field your questions and let's get on with the basics.

ED HOWARD, J.D.: Thank you Diane. Let me do a couple of logistics tasks before we hear from our presenters. There's a lot of background information in the package that you got on the way into the room, including speaker biographies that are more generous and lengthier than I'm going to be able to give them introducing them. There are the Power Point presentations that they will be using, they're available to you in hard copy here in the room, for those of you who are on the webcast, can go to allhealth.org and you'll find all o the materials as well as the Power Point presentations, which we didn't have in hand in time to mail them to you, on the website. If you are watching the webcast live, and something happens to your computer, you can always dial in on a conference call, and hear the audio. That number is 866-710-0179 with a passcode of 264110. Those instructions are on the website allhealth.org as well as if you didn't copy all the numbers go get them just in case. And of course, if you're listening on a conference call and you want to watch the webcast, that's at Kaisernetwork.org and we urge you to take advantage of that. There will also be a transcript of this meeting available on Kaisernetwork.org in

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a few days and there'll be an archived version of the webcast available tomorrow. One other note, at the appropriate time, once we've finished our formal presentations, we'll give you a chance to ask the questions Diane was talking about, those of you in the room have green cards you can fill out and we encourage you to use those cards because we want to make sure we get questions from both inside the room and outside the room and there are some floor mics as well. Those of you that are around the country can either use an e-mail to infoatallhealth.org, or you can call 202-789-2300 and someone will write it down and get it to us.

So, that was, was that as confusing as it was on Monday? [Laughter] Sorry about that. We, let's get to the program, that will be a lot less confusing I know. We have, as Diane noted, a terrific group of Medicare maidens with us today and after their presentations they are poised to answer your questions. Let's start with Tricia Neuman. Tricia is the Vice-President of Kaiser Family Foundation and Director of its Medicare Policy project. She's been with the foundation for a dozen of years and served on congressional staffs in both the house and the senate before that. Her assignment today is to give us a broad overview of this important program. Let me just ask each of our panelists, for the benefit of those watching the webcast, as you make reference to a particular slide in your presentation, if you would tell it's slide number

12 that would be very helpful for those folks who don't have the hard copy in, I mean, don't have the ability to, yes, a hard copy in front of them to be able to flip through it. Trish, thanks very much for being here, we look forward very much to your presentation.

TRICIA NEUMAN, SC.D.: Thank you very much Ed, and thank you all for being here to talk about Medicare. I'm going to start with slide one. Funny enough.

Medicare was enacted in 1965, at the time the program was needed because about half of all seniors lacked hospital insurance. The program was expanded in 1972 to cover people with permanent disabilities. And in fact today, about seven million people on Medicare are under age 65 with disabilities. This is a group that is often not given a lot of attention in some of the policy discussions, but it is one that clearly has some significant needs and relies very much on the program for their basic health coverage. Medicare as four parts and my job today is going to be to talk about the As, Bs, Cs and Ds of Medicare, it gets a little harder as we add the letters, but we are going to talk about those four parts. In a nutshell, part A does in patient hospital care, part B is physician and outpatient services, part C is what is referred to as the Medicare Advantage Program, which was the term for Medicare HMOs and the other plans that provide Medicare benefits, and

part D is the outpatient prescription drug benefit that went into effect in 2006.

Before talking about Medicare, I want to talk about what's not covered by Medicare, just so you know. Medicare of course, provides important benefits, but does have significant gaps, most notably there is no long-term care benefit. There is also no stop laws, no catastrophic benefit for basics A and B benefits, which makes it quite different from the typical plan offered to employees and large firms. Medicare's 13 percent of the federal budget, and that's important because that means as you, or your bosses get involved around deficit reduction, it is hard to do work around the budget without thinking about Medicare because it is such a large component.

Exhibit two, this exhibit shows you the diverse needs and circumstances of the Medicare population. As you can see, almost half of the people on Medicare have incomes below twice the poverty level, or about 20 thousand dollars for an individual. Many have chronic conditions; many are in fair or poor health. One particular bar I'd like you to notice is the fairly large share with cognitive impairments, 30 percent, and I think that's important because as you think about changes in the program, or making the program work for people who are on Medicare, it's important to remember that many people do need assistance because they are unable to manage and cognitive impairments includes Alzheimer's Disease or just other

impairments that make it hard for people to take their medicines, manage their finances, etc. Five percent are living in a long-term care facility and ten percent account for 66 percent or about two-thirds of all Medicare spending. And that's important to keep in mind because when there's all this discussion about Medicare expenditures, it's important to remember that it's pretty much a small share that are driving most of the spending in the program, and that's typical of the health insurance.

Exhibit three, this shows you how the dollars are spent and what you can see here is about 40 percent of the dollars spent on benefits go to part A services, again that's inpatient hospital, some skilled nursing facility, some home health, 34 percent are for part B services, that's a physician and outpatient side, 94 percent are for part AB, that's the segments at the bottom. These are services that are, we call it part C, the Medicare Advantage Program, but really these are part A and B benefits, and so that's why it's displayed that way. And finally, and what's new about this 2006 pie, is you can see seven percent of all benefit payments are going for the new Medicare prescription drug benefit.

Backing up a little bit on the As, Bs, and Cs of Medicare and exhibit four, you can see in part A the hospital insurance program, which now has about 43 million people covered by it, which is paying for the inpatient care. Part A

is funded by a payroll tax and for those of you who look at your payroll stub, you can see that typical employees pay 1.45 percent, the employer pays the other 1.45 percent. And that gets to put that into paying for part A services. Part B is funded in a different manner, it is a combination of general revenues and beneficiary premiums and this year the part B premium is close to a hundred dollars, a little bit more than 90 dollars per month, and together they finance part B services. In addition this year, there is a new income related premium which requires people on Medicare with higher incomes to pay a bigger premium and that has just gone into effect. And finally there's part C on this page, which is not separately financed, because as I mentioned before, it's part A and B benefits combined, so the financing comes from those other two programs. There are eight and a half million people actually in Medicare advantage plans.

Turning to exhibit five, I'm going to skip over this fairly quickly because I know we're going to be talking more, Cynthia's going to talk to you more about part D, but the point of part D is it's a very different structure than parts A and D, the benefit is offered by plans that are outside of the traditional Medicare program, either stand-alone drug plans or integrated Medicare advantage plans that provide A and B and the new drug benefit. People need to sign up for prescription drug coverage, it's not automatic, which makes it a little bit

different than the other plans. Enrollment is voluntary for most people other than those who are on Medicaid who are automatically enrolled in a Medicare drug plan. There is a standard benefit, which I'll show you in a minute, but plans benefits, premiums, very considerably across the plans. There are additional subsidies for the low income population; in fact, many say that these additional subsidies are really a terrific part of the benefit package because it makes the drug benefit affordable for people of low and modest incomes who also meet the asset test. The drug benefit is financed by a combination of premiums, general revenues, and sometimes what is called the club act, which is a state financing which contributes to the overall financing for the program.

