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Ask the Experts: Medicare Part D
October 6, 2005

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LARRY LEVITT: Welcome to Ask the Experts, our regular interactive web show that provides in-depth discussion of current health policy issues and allows you to interact directly with the nation's top policy experts. Unless a nation effort to delay had gained steam, we are just weeks away from the start of enrollment in the new Medicare drug benefit, the biggest expansion of a domestic social program in decades.

There is little disagreement that Part D, as the new benefit is known, is complicated. At the same time, there is also little dispute that the staff of CMS has done an incredible job of keeping implementation on track, given tight deadlines and an astounding number of moving pieces. Part D represents non-precedented expansion in the use of private plans in Medicare. Beneficiaries will be choosing from a minimum of 11 private drug plans – that is in Alaska – and many more than that in larger states.

Plans can offer different premiums, different benefits and different drug formularies and that does not even include the options available to beneficiaries that get comprehensive benefits through a private Medicare advantage plan, like an HMO or a PPO.

With all these plans able to advertise and market as of October 1st, we are about to hear a whole lot more about this in the coming weeks. But judging by the number of e-mails we have

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received, there are still lots of questions about how the new drug benefit is going to work. We are here today to answer those questions. You can reach us in two ways: E-mail your questions to ask@kaisernetwork.org or call us here at the Kaiser Family Foundation broadcast studio and ask your question on the air. You can phone toll-free at 1-888-kaiser8. That's 1-888-524-7378 and we will do our best to get to as many of you as we can.

If there is a question the panel of experts we have assembled here today can't answer, I am not sure it is answerable. Julie Goon directs Medicare Outreach and is a senior advisor to the Secretary of HHS. Aileen Harper is executive director of Center for Health Care Rights, providing Medicare advocacy and counseling services in Los Angeles county. And Tricia Neuman is vice president at the Kaiser Family Foundation and directs the Medicare Policy Project. Thanks to all of you for joining us.

And Julie Goon, let's start with you. Plans have started marketing this benefit, CMS is doing outreach, enrollment of low-income beneficiaries has already begun – give us a sense over the next several weeks what we are likely to see as implementation proceeds.

JULIE GOON: Thank you Larry. As you mentioned, plans were allowed to start marketing October 1st and I think we have seen some plans already go forward and start that marketing.

Other plans are waiting a little closer to the enrollment date, which is November 15th.

This week you will see the *Medicare and You* handbook arriving in all Medicare households across the country on a rolling basis, but every Medicare beneficiary should be receiving this handbook by the middle of the month. Two week's ago, there was an insert in Parade Magazine all across the country. We will also be advertising in Parade Magazine on behalf of Medicare on the 9th of October and the 16th of October, reminding people to look for the handbook and reminding people to start thinking about the choices they want to make for their prescription drug coverage.

Additionally, we have new material that will be going up on our website. Many people are used to using the Medicare Advantage Personal Plan Finder. We will have similar plan finder for the prescription drug plans. We have a cost calculator, where a beneficiary can enter what they are currently spending on prescription drugs and determine how much the new Medicare prescription drug plans will save them. And in addition, at CMS we have done a very intensive targeted outreach effort over the past year in an effort to build networks all around the country so that beneficiaries can find one-on-one personalized help in the areas where they live. And so we will have an eldercare locator on the website as well where a beneficiary can put in their zip code and determine

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what kind of resources are available in their community, just like Aileen's organization in Southern California.

LARRY LEVITT: So these are community groups, counseling centers?

JULIE GOON: Absolutely. SHIPs, area agencies on aging, counseling centers, people who have the capacity in their resources and the desire to really help beneficiaries make a decision about what choices are out there for them and what choices work best for their family.

All of this is building up to – you may have heard Secretary Leavitt talk about the national conversation we anticipate this nation having about Medicare prescription drug coverage and we are looking at the day after Thanksgiving as a targeted day for that conversation when people are home with their families and really have an opportunity to sit down, work through the *Medicare and You* handbook and start talking about the choices available in their areas.

LARRY LEVITT: And when does enrollment actually begin for beneficiaries?

JULIE GOON: Enrollment begins November 15th, which is in a little under six weeks right now.

LARRY LEVITT: It probably seems a little soon to you right now.

JULIE GOON: The drug benefit itself starts January 1st. And this first annual open enrollment period lasts until

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May 15th. So people don't have to rush to judgment, they have time to sift through the choices that are available to them, think about what is right for themselves and their family, think about the coverage they already have, think about what it is going to take to achieve peace of mind over the period of time that they are a Medicare beneficiary and really make a choice that they feel comfortable with.

So we are very excited about it. I think the announcements that have gone out over the past couple weeks about the specific plan options have made it clear to the rest of the world, as it's been clear to us, that this is a very, very good benefit for beneficiaries. There are a variety of choices.

If you want to make a decision based on the cost of a plan, there are plans that are very inexpensive, there are plans that cost more, there are different ways to do cost sharing. If you are looking for coverage in the coverage gap, there are plans that provide coverage for both generic and brand name drugs in that coverage gap. There are plans with low or no deductibles. So whatever works for a beneficiary, we have been trying to provide that kind of choice for them.

LARRY LEVITT: And these are relative to expectations – there are more plans out there than a heck of a lot of people thought might be the case. Would you say that is true?

JULIE GOON: I think that there was a worry that there

were going to be even more plans than there are. So I think maybe we hit it just right.

LARRY LEVITT: Aileen, you run a counseling center, you answer questions of Medicare beneficiaries everyday. What is your sense of how things are working on the ground, what kind of feedback are you getting from seniors and disabled persons?

AILEEN HARPER: I would say that until recently, there really was not a lot of beneficiaries contacting us about the new Part D program. And I think that the sort of interest and the concern will actually start as they start getting more and more information from CMS and other sources.

So far, some of the concerns that have been raised have been relating to just sort of understanding how Part D relates to perhaps other drug options they have, whether through a former employer, through an MA plan currently, if they are dual-eligible.

LARRY LEVITT: I think about two-thirds of beneficiaries have coverage now.

AILEEN HARPER: That is correct, although there is one-third without anything and for those people I think it provides a really important new resource. I think that in terms of some urgency, there is a lot of concern, at least in our state, about the dual-eligibles, given that they will be auto-assigned in transition from Medicaid to the new Part D benefit.

LARRY LEVITT: And these are people that have both

Medicaid and Medicare?

AILEEN HARPER: That's right, correct, both Medicare and Medicaid. And a lot of concern in terms of making sure that we reach these people so that they understand very clearly that they are being transitioned from Medicaid to Medicare coverage. But in terms of just sort of the general Medicare population, I think that there hasn't been a lot of interest, but as they get more and more information, whether it is the handbook or other sources, I think there will be a stronger interest.

One of the things that I am a little concerned about is that a lot of Medicare beneficiaries, for whatever reason, do not read information that is sent to them. So there are beneficiaries unfortunately out there who are not going to read letters sent to them, are not going to unfortunately look at their handbook. And for those people, we are pretty concerned that those people might be harder to reach and either, one, may lose the opportunity to enroll because they do not know much about it or might enroll, not realizing how it fits with their drug options and may make wrong choices.

LARRY LEVITT: What do you think because from one perspective, it seems like there is this blitz of information going out – the handbooks, the outreach campaigns, Parade Magazine, information at AAA and Walgreen's, sort of everywhere. But your sense is still there are seniors who

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might fall through the cracks?

AILEEN HARPER: I think so. Sometimes I think older adults are not a homogenous population. There is a lot of diversity, there are a lot of people who have cognitive impairment, there is literacy issues, there is language issues. In our county, half the Medicare population are people of color, many of who speak other languages. I think that although many people will respond to the information, there will be other people who may not and who may respond to maybe a TV ad or something else, but may not necessarily respond to something that maybe has a little bit more depth to it.

JULIE GOON: Just to pick up on what Aileen said, I think you are absolutely right, the Medicare population is very diverse and that is why, I think, this year CMS has made such an effort to, number one, build these networks of people who can help beneficiaries all around the country. We have relationships with over 12,000 organizations around the country right now who are dedicated to helping beneficiaries make these choices.

Secondly, I think more than any other year that I have seen, CMS has targeted its materials and publications in a way that we are attempting to speak to different groups, whether they are people with disabilities, whether they are people of color, whether they are people who speak different languages and all of the CMS publications are available in Spanish and

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English and there are other languages available as well.

And I think in terms of the information that we have been putting together, we have tried to do it in a way that takes into account, as you said Larry, that two-thirds of beneficiaries already receive drug coverage from someplace, and that is what a person really needs to think about as they look at this program, not that they are ever going to have to pass a Civics test on Medicare in order to make a choice, but if you have retiree coverage, you need to look at your retiree coverage and figure out if it works for you, if it is creditable coverage. If it is, you probably want to stay right there.

If you have a Medicare Advantage Plan, you should know that Medicare advantage plans are now going to be paid by Medicare to provide prescription drug coverage and so the prescription drug coverage you currently have with your Medicare Advantage Plan is going to be enhanced and if you are happy with your plan, you should probably just stay right with your plan and you do not have to make any decisions.

With respect to the dual-eligibles, I think that the concern that Aileen expressed is a concern shared by people throughout the government, as well as many of the advocacy community and CMS is committed to doing whatever is possible to make sure that these people know that they are being transitioned into Medicare. That is why there is this auto-

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enrollment period or auto-enrollment of the dual-eligibles.

LARRY LEVITT: Could you explain the auto-enrollment just briefly what has happened?

JULIE GOON: Sure. For every Medicare beneficiary who is dually eligible for Medicare and Medicaid, CMS is going to randomly assign them to a plan that they will not have to pay a premium in, that all of their costs primarily are covered and if they do not choose a plan on their own between when open enrollment starts on November 15th and when coverage starts on January 1, that auto-enrolled plan will be their plan until they decide to move out of it. We did that so that those folks would not fall through the cracks.

Now having said that, we all have a lot of work to do to make sure they understand the plan that they are in and how getting drugs is going to work for them.

LARRY LEVITT: Tricia, let me bring you in. The Foundation has been tracking public opinion on the Medicare drug benefit over a period of months, both among seniors and the general public. Give a sense of how that public opinion is shifted over in recent months.

TRICIA NEUMAN, Sc.D.: One of the striking things that we found is that the unfavorables about the Medicare drug benefit have gone down since the law was passed and we are not sure why that is true. We all have our own theories. It could be that it is really no longer a partisan issue, it is the law.

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It is a new benefit that is going into effect, so people are not talking as negatively about it and it could be the result of more positive messages coming from CMS, but people are now today about as favorable as they are unfavorable and that is a big change and I think it is an important step and maybe opens the door to at least people being more open to finding out how the benefit is going to work for them.

There is still some troubling news in terms of I think seniors really haven't quite tuned in, which is maybe consistent with what Aileen is saying. And consistent with it being early in the process, most seniors say they really don't know much about this drug benefit. They either don't know much at all or they don't know very much. It is about time for that to shift and maybe with the handbooks going out and the ads that they will see TV and Parade Magazine and all the other activities, that will start to change. But it still seems to us that people have not quite checked in and do not understand what is coming their way.

The other result that I think is important to at least pay attention to is that at this point, only 22 percent say they plan to enroll. That is actually an increase, which is again a promising finding, but that is not enough. That is a number that we would like to see rise in the next several months because we need more people to sign up, both to make the program stable and to keep the premiums affordable, so that is

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something else we will want to keep a close eye on.

LARRY LEVITT: And Julie, what is the CMS estimate of how many people you think may enroll?

JULIE GOON: I do not remember what the exact estimate is. I think when the bill passed, there were fairly high estimates of the number of people who would join early on. And I think that Wall Street analysts have also estimated that somewhere between 28 and 32 million people would join in the initial years.

But having said that, I think that is also counting those people who have retiree coverage and that coverage is considered creditable. Their employers will receive a subsidy from the government, so you count that whole, what is estimated to be about 10 million beneficiaries into that number. You count all six million of the Medicare Advantage beneficiaries, assuming they stay with their current plans. You count the six-plus million dual-eligibles as being enrolled.

LARRY LEVITT: Who will automatically be enrolled?

JULIE GOON: Right, who will automatically be enrolled. Social Security Administration, along with CMS, has been doing a very aggressive job in trying to find other people who would qualify for the extra help or the low-income subsidy. They did a mailing that started in late May and continued through the summer and recently announced the initial results of that mailing and I think they have received a fairly high number of

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applications – three million – which, if you do mailing work, you know that that's a really high response for a direct mail piece. Based on that, some of the analysts in New York have increased the number of people they think will enroll in the early goings.

There is a term I never knew, called "viral marketing" and I think that it is as things happen, it spreads out even more. And we found that as we have been doing a lot of the visits we have done over the summer with the Secretary and with Dr. McClellan that more and more people are hearing about it and that is reflected in the Kaiser Family Foundation's polling work. And I think as people start talking to each other, as they see the choices that are available in their area, as they talk to their friends, their family, their neighbors, we will see more of this interest level pick up. And that is, in part, why we are encouraging a national conversation.