Exhibit six is a diagram of the standard benefit, and as you can see, it's a somewhat of an unusual benefit design. There's a 265 dollar deductible this year in 2007, the plan pays 75 percent, the enrollee pays 25 percent of the next 24 hundred dollars in drug costs, then there is the famous doughnut hole, which you may have heard of, and this is a coverage gap and in the coverage gap the individual pays 100 percent of their drug costs until they reach a point in which the plan pays almost all of the 95 percent of the expenditures. The doughnut hole this year is three thousand fifty-one dollars and as you can see, the doughnut hole is expected to grow to 32 hundred in 2008.

Exhibit seven shows you the Medicare population by source of drug coverage, this is data from the centers for Medicare and Medicaid services, which you can see here is about 90 percent of people are believed to have drug coverage in 2007, half in part D, employer plans still play an important role covering about a quarter of all people on Medicare and there is some interest in the ninth percent without drug coverage, and some interest in understanding who they are, how to reach them, and how to help them get drug coverage in the following years.

Exhibit eight looks at the low income subsidy which I mentioned is one of the most important aspects of the drug benefit, it shows that about half of the people that are getting the subsidy are people who are dually eligible for Medicare and Medicaid, so it's giving them additional assistance for the low income subsidy. Another little bit more than two million are getting assistance through the low income subsidy program which is generally administered by social security. But notably there are more than three million people believed to be eligible for this important assistance who are not receiving it.

Turning to future challenges, and exhibit nine, this slide shows you the demographic imperative, which you may have seen before, which is there are more and more people coming onto Medicare with the ageing of the baby boom generation and

fewer workers to support aging retirees. So there's clearly a challenge in financing care for an aging Medicare population and that is something that will no doubt get attention as the trustees release their report, the Medicare trustees next year, talking about Medicare financing. You will hear about two different measures, I feel confident, one is called a Medicare funding warning, which is concern about general revenues when they exceed 45 percent of the total. That should get some attention, as with the trustees' report which is predicting when the trust fund will no longer be adequate to pay for part A benefits.

On exhibit nine you can see that, this exhibit shows you that trust fund projections are important as an indicator of Medicare's fiscal strength, but it also says that Medicare projections are very sensitive but the policy changes and the demographics. Just note two bars here, in 1997 the trustees were projecting that the trust fund would be belly up in 2001, look down to 2001 and you can see that the trustees were projecting that the funds would be adequate throughout 2030. So with changes in policy, there is a potential, and changes in economy, there is a potential to keep Medicare stronger for longer.

Finally, exhibit twelve shows, summarizes the broad challenges facing Medicare, there are financing challenges, there are challenges related to implementing the drug benefit

over time, getting benefits to everyone who needs them, including the low income subsidies and making the program work well both for the hospitals and other providers who are part of the program, but also for the 44 million people who rely on Medicare for their coverage and care.

ED HOWARD, J.D.: Thank you Tricia. We're off to a good start. Now we're going to hear from Tom Ault, who's a principle at Health Policy Alternatives, which is one of this towns most respected in health policy analysis firms, which is fitting since Tom has spent years as one of the most respected health policy analysts in town. He's been a senior policy official at what's now CMS and today he's going to explain some of the intricacies of how Medicare pays different providers. I'm looking forward to this one myself. Tom, thanks for being with us.

TOM AULT: Thank you Ed. It's a pleasure to be here and it's nice to have you all here with your interest in Medicare. This better? Okay, I can lean into it, that will work fine. My, first before Medicare can make a payment for an item or service, it has to be covered and that simply means that it has to fit into one of the statutorily covered categories, like a physician service, or ambulatory service center, or durable medical equipment, or inpatient hospital, or so on and it has to be reasonable and necessary. Decisions about whether a service is reasonable and necessary are made

according to coverage decisions, and these coverage decisions are both national coverage decisions and about ten percent of coverage decisions, those are developed by CMS national office. And local coverage decision cover about 90 percent of Medicare coverage rules, these are developed by local Medicare contractors, which today are mostly the fiscal intermediaries for part A and the carriers for part B, which is physician services. We are moving to combine these fiscal intermediaries and carriers into what are called MACs, M-A-C, Medicare Administrative Contractors.

Slide three, shows at the top that we have 81 percent of Medicare's beneficiaries in Medicare fee for service today. As Trish said, that about eight and a half million are in some other plan, managed care some other plan. This shows, gives you kind of an overview, going from the different types of services, so going from left to right, starting with professional services, provided by physicians and other healthcare practitioners, those claims are processed by carriers and the services are coded according to the American Medical Associations current procedure terminology, or CPT4. And then equipment and supplies, in the middle column are provided by certified Medicare, durable medical equipment suppliers, who are currently going to be undergoing some competitive bidding. And the claims are processed by durable medical equipment regional carriers, or DMERCs and the coding

system for that is called HCCPCS, stands for Health Care Common Procedure Coding System. And then lastly, the institutional services, hospitals, nursing homes and home health, those claims are processed by fiscal intermediaries in the coding system is ICD9.

Going to slide four, now looking at how these different payments are made, what are the rules for making them. When Medicare began in the 1966, payments were based on reasonable cost and reasonable charges. Most Medicare services, almost all Medicare services today are paid based on a percent to pay system or a fee schedule. So for inpatient related hospital, it's diagnosis related groups, or DRGs, for outpatient hospital, ambulatory payment classifications are APCs, this will give you some of the alpha effect that Medicare is so famous for. So when you DRG or APC you can kind of look this up and know what people are talking about. Skilled nursing facility is a prospective payment system and it's a per diem system, it is case mix adjusted, and then physician durable medical equipment and clinical laboratory are all paid on fee schedules. Home health is another perspective payment system, but unlike skilled nursing facility, it's for an episode of care. And then covered drugs and biological covered under the Medicare part B program, these are drugs that would be injected or in a physicians office, or hospital, those are paid

according to average sales price. Cynthia Tudor will be talking about the part D drug benefit later.

Turning to slide five, the physician fee schedule pays out about 75 billion dollars; it was implemented initially in 1993. There are three components to the fee that's paid to a physician, about 53 percent, or about 40 billion of the total is for the physicians work, that is what the physician does. About 43 percent is for the physicians practice expenses, office related expenses and that's about 32 billion, and then about four percent is for malpractice insurance, liability insurance, three billion. Each component is assigned a relative value and it's a resource based system. And these relative values are summed and then multiplied by a conversion factor to get a total payment. An additional point here is that most surgical services are paid on a global basis, so that means Medicare pays for the surgery and for all services thirty or ninety days following the surgery.

Slide six, most of, a lot of the talk in health, Medicare today is about the physician payment issue, and this has been going on for a couple of years because Medicare physician payments are overlooking, about to fall off a cliff, the trustees report that was issued a year ago projected five percent, negative five percent updates for the next nine years, it was ten years at that time for 2015. There will be a new trustees report released next Monday the 23rd of April and I

think we'll see that they're projecting yet another year of five percent negative updates. These negative updates are driven by something called the sustainable growth rate, or SGR, which limits the year to year growth in physician volume intensity, and when physicians' services grow faster than this target then the update is reduced.

This chart shows graphically what's happening. The top line is the Medicare Economic Index, which is a measure of the inflation in the cost of providing physician services. The top line is what it costs physicians to provide their services. The bottom line is the fee schedules conversion factor, that's the basic rate that Medicare pays. And you can see these lines diverging because the conversion factors going to fall 35 percent while the MEIs increasing 40 percent. This is all happening, as I mentioned, because of the sustainable growth rate, and this chart, while it looks complicated, it tells a really easy story I think, and that is the bottom two lines are just annual, I'm not going to use that word, annual growth in volume and intensity. And the lowest of all is the annual allowance in the SGR. And the top two lines are the same thing, the top line is the cumulative growth in intensity, and the line under that is the cumulative growth in allowance. So you can see that every year actual volume and intensity exceeds the allowance, and you can see that growth over time.

Slide nine, fixing the update problem is not easy, if it were it would have been fixed. It's expensive, even a ten year freeze, and when is any provider group or practitioner volunteered to have their payment rates frozen for ten years. A ten year freeze in the physician fee schedule would have a federal budget cost of 180 billion and an additional 50 billion dollars in increased beneficiary premiums. There are some administrative changes that could have been made over the years but both the current and previous administration hasn't made those and we're stuck with the current situation. As Tricia mentioned, the Medicare beneficiary premium has nearly doubled from 50 dollars in 1997 to 93 dollars and 50 cents, in 2007. This reflects overall growth in healthcare spending driven by many factors, but it also reflects a shift to more outpatient services.

This is for slide eleven, the hospital outpatient perspective payments that's in this page according to ambulatory payment transportation-

ED HOWARD, J.D.: Can't hear you, turn on the mic.

TOM AULT: Thank you, I realize I'm using the other mic, thank you. According to ambulatory payment classifications, or APCs, and APC is roughly equivalent to a single procedure, a clinic or an emergency room visit, or an item or service like a drug or device. Generally the outpatient prospective payment system makes a separate payment

for each and every item in service, item or service provided during an encounter in the outpatient department. So, every service gets a separate payment.

This next slide, the top row shows for 2003 to 2006 what the market basket inflation rate has been for hospital outpatient services, and in the far right you see the cumulative of it is 14.6 percent. And then reading down, that last column, see the, how different types of hospitals have faired over this period, and a couple jump out, mostly it's been around 14, 15 percent for most hospital types. Rural hospitals have seen their outpatient increase almost 21 percent and the exempt cancer centers have seen a 4 to 6 percent increase. The end payment hospital perspective payment system is an all inclusive fixed per admission payment and the payment is made for each DRG, or diagnosis related group. It's a bundled payment; it includes all services provided during the hospital stay. The guiding philosophy here is that hospitals should make the clinical and economic decisions, not separate price setting by the Medicare program. Cases are assigned to a DRG bases on the principle diagnosis, age of the patient, and whether surgery was performed and what type of surgery. And these weights are recalibrated each year by the Medicare program.

Looking at, I'm on slide 15, the last slide, some of the current issues facing Medicare payment, hospital inpatient

prospective payment system and massive proposed regulation was put on display a week ago today. It calls for a major change and the DRG system to severity adjusted DRGs. It also calls for an across the board reduction in Medicare's payment of 2.4 percent a year for two years, so for a total of 4.8 percent. I suspect you're going to be hearing quite a bit about that. The programs justification for that is that they believe switching to this new severity adjusted DRG system is going to cause what's called case mixed creep. Inflation and the billing, if you will, and so they're taking an advanced adjustment of 2.4 percent a year for that. Other issues in the inpatient hospital system are whether some of the special adjustments and disproportionate share hospitals and whether the outlier payment adjustments, especially expensive cases should be maintained or should be changed. Another major are quality and paid for reporting and value based purchasing. This cuts across Medicare, physicians, hospitals, home health and so on, and right now most of the reporting is paid for reporting for hospitals and home health. Medicare will be submitting a plan to congress in June this year for an actual value based purchasing program for hospitals where they'll have to more than just report, they'll have to achieve certain levels of performance or their payments will be reduced. And then the last major issue is the physician SGR issue, physician update, which I've already discussed. Thank you.

ED HOWARD, J.D.: All right Tom, tough sledding, that is very dense material, thanks for explaining it. Finally we're going to hear from Cynthia Tudor, who is the director or Medicare, the Medicare Drug Benefit Group. If we could have the pointer here. Thank you. That group is within the Centers for Medicare and Medicaid services, or CMS, it's the group responsible for making part D, the drug benefit, work, simply put. She's also helps CMS figure out its payment system for Medicare Advantage Plans, no easy task. And today we have asked her to explain how the Medicare drug benefit in part D actually works. So we're looking forward to that explanation Cynthia, thanks very much for being with us.

CYNTHIA TUDOR: Thank you Ed. Can you hear me? I'm on slide two. Prior to January of 2006, Medicare did not cover outpatient prescription drugs except in certain restricted physician settings such as the pneumococcal and flu vaccines and in other limited part B drugs. The Medicare Prescription Drug Improvement Modernization Act of 2003, which we call the MMA, was signed into law on December the 8th of 2003. For the next approximate year and a half we worked very hard to come up with a regulation for this and publish the final Medicare prescription drug benefit final rule on January 28th, 2005. To tell you how short our time schedule was, approximately 60 days later we got the applications for 2006. We published the prescribing and prescription drug program final rule on

November 7th, 2005 and that will help with electronic medical records and such things. We published a draft data rule on October the 18th of 2006, which is still in draft. And finally the tax relief and healthcare act of 2006 provided for the administration of part B vaccines, beginning in 2008.

Slide three, as Tricia talked about, to join a Medicare drug plan, individuals must be entitled to Medicare part A or enrolled in Medicare part B and they must reside in the plans service area. As she also pointed out, coverage is not automatic except people who qualify for this via extra help, the low income subsidy individuals in particular. People are entitled to, people who are entitled to Medicare, beginning February 1st, 2006, or later, have a seven month period for their initial enrollment in part D. Our annual enrollment period is from November the 15th through December 31st of each year.

Full benefit dual eligible's, which we call it, BDE's, lots of good alphabet soup here, can switch plans during any month effective the first day of the following month. And certainly some of our problems in early 2006 were because of this automatic change in plans from month to month.

Slide three, what is the low income subsidy? It provides people who have limited resources in income extra help with their Medicare prescription drug costs, and that includes premium deductibles and cost sharing. You must enroll in a

Medicare part D plan to receive this assistance and you can enroll in a stand alone prescription drug plan, which we call PDPs, a Medicare Advantage Part plan, which we MAPDs, or the program for coordinated care for the elderly, which we call PACE, to receive this assistance. We work with states to identify the full benefit eligibles prospectively and we enroll them in a part D plan as soon as they become eligible for Medicare.