The way seniors make decisions is different than the way you think about choosing groceries or choosing a car. And there is a lot of conversation that goes on between a Medicare beneficiary and their children, a Medicare beneficiary and their neighbors, a Medicare beneficiary and somebody that live next to you in a nursing home. So we really want to focus on this idea of everyone becoming educated about the changes in Medicare so we can all have those kinds of conversations with our family and loved ones.

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LARRY LEVITT: We have lots of questions from viewers. I want to make sure we get to them. We have a call on the line from Florida. Caller, please go ahead.

FEMALE SPEAKER: Is this to me?

LARRY LEVITT: Yes.

FEMALE SPEAKER: Okay. My question is that when a person purchases a card through one of the manufacturers, isn't that the way that you purchase a card, through a drug manufacturer?

LARRY LEVITT: Yes.

FEMALE SPEAKER: Okay, then the only medications that that person can receive on that card are the ones that this manufacturer manufactures, is that correct?

LARRY LEVITT: I think we can help clarify. Thanks for your question. Tricia, maybe you can help explain this. Before the drug benefit has gone into effect, there was a discount card program and also several discount cards available through drug manufacturers. The Part D benefit is actually quite different from that. Maybe you can explain how roughly it will work.

TRICIA NEUMAN, Sc.D.: Right. Today, before the drug benefit goes into effect, there are different types of cards and programs that are available to people. There are these Medicare-endorsed discount cards, there are other discount cards that are not even related to Medicare and then there are

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also cards or programs that are sponsored by some of the pharmaceutical companies and they typically are for products that they themselves produce and sell, although there are some consortiums of pharmaceutical companies that sell all of their products.

That is really very different from the Medicare drug plans that will be available in 2006. Those will generally be offered by insurance companies, rather than the pharmaceutical companies and they will be required to provide drugs that are not just from one company, but from a variety of companies. So that is a really different kind of product and it would be important to look for these new plans when they become available and you can enroll beginning in November.

LARRY LEVITT: Julie, this actually relates to a lot of e-mails we received about drug formularies and which drugs will actually be covered. I think it is worth just getting the basics out there first, and explain what a formulary is and what the basic rules are about what plans have to cover and what choices they have about varying the benefit and the list of accrued drugs.

JULIE GOON: Most insurance coverage now for people who are employed or under 65, provides what is called a formulary, which is a list of drugs that are preferred by the insurer that is providing the coverage within that benefit package. Those formularies generally are an indication of where your cost

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sharing for a drug is lower, rather than if you need a drug that is off the formulary.

LARRY LEVITT: You mean different tiers?

JULIE GOON: Different tiers. Sometimes generics are cheaper than brand, preferred brands are cheaper than non-preferred brands. And insurance companies over the last several years had developed formularies that are set up in a way that help them manage the drug benefit that they are providing to people.

There was a lot of concern when this legislation was going through Congress that the prescription drug plans that were going to be offering these benefits to Medicare beneficiaries have formularies that were adequate and fulsome, covering the needs of a senior and a disabled population. One of the provisions of the law was that an outside organization, called US Pharmacopeia, was required to come up with a list of categories and classes of drugs that if a prescription drug plan provided at least two drugs in each of the approved classes and categories, that formulary would be considered a formulary that pretty much meant the standards that were laid out by the government.

All formularies that the prescription drug plans have developed have to be approved by CMS. Those formularies were sent into CMS early on in the bidding process, so the agency had a chance to review those formularies, make sure that indeed

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they covered at least two drugs in every class and category, ensure that the formularies are required not to be discriminatory, so you can't pick drugs in a formulary that will then allow you to target your marketing to certain kinds of beneficiaries rather than other beneficiaries.

And in fact, we required that plans cover all drugs in six particular classes. And I am probably going to miss some of the six, but it is anticonvulsants, antipsychotics, antidepressants, anticancer drugs, immunosuppressant drugs...

LARRY LEVITT: AIDS drugs.

JULIE GOON: And AIDS drugs – thank you very much. So all the formularies cover all drugs in those six classes. Additional – and more of this information is becoming available as the benefit packages become available – we did take a look when we put out the round of information we released last weekend, on average, the prescription drug plans are covering at least 87 of the top 100 drugs used by seniors. That is an average, but that is an indication that people are being very serious about how they are putting their formularies together.

In addition, the beneficiary, the beneficiary's physician, will have the opportunity to appeal any decision about a drug. If someone wants a drug that is off the formulary and that is not approved, they will have the opportunity to appeal that decision. I know for dual-eligibles, there has been a lot of concern that if people are

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already stabilized on a drug regimen, that they would be allowed to continue on that regimen and there are transition policies in place to ensure that.

AILEEN HARPER: If I could address a couple of points that she made. First of all, I am pleased that the formularies do appear to be broader than we thought they might be. But there are a couple of concerns that I think advocates have. One is that even the beneficiary who does their homework and looks very carefully and selects a plan that they think is best matched in terms of formulary coverage, midyear plans can make formulary changes.

LARRY LEVITT: And how often? We got a number of questions about that.

AILEEN HARPER: I believe the formulary – you can correct me if I am wrong Julie – can't be changed obviously during the open enrollment period, but I believe it is two months after the open enrollment period ends, I believe they could potentially make changes.

But assuming let's say a plan does make changes and a beneficiary needs something that now is no longer on the formulary, there is the exception and the appeal process, but our experience in terms of working with beneficiaries is that most beneficiaries do not use the appeals process very well. And so I think using the exception process and the appeals process is going to be difficult for a typical beneficiary.

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Because if you look at the statistical data, you will see that most Medicare beneficiaries do not really use the Part A and the Part B appeal process that frequently. And so I think it is, in the ideal world, we would hope they wouldn't have to use it.

With regard to the dual-eligibles, yes, hopefully there will be a transition period and CMS wants the plans to cover the drugs for the duals during the transition period, but it is not mandated. So hopefully they will both do so.

LARRY LEVITT: Tricia, go ahead.

TRICIA NEUMAN, Sc.D.: I just want to make one point because there has been a lot of attention to formularies in terms of what drugs are covered on the list and that is obviously an essential question. But another question that is going to be important to people as they are picking plans, is what do they pay for the drugs once they are on the list. And it is almost impossible right now to provide any information about that. We have looked at a few of the formularies that the plans...

LARRY LEVITT: And this gets back to the tiers that Julie was talking about.