Slide five, how do people qualify for LIS, or low income subsidy? People who have Medicare and Medicaid, that is full Medicaid benefits, or who are members of the Medicare savings program will qualify automatically. We get this information from state files and typically their deemed for a full calendar year. And we only change their eligibility if they have a more favorable status that is they are going from a two five dollar co-pay to a one or three dollar co-pay. If you're eligible for SSI benefits, we get that information from the social security administration. If you have limited income or resources, you must apply, you must be approved by SSA, or by a state and you could have an event that would change your low income subsidy status mid-year.

As Tricia pointed out, here's out standard benefit for 2007. The sort of the top row shows the total of what drug spending will be and the bottom row sort of tells you what the beneficiary is responsible for under the defined standard

benefit. This is the benefit that is described in statute, essentially for 2007 it's a 265 deductible, 24 hundred dollars is the end of the initial coverage period, you reach catastrophic coverage when you have 545 dollars and 25 cents in total drug spend.

Slide seven, shows basically the changes in these kinds of benefit parameters between 2006 and 2007, and we have a new slide for 2008 as well. Each year the actuaries, bless their hearts, come up with what these changes should look like. So, unfortunately for 2008 we actually have some more changes in the one dollar LIS co-payment for people at 100 percent of the federal poverty level.

Slide eight, shows you the number of contracts and plans. We have for each kind of part D plan, and we basically have a contract with a major plan, for example, major organization for example, like Humana, or United, and under that are different plan benefit packages, and those plan benefit packages typically apply at a regional level, there are 34 regions in the United States, plus the five territories, essentially so we have over 37 hundred part D options for individuals in the 50 states and territories.

This slide shows you the four different general types, I'm sorry, it's slide nine, shows you the four different general types of plans that we have. The statute defined the standard benefit, a second option, and that benefit basically

says that there's 25 percent cost sharing throughout the deductible, after the deductible and until the initial coverage limit. Essentially this means that a cost share is 25 percent. For actuary equivalent plans they can then take the same kind of benefit, make it actuary equivalent and charge co-pays rather than co-insurance. Basic alternative plans allow sponsors to essentially come up with plans that have lower deductibles than the standard for the year. For example, less than deductible for 265 for 2007. Enhanced alternative plans allow a lot more flexibility, but require that the beneficiary pay a supplemental premium. And these would include a reduced deductible to zero and you'll see many of the plan offerings out there with a zero dollar deductible. It also allows coverage in the gap but many plans including Medicare advantage, as well as standard prescription drug plans, stand-alone prescription drug plans, are offering enhanced alternative plans, typically those plans cover generics through the gap and a few have covered all drugs, only formularies through the gap.

Enrollment through benefit type is showing you again, our four standard types of plans; this is slide ten, basic alternatives. The largest percentage of the Medicare individuals are drove in enhanced alternative plans, typically those plans are offering zero deductible as well as generic coverage in the gap, the largest single group of PEP enrollees

are in basic alternative plans with a large percentage of enhanced plans. For 2007, every state has at least one plan option with a premium less than 20 dollars per month. At least one plan available with no deductible and several plans with coverage of generic drugs in the coverage gap. On average, our premiums between 2006 and 2007 increased by less than eight dollars over the 2006 rate. And in several states we actually had decreases in premiums.

Beneficiaries have access to between 27 and 41 plans with no deductibles in 2007, and this is an increase in what we saw in 2006, and in every state the majority of plans does offer a mail order pharmacy services. The number of PDP sponsors, and that is the stand alone sponsors, ranges from 20 to 29 per state and that's an increase over our 2006 level. The number of stand alone PDPs sponsors ranges from 45 to 66. In general between 2006 and 2007, we saw the largest increase in enhanced alternative coverage, and that pretty much was because of the effort by CMS to make sure that this happened. We basically see that enhanced plans represent about 50 percent of the plans in the state.

What is a part D drug? A part D drug has to be a prescription drug; it must be approved by the FDA for safety and efficacy. It includes biological, insulin and medical supplies associated with the injection of insulin, vaccines, and now vaccine administration, and it must be used for

medically accepted administration. We don't cover all drugs, I'm sorry, this is slide 14, we don't cover all drugs. If it is administered and available under parts A and B we don't cover it. If it's used for anorexia, weight loss, promoting fertility, cosmetic purposes, symptomatic relief for cough or colds, vitamins, and the important ones are at the bottom, the non-prescription drugs but also we do not cover barbiturates or diazapines. As of 2007 we also no longer cover ED drugs.

What is a formulary? A formulary is a list of drugs that Medicare prescription drug plan must cover without granting an exception. Our formularies for 2008 were due on Monday; we have over 500 formularies to look at for the approximate three thousand to four thousand plans we're going to have. The purpose of formularies are to help contain cost. The general requirement for CMS is that the formulary must include at least two drugs in each therapeutic class and a class of covered part D drugs. These classes and categories are derived for us by the US Pharmacopeia. This formulary, this kind of formulary would represent to us a floor rather than a maximum number of drugs that have to be covered. We use a number of clinical conditions and other mechanisms to make sure that the formularies are broad and cover the range of conditions that Medicare beneficiaries are likely to have. We allow utilization tools, including prior authorization, step therapy and quantity limits.

Slide 16 shows you part D enrollment, again Tricia covered some of this, we have about 11 million people who are not LIS that are in standard, stand-alone prescription drug plans and another 5.5 million of the Medicare Medicaid group with its leaving us with about 17 million in stand alone PDP, remaining about 7 million people are enrolled in part D plans under Medicare advantage. About 7 million people also are covered under the retiree drug subsidy and we have about five million that have additional sources of credible coverage.

My last slide shows a number of sources for additional part D information.

ED HOWARD, J.D.: Thank you very much Cynthia. And it leads us actually into the part of the program where we're going to be asking you to ask the questions, I remind you that you have a green card that you can use, which we encourage in this context. We will get questions from our folks listening at the webcast and on the conference call as well. You can, for those folks, let me remind you, submit those questions by calling by phone, 202-789-2300, I feel a little like Jerry Lewis here, [laughter] or emailing info@allhealth.org. And a couple of folks submitted some questions in advance and it seems so appropriate to follow Cynthia's presentation and I think I'm going to take the liberty of doing that. Have any of the panelists, this person asks, every tried to explain the prescription drug program to an 80 year old?

CYNTHIA TUDOR: Absolutely. The answer is absolutely. And I think the key to doing this is to get the individual to use either our 1-800-Medicare help or our Medicare prescription drug care finder, and I've been able to over the phone, without even sitting next to a person, be able to lead them through this. But other information is available to beneficiaries at the state health insurance programs and other local kinds of networks.

ED HOWARD, J.D.: What, Tricia, we'll get to you in a second, but I just ask Cynthia to repeat that phone number.

CYNTHIA TUDOR: 1-800-Medicare.

ED HOWARD, J.D.: Okay, that's important to remember. Tricia?

TRICIA NEUMAN, SC.D.: I would imagine that many of you in the room have tried to help a family member look for a Medicare drug plan, and as Cynthia said, there are two very good resources made available by CMS. One is the telephone number 1-800-Medicare, the only place you can get comprehensive information is by going to the website, because that's the place you can get detailed information, not only about premiums and benefits, but also about covered drugs, and restrictions, which are fairly important for people who are trying to choose among plans. The problem is that only about a quarter of people on Medicare have ever gone online, so in order to use these resources people need help from others and sadly our

research shows that people on Medicare seniors don't really want to ask their children for help of these topics. They may ask their grandchildren but their not inclined to ask their children so there needs to be resources to help and support people with these decisions because what we also find is that the decision really matters. Choosing a plan is really important and can have significant costs implications for someone, there's a big range out there and everybody's needs vary.

ED HOWARD, J.D.: Let me just pursue that for a second Tricia, what are the counseling programs that are available for people?

TRICIA NEUMAN, SC.D.: Sorry, I should have mentioned that. There are state health insurance programs in every state and these are really terrific organizations, often staffed by volunteers and they are set up to help people make these decisions. There are also area agencies on aging, there are also grassroots organizations and non-profits, I think the issue is getting people to those counselors because lots, it wouldn't occur to so many people on Medicare to go to what's called a SHIP, these state health insurance programs. So, yes, they are out there but we don't have a sense that people know about them and they aren't using them maybe to the extent that they could.

ED HOWARD, J.D.: And is there some central place where people can find out where the SHIP is sailing in their particular state.

TRICIA NEUMAN, SC.D.: Cynthia, you might want to talk about this but the back of the Medicare handbook I believe there is a list of resources and this is one of the resources that's made state by state resources list.

CYNTHIA TUDOR: I would say that, again, an individual that's all alone is best off trying to go with 1-800-Medicare first. 1-800-Medicare will actually get on the plan finder, enter the individuals drugs, mail out the finding from the personal plan finder to that individual so they can then choose. So they are providing more than just talking to the person, they will actually lead them through this plan finder and help them come up with the lowest cost plans according to their prescription drug needs.

DIANE ROWLAND, SC.D.: One of the questions we've gotten is, could you further explain the doughnut hole and the reasons and justification for its creation. What effect does this have on beneficiaries needing the most medication?

CYNTHIA TUDOR: Well, I'm not into career limiting moves, so I'm not going to explain the motivation behind the doughnut hole, except to say that it is a cost saving move. It was designed that way and we are simply, we are simply enforcing the statute. But essentially the doughnut hole

doesn’t, is, what we call the coverage gap, does not provide for coverage of drugs in that part of the benefit. But as I said, a larger and larger percentage of plans are offering some sort of coverage in that period so that our beneficiaries can get better access to drugs.

ED HOWARD, J.D.: Let me just clarify, if I can, so the coverage gap, or the doughnut hole, is in the standard benefit package that’s in the statute. Is that right?

CYNTHIA TUDOR: If it’s for 2007, it basically is reached after the initial coverage limit of 24 hundred dollars, is reached.

ED HOWARD, J.D.: So when you’re looking for a drug plan, and you have the anticipation that you’re going to get to that threshold, that would lead you to want to have a plan that has some kind of coverage in the gap.

CYNTHIA TUDOR: Well, I think, again, that’s what the Medicare personal drug plan finder does for you, in essence, if you enter your drugs, it’s going to tell you what your costs are going to be in the deductible under each plan option that’s available to you, what it’s going to look like in the initial coverage limit, whether or not any of your drugs are covered in the gap and what would have if, and do you reach catastrophic if you reach the coverage gap. So it really tells you all of these kinds of things.

ED HOWARD, J.D.: Tricia?

TRICIA NEUMAN, SC.D.: I think it's absolutely true that people who anticipate having high drug costs would benefit from having brand coverage, of brand name drugs in particular, in the coverage gap and it's also true that most of the plans that are out there do not cover brand name drugs in the coverage gap and even the plans that are doing so this year, I think, are talking about getting out of it for next year because of some of the problems that they've had. So it may be hard for constituents to find a plan that will cover their brands in the coverage gap.

ED HOWARD, J.D.: Yes, there's someone standing at each of the two rear of the auditorium mics. So why don't you introduce yourself and try to be as brief as you can.

MATT: My name is Matt; I'm from the American Sign of Humantology. What's the purpose or rationale for delegating the responsibility from making most coverage decisions to local Medicare contractors?

ED HOWARD, J.D.: Tom, you want to take a crack at that?

TOM AULT: Sure, that's a great question. It's the local contractors that process all of the claims as they come in, so every, when a claim comes in you have to have a coverage policy for paying it, so they're the ones processing the claims, they're the ones that know local medical conditions, and so they develop the coverage decisions. Medicare has been

moving in the last few years to make more national coverage decisions and to have a better process for doing that, a very open process for doing that. As a deputy administrator of HPCCA, a few years ago, having 100 percent national coverage decision would be like asking CMS to write a medical textbook every year. It would be virtually impossible.

ED HOWARD, J.D.: Yes, sir, go ahead.

SEAN O'NEIL: Hi, Sean O'Neil with the National Multiple Sclerosis Society, I was wondering if there has every been a score to show what it would cost for Medicare to fill the doughnut hole and if so, what was that estimate?

CYNTHIA TUDOR: I think we'll have to get back to you on that.

ED HOWARD, J.D.: Let me just say, if we have questions like that that are going to require follow-on we'd be delighted to post answers on our website for people to get back to. Go ahead, Tricia and then Tom.

TRICIA NEUMAN, SC.D.: I think, as far as I know, there have not been estimates of that released by the congressional budget office in the past few years. That was something they came up before 2003, but I don't believe there are formal estimates that are out there, but we can look and make them available to you after the session.

ED HOWARD, J.D.: Diane?

DIANE ROWLAND, SC.D.: Okay, Tom, this question is, why has there been so much interest in cutting funding to Medicare Advantage to pay for other programs like SCHIP. You've gone into a lot of payment policy, their questioning what this aspect of Medicare Advantage is and why it's being talked about.

TOM AULT: I think the reason it's being talked about is that there are a lot of studies showing that Medicare Advantage plans are, have excessive payments compared to what it costs to provide the care to those payments. So when you make that comparison and that's the primary reason. I don't know if Tricia, if anybody wants to add anything to that.

CYNTHIA TUDOR: Well certainly I think another reason is the current environment of pay-go, where if you want to, the reference here is to SCHIP, if you need additional funding for the SCHIP program, you either have to come up with the revenues to be increased to pay for SCHIP or to find savings elsewhere, and the Medicare Advantage plan payments are being looked at as one source of financing because of those budgeting rules that the house and senate are operating under now.

ED HOWARD, J.D.: Let me just say as we go through this question and answer period, those of you in the room, if you would pull out those blue evaluation forms and give us your reactions, as well as to fill out the green question cards, that would be very helpful. And those of you who are tuned

into either the conference call or the website, you should have received an evaluation form that you can fax back to us in the materials that were mailed to your office, or if you do online to allhealth.org theirs is an evaluation form that you can print out and fill out and send it back to us if you would. We have another of other questions on cards, Diane if you want to take a look at them.