TRICIA NEUMAN, Sc.D.: ...have posted and there really is considerable variation because some plans may or may not require you to pay cost sharing in the deductible period and then once you are in the initial benefit period, you may pay a

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tier one, a tier two, a tier three, which could range from five to sixty dollars or seventy dollars and sometimes it might be expressed in terms of coinsurance, so it is an important thing for consumers to look for because it will really effect the bottom line in terms of what they pay when they choose a plan. And it may or may not be so easy to make these apples to apples comparisons.

JULIE GOON: Just to add to the discussion, I think that there are – and I completely understand that beneficiaries are not necessarily used to using an appeals and exceptions process – but there have been safeguards built into that as well, so that a beneficiary or their physician or their authorized representative can go to expedited appeal and actually very quickly work through a redetermination of an adverse coverage decision.

And I think I completely agree with Tricia, people are going to need to look at that cost sharing and whether it is expressed in terms of coinsurance or whether it is in terms of this tiering, whether it is just a set copayment, depending on the tier you are in, will probably make a big different in how people think about their out-of-pocket expenses.

LARRY LEVITT: Julie, we also got question from a doctor in North Carolina. It stands for reason that beneficiaries will rely a lot on their doctors and pharmacists for information about the benefit. Are there efforts to help

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doctors understand these formulary issues and be able to help beneficiaries compare different plans and understand what is on the formulary and what is not?

JULIE GOON: Doctors and pharmacists are the two groups of people that come up as the most trusted sources of information for Medicare beneficiaries and what we found – and we have done extensive outreach to both of those groups of folks – is that physicians want to feel comfortable with the program and the benefit overall and they want to feel comfortable with directing their patients to where they can go to get further information. But they don't necessarily have the time or the resources to actually help a beneficiary determine which plan is absolutely right for them and in fact they are not allowed to actually enroll beneficiaries in a plan.

So the work that we have been doing with the physician community has been very focused on making sure they know where to get more information, where to direct their patients to, making sure they have easily understandable materials available in their office. We have arranged for continuing medical education credit for physicians who want to learn more about the drug benefit and have provided a whole series of what's called "Medlearn Matters" articles through the part of this CMS organization that is very specifically directed to physician education.

The pharmacists, we have been working very closely with as well. And they actually got started in a lot of outreach and awareness work when the Social Security Administration started their outreach effort to try and find people that will qualify for the low-income subsidy. And many of the pharmacists and the drug stores helped with trying to identify people who would qualify for this. And so they have been extensively working to try and both identify those beneficiaries and help them learn more about how this benefit is going to work.

LARRY LEVITT: And where should physicians or pharmacists go for information?

JULIE GOON: Definitely go to cms.hhs.gov, yes. They can call 1-800-Medicare as well, but all the materials that we are providing are right on cms.hhs.gov. There is a partnership website and within that, there are specific areas directly designed for the physician community and for the pharmacist community.

LARRY LEVITT: We have another caller on the line from Alabama. Caller, please go ahead.

MALE SPEAKER: I was wondering, how does this new drug benefit impact the ADAP programs?

LARRY LEVITT: Thanks for your question and it was a very common question in the e-mails we got as well. And Julie, I hate to keep coming back to you, but maybe you could start.

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ADAP programs are Aids Drug Assistance Programs run by the states for people with AIDS. And maybe give a sense of how the benefit will interact with existing ADAP programs.

JULIE GOON: This is one of those questions that I am probably going to fail to give a fulsome answer to. We have divided up our outreach efforts so that there is a specific outreach effort targeted towards the AIDS and HIV community and we have been working very closely with the advocacy community in those areas to ensure that these programs do work very well together. And we have been working on materials specifically directed to that community. I can certainly get back to the caller with a lot of information about how that ended up, but I am probably not going to be able to be much more specific than that. I apologize.

LARRY LEVITT: And how about generally, because we also got a lot of questions about how the drug benefit will interact more generally with other programs, whether it is existing state pharmacy assistance programs that exist in many states.

JULIE GOON: We have been working extensively with the states to try and make sure that those interactions are as seamless as they can possibly be. I think it is fair to say that we have worked out most of those issues in most states and there are still some other states where we are continuing to work with the states to try and refine the details of how these things are going to work together.

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LARRY LEVITT: So many of these programs you think will still exist?

JULIE GOON: Oh yes, definitely. I think what a lot of states are looking at is using their state pharmaceutical assistance programs to wrap around the standard coverage and to fill in the gaps that are available in standard coverage.

LARRY LEVITT: So that might be the deductible or the donut hole.

JULIE GOON: Exactly. The deductible, the so-called donut hole, the cost sharing, they can use the resources that they previously dedicated to helping people purchase drugs to actually fill in the gaps in this kind of coverage. And we are hopeful that we will finish work with all the rest of the states in time that all this is worked out.

TRICIA NEUMAN, Sc.D.: You know getting back to the ADAP question, one of the differences in the way the law treats certain programs with which the Medicare drug plans coordinate, with the ADAP programs, state programs can coordinate and pay what the Medicare prescription drug plans do not pay, but the amounts that they have paid do not count against an individual's true out-of-pocket expenditure limit. So it does not help the beneficiary reach the catastrophic benefit. That is a little bit different from the way the state pharmacy assistance programs are treated because the amounts that the states pay will count toward the true out-of-pocket limit.

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JULIE GOON: That's exactly right.

TRICIA NEUMAN, Sc.D.: A slightly technical point. [Laughter]

LARRY LEVITT: We have the caller from Alabama who wanted to ask a follow-up. Sir, please go ahead.

MALE SPEAKER: Also I was wondering, I had heard that Medicare Part D was not mandatory and that you did not have to go over to it if you did not want to or if you chose to stay on the ADAP program.

LARRY LEVITT: Sure, thanks. Julie, I am sure you have heard this question a lot.

JULIE GOON: And the caller is absolutely right. The Medicare Part D program is a voluntary program. People have the choice as to whether they want to sign up for it or not. I think it is important for people to know that if you do not sign up for it when you are eligible, and initially that is in this first open enrollment period between November 15th and May 15th, and you don't have creditable coverage, or what is called "creditable coverage...

LARRY LEVITT: That is coverage that's at least as good as...

JULIE GOON: ...coverage at least as good as Medicare Part D, and then you decide several years down the road that you do want to join, you will pay more in premiums the longer you wait, just like any other insurance program. And actually

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it is just like Medicare Part B, the physician part of Medicare – you pay more for Medicare Part B coverage if you do not sign up when you are initially eligible.

LARRY LEVITT: How much is the penalty?

JULIE GOON: The penalty is one percent added on to the premium for every month that you do not join.

TRICIA NEUMAN, Sc.D.: And initially that is not very much, but if you wait a couple of years, that can really add up and it is a penalty that you would pay permanently for as long as you are in a prescription drug plan. So for people who are now eligible to sign up and do not have comparable coverage from another drug plan, it probably makes a lot of sense to think about signing up because the penalty could get quite steep over time.