DIANE ROWLAND, SC.D.: This one is coming from the field called a constituent issue. Our office continues to receive many letters and calls from constituents who are denied part, declined part B when turning 65, because they already had private insurance through part-time work or spouses, after undergoing medical procedures they are notified that their second carrier denies their claims stating Medicare is their primary carrier. Bills continue and frustration mounts. What is being done about this persistent problem so that when people opt out of part B, secondary carriers will stop denying claims assuming consumers are on part B. What can my constituents do to prevent this problem, other than posing the question today?

TOM AULT: Wow, I think that it would be good to write to Medicare regional office. There's an ombudsman that can get on that, that absolutely should not be happening, it's definitely a contractor problem and if the contractors not responding then the Medicare regional office ombudsman, I think, would be the person to contact.

DIANE ROWLAND, SC.D.: Next question, is Medicare sponsoring any programs to encourage electronic medical records?

TOM AULT: Medicare is not directly sponsoring electronic health records in the sense of providing any financial assistance or any financial help in moving to electronic health records, but Medicare has been leading the way in pointing to the importance of that, and there is, as probably as you all know, there's been legislation considered, I think it actually passed the house and the senate but didn't get through the conference committee in the last congress, and there will probably be, hopefully be, legislation considered in the current congress as well.

ED HOWARD, J.D.: Okay, we have some people at the microphones, we'll start on my left. If you would identify yourself.

JOHN WESTON: Sure, John Weston with United Jewish Communities. Thank you Ed for having this wonderful presentation today. My question regarding pay for performance, I'm particularly curious as to what accountabilities, hurdles, and other challenges, what will the providers face regarding those other accountabilities and other challenges moving forward as we continue with these pay for performance implementations?

TOM AULT: That's a great question. I mean, because not only Medicare but Medicaid and private payers all want to be moving towards value based purchasing and that is not only having a flat rate but also being sure that they're getting a certain quality of care and providing incentives to improve the quality of care. The area of Medicare that's the furthest along is the hospital payment system where there are, it's 20 some measures that hospitals are reporting on and that's growing rapidly, it's envisioned that starting in 2009 there will actually be a incentive program where a hospitals payment depends on their performance. And for ambulatory care, physician and other ambulatory care, there's a number of measure and there's actually 74 measures there but of course with different specialties and so on they don't all apply to a particular physician. And starting July 1st, this year, there's the physicians will be reporting and will be getting an incentive payment for pay for reporting which is what hospitals have been doing. There are going to be a number of difficult issues for everyone involved in making this work in terms of keeping measures up to date and also making it a program that has properly aligned incentives and achieves improved quality, which is the ultimate goal we all want.

CARL ESTICO: Carl Estico with the national rural health association, I've got kind of a two part question, first part being with the version of population basis of payers and

utilizers, do you feel that the economic principles of the Medicare program may be backward, and expounding upon that, if it was reversed, would moving the initial costs of the utilizers address the moral hazard maybe driving up some of these costs.

ED HOWARD, J.D.: And somebody had better explain what moral hazard is, those of us that are not actuaries.

TOM AULT: You can correct me if I'm not comprehending the question you were getting at, I think what's behind it is a concern about moral hazard which is, as I'm going to define it right now casually, is that when there's insurance for a service that it doesn't do anything to control utilization, it actually tends to increase utilization. And there certainly is a lot of proposals over the years, there have been a lot of proposals over the years for having better increased cost sharing and what that would do, but you have, the other side of that coin is that when you increase cost sharing then there are many studies that show that people don't get needed services and I think that what the programs, Medicare and Medicaid, try to do with their different populations and their different needs is to get a reasonable balance between a third party payer, like Medicare and Medicaid, paying for the service, and having some responsibility for the individual.

DIANE ROWLAND, SC.D.: We have a series of questions that really do relate back to the Medicare Advantage question,

one is why are there so few people enrolled in Medicare Advantage, and what is the advantage of Medicare Advantage? And then a follow up that is to discuss the current level of funding for MA plans is that's cut, what will the result be in terms of its effect on membership in our geographic areas offering these plans? Tricia you want to start?

TRICIA NEUMAN, SC.D.: Yeah, on the first question of why so few people in Medicare Advantage plans, there's actually been enormous growth in the past few years, from five million just a few years ago, to eight and a half million today. So after a period of relatively steady enrollment, if you look back historically with about five percent or so, there is a, there has been a major increase and in the 1990s and then when payments were modified in the DDA, there was a decline both in the number of plans service people in Medicare on Medicare Advantage, and the number of people signed up and more recently there's just been this big increase again most likely do to a more favorable climate. I think another factor has been the drug benefit which has given some companies another marketing opportunity to reach out to people on Medicare and recruit them to enroll.

What are the advantages of Medicare Advantage, well, that's a big question and it really depends on the plan. There are many different types of Medicare Advantage plans. There are traditional HMOs, there are special needs plans, which are

for targeted populations, there are regional PPOs which don't have much enrollment, and there's a new type of plan called a private fee for service plan which is actually seen tremendous growth just in the past two years going from 200 thousand people, virtually no one in a 44 million person program to one and a half million this year. So there are different programs and different plans and the different plans offer different benefits, so it's pretty hard to generalize about the advantage of Medicare Advantage. But because of the payments that, as Tom said, that have been relatively generous when compared to traditional Medicare, plans are able to offer extra benefits to people who sign up and for some that is very attractive, particular people who feel they can't afford, for example, a Medigap premium. So that is, that can be an advantage depending on what the benefit is. There is discussion about cutting payments to plans and that could have some effect, it could mean that some of the newer plans and high payment areas that see a reduction don't stay around for long, it's hard to say for sure. It could mean that the benefits are no longer as generous and as favorable as they are this year. But I think an important point to remember is that Medicare Advantage serves a relative, as you said, the question said, it's a minority of people who are on Medicare and when you think about the issues around benefits, it's important to remember that the majority of people on Medicare are not choosing Medicare

Advantage plans yet, and so the issue of protecting benefits in Medicare Advantage might be thought also in a broader context in remembering to provide benefits in an equitable way to people both in Medicare Advantage and traditional Medicare.

DIANE ROWLAND, SC.D.: This is a question related to the wisdom of installing systematic cost effectiveness studies for payment and coverage decisions instead of relying exclusively on the contractors, or how are these decisions really made?

TOM AULT: I guess I need training in how to push a button. The cost effectiveness studies are, and just plain old effectiveness studies, evidence based medicine type studies are used both by Medicare in making national coverage decisions and by the local carriers. Their used as a guidance because Medicare cannot explicitly choose to not cover a service because it falls below some cost effective threshold. And so what, the way Medicare decision makers were more likely use these cost effectiveness studies is in a comparative of effectiveness way, but even there's, as I think the questioner probably knows, there's been a great reluctance to actually deny coverage or to limit payment. In a couple of cases Medicare has implemented what's called least costly alternative. And that is where they have two items, say two drugs, and if one drug is not shown to be any better than the other drug than Medicare will say okay, we're not going to pay

any more for the more expensive drug than for the cheaper drug, we'll limit our payment. And those kinds of decisions could be increasing over time but we don't have very many of them now.

ED HOWARD, J.D.: Can I just do a commercial here, a week from today, the alliance will be doing a briefing on comparative effectiveness and the state of the art in that area, not necessarily tied to Medicare, but certainly related to it. You'll be getting that announcement probably on Monday.

DIANE ROWLAND, SC.D.: This is a caller question, what does the panel suggest clients who use specialty drugs do with the deductible if their drugs average two thousand dollars and part D only covers 80 percent. Prior to part D the drug assistance program allowed them to receive drugs for free of at a minimal cost.

CYNTHIA TUDOR: Well CMS is aware of this problem, we've been working with pharmaceutical systems in these programs, which is what I think the caller is referring to, to see what kinds of special programs they can still put in place. These drugs, these expenditures by PAP, the pharmaceuticals assistance program may or may not apply to the beneficiaries true out of pocket cost counter depending on how that PAP is operating. I think still the best news is to get in touch with the individual pharmaceutical assistance program and see under what conditions they can still provide these drugs if the beneficiary is in either the coverage gap, is in the coverage

gap. I think in my mind, once you hit two thousand dollars, say a month, you're going to be in catastrophic coverage fairly fast, typically now we're in the second month or so. So I think then catastrophic will kick in and you'll be paying five percent of the cost, which I understand is not a small amount of money when you have such high drug expenditures.

ED HOWARD, J.D.: Yes, would you like to ask your question from the microphone?

LAUREN CHRISTOPHER: Thank you and good afternoon, my name is Lauren Christopher with the administration for children and families. I'm interested in hearing more about the low income subsidy program and specifically how the automatic enrollment works in relation to selecting the plan if the applicants are working with a case worker in trying to determine which plan to enroll with. I'd also like to hear about the outreach efforts to try to specifically target the vulnerable populations and whether or not there has been outreach involving the medical community in trying to identify these vulnerable populations and referring them to the program. Thank you.

CYNTHIA TUDOR: The first question I think was about how we find out about low income subsidy people, we essentially work with states, we get state files, both of their current LIS people and other, perspective LIS people and essentially work to get them randomly assigned to plans as required by statute.

If a state wants to work with us typically on an SPASS kind of function-

ED HOWARD, J.D.: On a what?

CYNTHIA TUDOR: State pharmaceutical assistance program. Sorry, alphabet soup, you know it's great. If the state wants to work with us on something like the state pharmaceutical assistance program, once they are operating within our rules we can work with them to use a different kind of assignment approach. But generally, end of it, because our formularies are very, very broad and I don't want to minimize how broad they in fact are, most individuals can find therapeutic alternatives on any formulary to which they are assigned.

The second issue which was I think outreach, I'm not the outreach expert here given I'm the operational person, but essentially there have been hundreds and hundreds of fairs that CMS have held where they are working with local providers, local advocacy operations, all kind of different groups to make sure that we are reaching out to identify as many low income people as we can and to get them into the program.

ED HOWARD, J.D.: Tricia, you want to add to that?

TRICIA NEUMAN, SC.D.: Yeah, I just wanted to back up for people who are helping people who are Medicaid and have been randomly assigned to a plan, the process of assigning people to a drug plan does not take into account what their

needs might be, which drugs they use, so someone who is assigned to a plan, it's very important to look at the formulary to look at the drugs they take are covered. And if not, look for an alternative plan that accepts people of low income subsidies. That's very important for making sure that people can stay on the medications that they depend on. And in terms of outreach social security I think has taken the lead for the government in doing outreach but I think they have discovered how hard it is to reach out and find people and that's why there are an estimated three million people out there who could be benefitting from this assistance but still are not getting it.

TRENT MARTINSTEIN: Trent Martinstein, prior HIPPA consultant. The tragedy of Virginia this week pushed the need of adequate healthcare. Most major psychiatric illnesses have been shown to be biologically based and it's incredibly new evidence such that people who are depressed and have a heart attack die much more quickly if they don't get anti-depressant treatment. I've noticed that of all the medical procedures or treatment here, psychiatric care is only covered at 50 percent co-insurance where all the other medical treatments are close to 20 percent so my question is, and also 50 percent is a lot of money for a patient in needs to pay and particularly the chronic population of schizophrenics and other chronic mental illnesses also don't have that kind of fronting, so my

questions is are you considering putting mental health benefits on parity with other medical benefits. I think that's my question.

CYNTHIA TUDOR: You're absolutely right about the 50 percent co-insurance for mental health visits. There has been legislation proposed over time that would bring that co-insurance down to 20 percent to be parallel to what physicians, other physicians are receiving. I think the issue there is cost because it would add cost to the program and that's probably the biggest barrier.

TOM AULT: I'm strongly in favor of mental health parity, myself and it's greatly needed. I did want to make an additional point and that is certain visits, that is medication management visits for psychiatric care are covered at a 20 percent co-insurance rate and the drugs that beneficiary would be getting would e covered most likely under their part D plan if they're enrolled in part D. SO it's a little better than it had been but we've got a long ways to go.

DIANE ROWLAND, SC.D.: This is a caller question, can anyone over the age of 65 opt out of part A, and also why is enrollment in part A automatic?

TOM AULT: You're enrolled in part A automatically, and I guess I'm not sure why someone would want to opt out of part A.

ED HOWARD, J.D.: What about costs?

TRICIA NEUMAN, SC.D.: Because there's no premium if you've been paying into part A, if you've been paying your payroll tax, when you turn 65 there's no monthly premium, so it's not clear why you would want to turn down the coverage you could get.

CYNTHIA TUDOR: In fact some people choose to buy into part A as opposed to opt out of it.

DIANE ROWLAND, SC.D.: Question also from medications that are covered under part B, how is the average price set, how are decisions made to cover exclude drugs under that part of the Medicare, but not in the part D program but in the traditional part B.

TOM AULT: The average sales price for injected and infused drugs is set based on reports that manufactures are required to file with Medicare quarterly and in these reports the list all their total sales in dollars and their total units as a number and those are divided to get an average sales price and with a two quarter lag, Medicare lets that be the rate.

DIANE ROWLAND, SC.D.: This one gets a little political, but we'll do it anyway, what is the purpose rational for providing drug benefits part D exclusively through the private sector as opposed through the public or private sector as with parts A, B, and C.

ED HOWARD, J.D.: Want to try another one of those career enders?

CYNTHIA TUDOR: Those are called CLMs, just to keep the alphabet soup up, the congress that passed this law was interested in private sector solutions to the drug, to the outpatient drug prescription problem, they saw private sector solutions, they were able to get it through congress and that is why it is what it is. I would say that part C is a private sector solution as well, you're looking for private plans that offer drug benefits, so these are not, this is a different, it's a way of offering different options, not just to Medicare beneficiaries, there's one offered by the government but one available to individuals, for example, in the commercial market, so I think the feeling was if you are using a certain kind of provider when you are under 65, why should all care be provided through a government solution once you reach 65.

DIANE ROWLAND, SC.D.: And this question-

ED HOWARD, J.D.: Tricia had an additional comment.