JULIE GOON: And that is why I think we are encouraging people not always to just think about what they are spending on drugs right now and seeing if this is a good deal for them, but to think about what their needs may be over the whole period of time that they are a Medicare eligible beneficiary. You may be a perfectly healthy 68-year old or 70-year old, but you do not know what you are going to be like at 85. And I think that is one of the good things about having the variety of plan choices that we have because there are plans that provide the standard coverage so you will be considered as having comparable coverage at a fairly low premium in every state in the union,

and it is worth thinking about signing up for that just to make sure that down the road when your health needs change, you have that coverage.

LARRY LEVITT: Aileen, do you have a sense that the issues of this being voluntary versus mandatory and the penalty for late sign up?

AILEEN HARPER: There is a lot of reaction among the beneficiary community about that. I think, as both Julie and Tricia have mentioned, there is a penalty for late enrollment in Part B and Part A in fact. I think people understand that, yes, there is a penalty. I think they see it as a punitive thing. Whenever someone has to pay more money, obviously they do not like it. So I think some people, particularly middle income older adults, may look at, in terms of a cost benefit, might say, "Well if I wait, don't enroll, am I better off, let's say if I do not have high prescription drug costs now in terms of the penalty." I think the penalty the first year is 36 dollars, let's say for a full year's worth. So that doesn't seem like a lot of money, but as Tricia said, it does add up. I think the reaction though for beneficiaries is more like a little bit of resentment though in terms of the penalty.

JULIE GOON: It is interesting because when we first started doing marketing research at CMS about a year ago, all the focus groups said, "Don't talk about this penalty. Just say you will have to pay more, but don't call it a penalty."

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And that is where our materials initially started out. About four or five months later in the spring, we went back and did focus groups again and basically people were a little resentful of the fact there was a penalty, but they said, “You got to tell us there is a penalty because this is a motivating thing.” So they are resentful, but it does motivate people.

AILEEN HARPER: It is a reality check.

JULIE GOON: Yes it is.

LARRY LEVITT: We got a number of e-mails about this one as well and one from a report in Florida that is related, that has to do with enrollment in Medicare Advantage Plans, which are private HMOs or PPOs that offer comprehensive coverage under Medicare. And he asks whether if someone does not sign up for Part D now, but then later wants to enroll in a Medicare Advantage Plan with drug coverage, would they be subject to the penalty as well?

JULIE GOON: Yes. That is absolutely right, you still would be. The Medicare Advantage Plans have to offer Part D coverage, but Part D is still voluntary. Some Medicare Advantage Plans are providing coverage without Part D for those people who do not want to join Part D right now. So the penalty will still apply if you join a Medicare Advantage Plan down the road and you have not signed up for Part D when you initially become eligible.

LARRY LEVITT: And Julie, could you explain this choice

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a bit for people between enrolling in a PDP, a prescription drug plan, versus enrolling in a Medicare Advantage Plan and what that choice involves.

JULIE GOON: The standalone prescription drug plans are the way to get Part D coverage if you want to stay in traditional Medicare. And traditional Medicare is what the vast majority of current Medicare beneficiaries are in right now. Medicare Advantage is a program that has been around in the Medicare program I think since the early 70s as a way for people to receive comprehensive Medicare coverage through a coordinated care plan, which for many years of its history, has been primarily HMO coverage. The Medicare Modernization Act also put a premium on - that's probably not the right way to say it [laughter] – also had a goal of expanding the Medicare Advantage Program to include a lot more PPO coverage. And PPOs are the way most Americans receive their health coverage in the employed market now. And as a result of provisions in the Medicare Modernization Act, we have seen enormous growth in the Medicare Advantage Program already, both in terms of the kinds of plans available so that most beneficiaries now have access to a preferred provider organization.

LARRY LEVITT: And that is across the country?

JULIE GOON: Across the country, except in Alaska and Vermont. Those are the two states that do not have Medicare Advantage Plans available.

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One of the provisions of the MMA called for regional preferred provider organizations and those are fairly extensive as well and even in states where there are not regional PPOs, we found that some of the local PPOs or HMOs have expanded their service areas to be statewide. So there are I think 44 states where 100 percent of Medicare beneficiaries have access to a Medicare Advantage choice now, which is a huge change from the way we were with this program just a few short years ago.

And in fact, if you are familiar with the Medicare Advantage Program, you know that many Medicare Advantage plans in certain parts of the country had zero premium; provided plans with zero premium for your Part A and Part B coverage. Some bought down the traditional Part B premium as well. And we are finding now that 70 percent of all Medicare beneficiaries will have access to a Medicare Advantage Program or choice that has a zero premium for Part A, Part D, and in many cases, for Part B as well.

LARRY LEVITT: So this is a plan that might cover more benefits than traditional Medicare and drug coverage and still have zero premium?

JULIE GOON: Absolutely. More benefits, zero premium, lower cost sharing, also the drug coverage. It is really worth having people take a look at it.

AILEEN HARPER: Larry, I wanted to add a comment about the MAPDs and that is, even though the number of Medicare

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beneficiaries in MA plans is still small, I think that the new Part D program is going to result in an important change for beneficiaries in these plans and that is the lock-in. We had lock-in briefly. I think it was in 2003 – lock-in has been brought back.

LARRY LEVITT: And could you just explain?

AILEEN HARPER: So sort of a short version. Basically the way it works is when a Medicare beneficiary is in a Medicare Advantage Plan, generally a Medicare HMO essentially all their Medicare benefits, A and B, are received through the HMO and they are locked in, meaning they have to receive all the services through the plan providers unless it is an emergency or urgent care situation.

With the MMA and the new Medicare Part D program, lock-in has been brought back, so sort of a simple description of it is that when someone is in an MAPD as of January 2006, they are going to be in the plan for the balance of the calendar year. They have an opportunity during I think the open enrollment period to make one change. But pretty much they are in. And this is a very, very big change for beneficiaries in these plans who are used to monthly enrollment/disenrollment.

In our county alone, there is more than 30 percent of our Medicare beneficiaries who are in MA plans currently. And the reason why it is so important is that people unfortunately vote with their feet when they are having a problem in an MA

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plan. They get out. They do not go through the appeals process even if that is maybe the best way to do it. And I think with the change to the MAPD model with lock-in, this is going to be a tremendous change for these people because they will not be able to get out when they are experiencing a problem. They will have to use the appeals process and some will use it successfully, some will not.

LARRY LEVITT: And if I could just summarize just to make sure. If you enroll in a Medicare Advantage Plan, a HMO or PPO, you will be locked in for a year.

AILEEN HARPER: That's right.

LARRY LEVITT: Drug plans are also locked in for a year, even if the formulary changes throughout.

AILEEN HARPER: That's right. But with the MAPD, it is more serious because everything is within the plan.

TRICIA NEUMAN, Sc.D.: That's not necessarily just having a problem with your plan. If you develop some kind of an illness and you are in a more tightly managed plan and you want to go see a certain doctor or go to a certain hospital, one of the tradeoff you make when you sign up for a managed care plan is that you will go to their network of providers. But if you get sick, your circumstance may change and with the lock-in, you are really not free to drop out of that plan and go to any doctor you choose.

So there are tradeoffs to be made in making the

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decision about traditional Medicare versus a managed care plan. It does look like there are going to be a large number of very low, no premium plans, which will make it very appealing to people who are making the decision solely on the basis of their pocketbook. But other factors could be important too.

JULIE GOON: That is why I think it is important for those beneficiaries to take a look at these new PPO options as well, because those are looser networks of providers and the ability to go outside that network if that is important to the beneficiary is going to be more readily available than it had been in the past.

The lock-in came about, as you mentioned, because the decision was made that once people chose a prescription drug standalone plan, they would be locked into that coverage and so correspondingly on the other side, the Congress and its wisdom felt it was necessary to also lock people into the Medicare Advantage Plans. And that is the way typically employer insurance works for those of us in our own jobs. Once we choose a plan, that is our plan for the year. And that is more of a problem I think for the aging part of Medicare than it is for those people who are aging into Medicare right out of the workplace.

I did want to get back to – you had mentioned earlier that people could change their formularies mid-contract year. I did want to make sure that people understood that if a plan

does want to remove a drug from its formulary, they do have to notify their beneficiaries, they have to provide I think it is 60 day's notice, and they also have to have that change approved by CMS. So CMS will be looking at the changes that prescription drug plans want to make to their formularies, and if you look at the prescription drug discount card experience, it was only a short 18-month program, but people were very worried that those discount cards were going to be dropping drugs off the formularies and we did not find any evidence that that happened in any significant way whatsoever. We are hopeful that with the checks and balances on the formularies that we also won't see a problem with the formulary changes.

LARRY LEVITT: We do have another question on the line from Virginia. Caller, if you are still there, please go ahead.

FEMALE SPEAKER: I was thinking about the appeals process and the fact that you have already cleared up and you said in terms of barriers to this. I want to know who is going to help with the appeals process for people that have disabilities. I know that Social Security here in Virginia had said that they were coming out and they would do classes for people. I want to know if Social Security people are going to be able to help people with the appeals process.

LARRY LEVITT: Thanks for your question. Aileen, I am guessing you are going to be helping people with appeals.

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AILEEN HARPER: Yes. I think the caller is bringing up a very important point, which is the appeals process that beneficiaries are used to with Medicare Part A and Part B, generally the appeals are done through either you can file them through the carriers and then you can even file them through Social Security. Social Security will have no involvement in Part D. So in terms of the appeals, the appeals process initially will be through the plans themselves, and then at later stages, through an independent review entity and then later on you have additional appeal rights.

But she brings up a very important point, is that I think sometimes beneficiaries are used to certain entities as the locations where they go for an appeal, like Social Security and those entities won't be involved. The SHIPs will be involved in helping people with the exceptions and with appeals. Other legal services, other advocacy groups out there will as well. And we will see what happens. I mean hopefully people will not be requiring a tremendous amount of help in terms of requesting the exceptions and appeals.

LARRY LEVITT: Julie, you had mentioned earlier where people could go to get more information. Do you have listings of, for example, the State Health Insurance Assistance Programs by state?

JULIE GOON: Yes we do.

LARRY LEVITT: And those are also on the website?

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JULIE GOON: They are on the website, they are in *Medicare and You* in the handbook, they are available if you call 1-800-Medicare. 1-800-Medicare can direct you to those SHIP programs as well.

AILEEN HARPER: Larry, to sort of go to the role of the SHIPs, I think the SHIPs will play a very, very critical role, as well as other partners. But I think we have to be cautious here too because our SHIP I think has good infrastructure, we have a strong staff core, as well as our volunteers, but many other SHIPs are volunteer-based in terms of services. So I think that if there is a tremendous demand for help and assistance directed to the SHIPs in addition to the 1-800-Medicare hotline or using the website, I think it is going to put a tremendous burden on the SHIPs. And I think we will want to respond to it. But I know our agency cannot take hundreds of calls a day. We are just not set up to do that.

LARRY LEVITT: How many calls do you get?

AILEEN HARPER: Right now, we are actually increasing our call volume from about 36 calls to 72 calls per day.

LARRY LEVITT: And this is for all of Los Angeles?

AILEEN HARPER: That is for all of Valley Canyon with one million Medicare beneficiaries, so you can see we are hitting the tip of the iceberg. But what I do want to say too is that we also do not want to lose our capacity to respond to other Medicare problems. Part D is just a part of what we are

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doing here and people have other Medicare-related issues, sometimes very serious issues, and so if we are dealing with this tremendous onslaught of Part D, that is less resources unfortunately for other very important Medicare issues too.

LARRY LEVITT: And Julie, at CMS, if you find that there is a need out there for more information in the community, are there ways CMS can respond to that?

JULIE GOON: I sure hope so. [Laughter] We have made such a concerted effort this year to try and do exactly that and to really be as locally-based as we possibly can, working through our regional offices, working through the states, working through local communities, working through all sorts of partners that, in many cases, we don't have financial relationships with them, these are just advocacy groups who, this is a part of their mission and it is important to them to serve their constituencies that way.

Again, 1-800-Medicare - if you remember the experience with the drug discount card with 1-800-Medicare and with our website, volume on that number and on that website went up considerably when the drug discount card program started. A lot of that was from reporters. A lot of that was from advocacy groups. But a lot of that was also from beneficiaries and we plan for and are stepping up the resources that we made available to the 1-800 number as well as to the website to ensure that we can take care of those things as much as we

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possibly can, and have increased the resources that have gone out to our regional offices. I think Congress provided for additional funding for the SHIPs for the last two years and I think all of us are hopeful that that will continue as well.

LARRY LEVITT: There were a lot of questions about dual-eligibles, people eligible for both Medicaid and Medicare. So I want to turn to a couple of those that we got by e-mail. One woman from New Jersey lays out a scenario where someone, for whatever reason, is auto-enrolled into a plan, but does not realize this, whether it is through cognitive impairments, illiteracy or what have you. January comes and this beneficiary goes to fill his or her prescription at the usual pharmacy and finds out that pharmacy is not in the network of the plan that he or she has been auto-enrolled in. Aileen, what happens at that point?