TRICIA NEUMAN, SC.D.: The slight distinction between part C and part D is in part C people have the option to be in traditional Medicare for their Medicare benefits or their Medicare Advantage Plan, in part D people really do need to choose either the stand alone plan or the Medicare Advantage plan because it's not available under traditional Medicare.

DIANE ROWLAND, SC.D.: What causes the wide swings in solvency dates at the trust fund, four years to ten years, and

what options exist to address these solvency swings, and perhaps can one can also comment on the 45 percent trigger.

TRICIA NEUMAN, SC.D.: Well, there are a number of factors, that's a good question, and what explains these swings, it's certainly not anything to do with the trustees and whether they were right or wrong one year, it has more to do with the economy, remember that the money that goes into the trust fund is from payroll taxes so in good years when salaries go up there's more money that goes into the trust fund, that is a major factor, changes in policy also matter, so, for example, if congress chooses to modify payments to hospitals, as slow the growth in future years, that's going to affect the future obligations of the trust fund, that too has a big effect. Another factor is shifts in care, if care was more on the inpatient side and it moves more on the outpatient side, that takes the burden off of the program that pays for inpatient care. So there are real reasons why there are fluctuations, and those are just three examples. In terms of options for helping out the trust fund, congress has come back year after year with changes in policies that effect provider payments that come out of the trust fund. That's payments to hospitals, payments to skilled nursing facilities, home health and hospice, and every time congress slows the growth in payments to those facilities, that breeds new life into the trust fund.

And so that's a very clear thing that can be done to help the financial outlook there.

In terms of that solvency trigger, which is pretty new and pretty complicated to explain, there is, this is a new measure that was put into law that says when general revenues, which is a portion of Medicare financing is projected to exceed 45 percent of total spending and that projection is made by the trustees two years in a row, then funding warning is set off, and so last year was the first year that the trustees projected that the Medicare general revenues will exceed 45 percent of the total, I think it's six years from now, if the trustees next week issue the same warning, so that will be the two years in a row, that sets off a set of requirements and the president is required to submit a proposal to the congress within a year for expedited consideration. So next week when the trustees release their report this will be an important thing for you to look for, because that will effect what transpires over the course of the next year or so.

DIANE ROWLAND, SC.D.: And then moving to part B, which is not part of the trust fund, we have a question here for Tom, what options exist to address the physician payment problem, the SGR problem, besides just more dollars.

TOM AULT: That's a very good question-

DIANE ROWLAND, SC.D.: You should be clear about, for those who are really at the basics what's in the part A trust

fund that Tricia just talked about, versus how part B is financed.

TOM AULT: As Tricia said, part A is primarily hospitals inpatient services, skilled nursing facilities, and home health agency visits. Part B is physician, hospital outpatient, ambulatory surgery center, clinical lab part B drugs, the injected and infused drugs, and a number of other items, the ESRD program also for example. One of the, one question to ask about the physician target is this SGR target, is this a reasonable level and physician spending is just way out of control? Or is the level maybe too low. And the allowance in the SGR is for the growth in the economy, real GDP growth, that's the SGR.

ED HOWARD, J.D.: Excuse me Tom, let me do one, let me do this one. SGR stands for Sustainable Growth Rate.

TOM AULT: Thanks Ed. And the limit is GDP growth. Since the whole history of the Medicare program since 1966, only when the physician fee schedule was implemented in 1993, and a couple years there after was growth at two percent or less, which is what the economy grows once a year, 2.1 percent. And in fact when this limit was enacted, congress and the administration was President Clinton at the time and the advisory bodies of congress agreed that the limit should be GDP plus a higher number, so the limit is probably too low, that's not going to find the revenues though to get the problem fixed.

The Medicare payment advisory commission issued a report a couple of months ago, maybe just back in March actually, on options for addressing this, and what one of their options involves expanding these growth targets not just to physicians but all health spending, so hospitals, home health, every, you would have geographic targets, regional targets for all of Medicare with feedback mechanisms and so on to try to attack this in a more holistic way.

DIANE ROWLAND, SC.D: This is a question regarding the part D benefit again, I have heard of beneficiaries who have withdrawn from a part D plan, but they are still having their premiums taken out of their social security check, this is a problem, is there some way to address this, can you explain what's going on?

CYNTHIA TUDOR: When an individual enrolls in a part D plan, that individual selects whether or not they want to have direct pay or the want to have social security withheld from part D premium. What seems to be happening is that when individuals change their minds and either they want to go on direct pay or alternatively they actually want to withdraw from the plan, the timing of various company systems are not in synch. And that is the individual may make a withdrawal from a plan on the 31st of the month, that obviously is not going to reach social security in time for the next months checks because it must first go to the plan and then to CMS, there is

an even likelihood that it may miss the following months deadline. So it's an issue of making sure all this is in synch. Obviously any beneficiary who is having these kinds of problems, needs to first get in touch with their plan, get, make sure that plan has this problem in their database, it's not their fault, I'm not saying that, but simply they start there and then CMS and the plan, and the regional offices in particular can work to get that beneficiaries problem solved.

DIANE ROWLAND, SC.D.: And as a final question from the field, some physicians will not accept MA plans, are there any plans in CMS or other options to deal with this issue?

ED HOWARD, J.D.: We're talking about Medicare Advantage plans?

CYNTHIA TUDOR: Medicare advantage plans are all different types as Tricia pointed out, I think most plans have contracted providers, most HMOs do, most of the PPO options do, so most plans have contracted providers and they simply work with that group of contracted providers. The group of the kind of plan that does not have a system or contracted providers, or private fee for service plans. And in those circumstance, the physician on a case by case basis whether they want to accept that patient and they decide to or not. I don't know of any legislation or any change that's requiring people to accept a Medicare Advantage kind of thing.

TRICIA NEUMAN, SC.D: So getting back to what this means for constituents, this is a real issue when thinking about choosing a plan, it really puts a little bit of a burden to talk to the beneficiary to talk to their providers, all their doctors, lost of people on Medicare have more than one doctor, to find out whether their doctor will accept payment from that plan, maybe even find out about the local hospital, because we know that senior tend to prefer certain hospitals because the last thing they want to find out over the course of the year is their going to have a problem with payments after they have received a service.

DIANE ROWLAND, SC.D.: I think that we have gone through the majority of your questions; I hope that your questions have been answered. I find it interesting that today's Medicare discussion had more alphabet soup than the previous Medicaid discussion and may have been even more complex, which is not something that everyone assumes when they look at Medicare versus Medicaid. We did get a few questions that asked us to speculate on how Medicare would fit in with universal coverage, and other proposals, we are saving that for a follow up discussion because we were just really today trying to do the basics. But on behalf of the Kaiser Foundation we did get a lot of great questions and we especially thank those of you watching with the webcast. Ed.

ED HOWARD, J.D.: Let me add the thanks of the Alliance, not only of those of you watching the webcast but those of you who sat through it here in Washington, I ask all of you to fill out those evaluation forms so that we can make the next one we do even better. And add also that we had a panel that fielded an incredible variety and complexity of questions, and I'd like to ask all of you in the room anyway so that we can hear you, to join me in thanking that panel.

[Applause]

[END RECORDING]