AILEEN HARPER: That is a very, very good question. What I understand from CMS is that they say that ideally speaking, the pharmacy, I suppose if he is hooked up to the Part D network or information system, should be able to identify that Part D plan that this person is enrolled in. But I think what the person who sent the question in is identifying is something that very likely is going to happen, where there are people who are not going to read, unfortunately, the CMS auto-enrollment letter. In our state, our Medicaid program is doing a really great job of trying to send out additional

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mailings as well, but some people are just not going to get it, even if they do get it.

And I think that those people may encounter some serious problems in terms of getting their medications filled in the immediate term. Now I know that there is some transition coverage, but how long is it going to take for that person to hook up with their Part D provider, with the right Part D provider. What if it is not on the formulary? For us, a day or two may not sound like a lot, that could make a huge difference.

TRICIA NEUMAN, Sc.D.: My understanding – and Julie correct me if I am wrong here – is that there is supposed to be a system placed in all the pharmacies that would connect people to their plan to which they have been auto-assigned. One of the concerns though is that there just could be a data glitch. We are talking about six and a half million people in all 50 states and states are working very hard with CMS right now to make sure that their data systems match.

But there is a worry at least that there could be people who fall through the cracks and concern that when people come to the pharmacy in January, the pharmacist will look up their plan and say, "Gees, I am sorry Mrs. Smith, I do not have you listed" in which case she leaves the pharmacy empty handed. And I know one of the ideas that has been floating around is, is there a realtime place where somebody or the pharmacist can

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call that says, "Here is somebody who showed up with her Medicaid card. I don't have her listed in a Medicare plan. I need to fill her prescription or she is going to have a huge problem. What can I do?" And I think CMS has been trying to think about what it is they can do on a realtime basis.

JULIE GOON: Yeah. I think you are absolutely right. Number one, first to the respect to the pharmacist being hooked up in an electronic way to information that hopefully will have all of those beneficiaries and the plans that they have been auto-assigned to listed so they can help that person when they walk into that pharmacy.

In addition, there is a lot of work going on to test those systems. I think that is probably everybody's biggest worry is that there will be a systems glitch on day one of this program. So there is a lot of testing and a lot of retesting and a lot of trying to account for any possible glitch that could happen. And in addition, people have been thinking about ways that they can, beyond the transition requirements that have been placed on the plans, do something with respect to helping out this situation where someone needs immediate access to drugs and they clearly were Medicaid eligible and there is trouble finding out who their new plan is. People are definitely working on that. So I can't tell you what the answer is, but I can tell you that people are aware of that problem and are working very hard to solve it before we get to

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January 1.

LARRY LEVITT: And Julie, just to clarify, there is a transition period in which these dual-eligibles can also switch plans out of which plan they may have been auto-enrolled to.

JULIE GOON: Absolutely. In fact, dual-eligibles are the only category of beneficiaries that can switch plans on a regular basis. They are not locked in.

AILEEN HARPER: Right, they have monthly enrollment/disenrollment.

LARRY LEVITT: We also got some similar questions from providers, concerned about how they are going to deal with all this, and one from a community health center in California, who is wondering about dual-eligible beneficiaries who are coming to the health center now and getting prescription drugs at that health center. Once that person enrolls in a plan or gets auto-enrolled into a plan, is there any way the health center can get reimbursed for the drugs that are provided to that person anymore?

TRICIA NEUMAN, Sc.D.: I think it would depend on the pharmacy being in the network of the plan. If the pharmacy is in the network, yes; if the pharmacy is not in the network...

LARRY LEVITT: And there is no guarantee that the pharmacy will be in the network.

TRICIA NEUMAN, Sc.D.: That's right.

JULIE GOON: It provides an incentive for the health

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center to look at being in the networks of people who they are going to be...

AILEEN HARPER: But it does put that provider in an awkward situation in that let's say the person is one of these people that does not know their Part D plan, they seem to be really lost. Let's say they have been out of their meds for a few days or a week or so. They go to the provider and say, "Can you help me? Can you give me some medication?" If they are not a network provider, they are going to be in a very tough dilemma.

TRICIA NEUMAN, Sc.D.: I think it speaks to an issue that a lot of providers are going to face generally. Because there are rules that limit their ability or prohibit them from steering people to certain plans, that it is highly likely that their patient, whether they are coming to a pharmacist or a physician or a nursing home administrator or a clinic operator for help in choosing a plan. And they have conflicts of interest that they need to worry about, but they also want to help their patients. And that is something that needs to be monitored very carefully.

JULIE GOON: And I think we have been fairly clear that it is perfectly appropriate for a provider to let a patient know what plans that they are in a network of so that is the kind of information that would make a difference to a beneficiary.

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LARRY LEVITT: So someone could walk into a pharmacy and ask, "Are you in this plan?"

JULIE GOON: Absolutely, right.

LARRY LEVITT: We also have a caller on the line from California. If you are still there, please go ahead.

PAUL SMITH: Hi. My name is Paul Smith. I was hoping the panel could address the following issue: Given lock-in, how, from both the patient and the provider's point of view, how do institutionalized patients get or receive their drugs? Or how do institutions get drug for these patients?

LARRY LEVITT: Thanks for your call. Certainly Julie, we are talking about the elderly and the disabled, so many of them are in institutions like nursing homes. What are the rules? Are there special rules?

JULIE GOON: There are special rules for people who are in long-term care facilities. And the plans will require to make sure that the folks that they enroll who are in long-term care facilities have convenient access to prescriptions in a way that they are used to doing it. And so there are all sorts of special categories of how the plans are required to deal with the – in many cases, there are pharmacies available in the long-term care facility.

And at the same time, not penalize a beneficiary who is in a long-term care facility by forcing them to get their medications that way, but also requiring the plan to make

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arrangements with its pharmacies outside the institution so that they also are packaging drugs in a way that someone in a long-term care institution is used to getting them.

AILEEN HARPER: And just to clarify for the caller, institutionalized elders are also not locked in. They have an SEP for the monthly enrollment/disenrollment. And actually they are the only population that CMS says that plans do have to provide emergency coverage if the drugs are not on formulary.

TRICIA NEUMAN, Sc.D.: But there are rules that are slightly different. There are special provisions for people in nursing homes that do not apply to people in assisted living facilities and board and care facilities.

AILEEN HARPER: That is correct.

TRICIA NEUMAN, Sc.D.: I think this is an important area to watch. There is another issue about just choosing a plan for people who are in nursing homes. Those who are dually eligible for Medicare and Medicaid will go into a plan because they will be assigned to a plan, but there is a question about what other folks who are in nursing homes will do if they don't happen to be on Medicaid and who will help them choose a plan and the same would be true for assisted living facilities.

LARRY LEVITT: We did get a number of questions about who can act on a beneficiary's behalf. If someone is institutionalized, can their family act on their behalf? Can

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the nursing home act on their behalf to help them sort out which is the right plan for them and help them enroll?

AILEEN HARPER: I think that is an important question. Obviously if someone has the Power of Attorney, they have the right to select a plan, but then beyond that it starts getting fuzzy in terms of – Tricia has already mentioned that frequently these people don't have anybody. They may not be incompetent, but they may be a little bit confused.

And so if they are pretty isolated – we see a lot of older adults, whether they are in assisted living or residential care and they really do not have a support network. They don't have close family, they may have some friends, but they may not want to be put in that position in terms of helping select a Part D plan. So I think it really does bring up a very important point, is these people could sort of get lost in all this in terms of selecting a Part D plan.

TRICIA NEUMAN, Sc.D.: And I guess those are folks who are in nursing homes and assisted living facilities and they at least have the advantage of being in a place with other people. There are an awful lot of people who are getting care at home, who are comparably frail or maybe cognitively impaired and that is a group of people who will need a lot of help choosing a plan and getting their drug coverage.

JULIE GOON: I think all of this underscores why it is so important that everybody learn about the changes to the

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Medicare program, not just people who are Medicare-eligible. This is the biggest change in Medicare since the program started in 1965 and at that point in time, there was no Medicare system. And so the government had to go out and educate people just about the fact that there was going to be a healthcare system for them. At that time, there were only approximately 20 million people who were eligible for Medicare. There are 42 million people eligible for Medicare now. And I think it is incumbent upon all of us to learn what we can so we can help our families and the people that we know make a decision about this.

LARRY LEVITT: And Julie, could you just repeat – I am sure you can't repeat it enough – but where people can go for information, the phone number and the website.

JULIE GOON: Yes absolutely. You can get more information at 1-800-Medicare and you can get more information at www.medicare.gov and you can get information from www.cms.hhs.gov. And that is probably more useful for advocacy groups. But all the Medicare information is right there on medicare.gov. And we encourage people to check this out.

LARRY LEVITT: We are coming to, amazingly enough, the end of the hour. And we have answered at least some questions I think that people have, though I am sure there are more.

Julie, let me - to help wrap this up – clearly there are a lot of challenges that you all have faced and will

continue to face. Give us a sense looking forward over the next several weeks and months, what keeps you awake at night? What is your biggest worry and what is the biggest challenge you all still face?

JULIE GOON: I think a lot of us have been raised on this program today. I think we are all very, very excited about how this has been going to date. As you mentioned at the very beginning of this program, implementation has been proceeding on time, the news that keeps coming out is better than people expected, both in terms of the costs of the plans that are available, the fact that plans are filling in some of the holes in this coverage that had people very concerned.

So I think things are proceeding at pace and we just need to make sure that we get the word out as far and as wide as we can and help people understand that this is really something to take a look at. They don't have to rush to judgment. They need to sit down and think about it and they need to think about it from the perspective of what will give them peace of mind over the period of time that they are in Medicare because this is an insurance program and it is a little different than what people have been used to in Medicare. I think we are all very concerned about what happens January 1 and trying to identify possible things that could go wrong and try and mitigate against those ahead of time is what people are really working on right now over at CMS and you've

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got a lot of people who are very smart and very dedicated who are working very hard.

LARRY LEVITT: Unfortunately, its not the change of a century too so you don't have to worry about that.

JULIE GOON: That's right. [Laughter] And things went pretty well with that. There was a lot of concern about that change as well.

LARRY LEVITT: And Aileen, from your perspective in a community-based organization, what keeps you awake at night? What do you think your biggest challenge is in the weeks and months ahead?

AILEEN HARPER: I think the biggest challenge is helping people understand a benefit package that is complicated. It is a complicated benefit package. And even though the quantity of choice is good in that people have choices to make, I think sometimes too much choice can be also overwhelming too. I think what our challenge will be is helping people navigate successfully through the Part D program, helping people understand how it fits with their current healthcare choices, how it fits with the affordability in terms of what they can afford. But also making sure that people not only just select a plan, but they really have enough of an understanding of their benefits and rights under this new program.

LARRY LEVITT: And you are a key group in your area, in

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Los Angeles, but you are not the only group. Do you have confidence that there is enough resources at the community level to make this work?

AILEEN HARPER: I think even though CMS has worked hard to build these partnership relationships, I think that there is a lot more people that know about Part D, whether that translates to being able to sit down with someone and understand how Part D fits with their current healthcare coverage, with their current financial situation, I do not know.

I would say there is going to be people out there who are learning about Part D, what that depth of understanding is and whether it translates to someone really being able to help someone to successfully pick a Part D plan is a different story. And also, the second part, which is after January 1, which we will really be helping people navigate through the problems, whatever new problems arise.

JULIE GOON: Let me just put in a plug. We are doing a webcast on October 14th I think, that will help train people on the new plan finder tool on the website. It is for everybody across the country, but we are going to continue to do lots of training to help with some of the issues that Aileen raised.

LARRY LEVITT: And we'd be happy to link people.

JULIE GOON: Good.

LARRY LEVITT: Tricia, you get the last word. When we

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look back on this, whether it is a few weeks from now, a few months from now or a few years from now, what is your sense of how we will judge success or failure for that matter? What will we use? What guard sticks will we use to judge how this program has done?

TRICIA NEUMAN, Sc.D.: I think we will look to see that there were not any major glitches. I think if there are big glitches, that will be a terrible start to what could be a very helpful program. Assuming there are none, which is an assumption, but hopefully will be true, I think we will look to see how did people respond? This is a brave new world for people on Medicare and it involves lots of new choices.

In some of the presentations I have given, I say that Medicare is not for couch potatoes anymore and it really means that people do need to stand up, they need to pick a plan, they need to make some decisions. It is not a passive program and in many respects, it is a very active consumer-driven, consumer-based program looking forward and it will be interesting to see how people on Medicare respond to the dynamics that have been set in place and whether it works or not.

LARRY LEVITT: Thanks to all of you for answering a tough hour of questions. We could go on for hours with this, but I think we have helped people quite a bit. I am Larry Levitt and you have been watching kaisernetwork.org. Thanks to

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our panel of experts and thanks to all of you for joining us.

We will see you next time for Ask the Experts.

[END RECORDING]

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