

National Academy of Social Insurance: Part 2 Medicare Part D - A New Approach to Medicare Benefits July 14, 2006

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MODERATOR: Our second panelist this afternoon is Bob Rosenblatt, who is a retired journalist and a senior fellow with NASI. You may know his work through the *Los Angeles Times*, where he worked for over 26 years. As a journalist, he has covered many topics about the Baby Boom generation, pensions, Medicare, Social Security, and the revolution regarding health maintenance organization or HMOs. He has been a member of NASI since 2003 and received his MS in journalism from Columbia University. He has a wealth of knowledge and experience with social insurance issues. He has headed up quite a few educational initiatives with NASI and other organizations. He will now talk to us about Medicare, Medicaid and how it relates back to Medicare D.

BOB ROSENBLATT: Okay, how's that; is that working? All right, good. I think we should step back a little bit. All of this comes down to money, how much is spent and who spends it. Think about the United States' gigantic economy as dollar bill, everything we do economically; \$0.15 of this is spent on healthcare at current trends. Although, as Marilyn says, we don't know what the future is going to hold, but it's headed towards \$0.20. Healthcare is going up faster than anything else, which means there is less for other things. General Motors is in trouble because they've got

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huge costs because they spend about \$1,200 per car on healthcare costs. Toyota, Nissan, Honda have younger workforces; they don't spend nearly as much on healthcare. Ours is 15-percent; it might be 9 or 10-percent in other countries. So the question is how much more will that grow? Who's going to pay for it? Can we afford it? So that's stepping back.

Now in terms of Medicare, Medicaid and Part D, since only half of you are majoring in healthcare, let me give some simple definitions. Medicare is when you turn 65 and you've worked under Social Security for 10 years or your spouse, whether the spouse worked or not, turns 65, you get on Medicare. The other way to get on Medicare is to be disabled, which means you have to have a physical or mental illness that prevents you from working for at least a year, or you have to have a fatal illness, either one. Then you get on Medicare and you have to wait two years while you're disabled before you get it. So that's the Medicare pop. Medicare is an entitlement you qualify by reason of age or physical disability. Medicaid is very different. Medicaid is a program for poor people; you qualify by being poor. We don't have Welfare anymore, but in effect, that's medical Welfare. Medicaid has even more people than Medicare. Medicaid has about 50 million people. They are pregnant women, children up to age 18 in households which are poor.

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Each state has a different standard. Here's how it relates to Medicare. The other way is if you're in a nursing home. Let me explain it this way. Let me give you two examples. Your grandmother falls down and breaks her hip; she goes in the hospital. Medicare pays for her new artificial hip. She needs three weeks of rehab. She goes in a rehab facility. Medicare pays for that, okay? Medicare pays for acute care, you have a physical problem and you're going to get better. So your grandmother is covered by Medicare. No problem for her, no problem for your parents, no problem for you. Case number two: Your grandmother starts to forget who she is. She wanders around the neighborhood. She leaves the stove on. You go to the doctor and the doctor says, "It's terrible. I think your grandmother has Alzheimer's disease. She has dementia. But she's healthy. Her heart's fine. Her blood pressure's fine." Your parents try to take care of her; they go over to her house. Then one day a neighbor calls and says, "Your grandmother is wandering in the street, half-undressed. She doesn't know who she is. The police have picked her up." So your parents decide that it's terrible, but we've got to put Grandma in a nursing home. You put Grandma in the nursing home. Remember, physically she's okay, but she needs custodial care. She needs to be in the nursing home. Medicare does not pay for it. Your

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grandmother pays out of her money or your parents pay out of their money.

Here's what happens on Medicaid. People go into nursing homes. They use up their money. Nursing homes cost about \$70,000 a year. When you use up all your money, that means you don't have to sell your house or your car, but you use up your stocks, your bonds and your checking account. When you get down to \$2,000 you qualify for Medicaid. In other words, you're impoverished and you qualify for Medicaid. That's what happens. So a lot of people who are over 65 are in nursing homes that started out as middle class and they're now on Medicaid. So the government is paying for that and they're being taken care of. So that's a lot of people and it will be a growing number because the older population is growing.

Now here's how it relates to broader politics. The states have to share in Medicaid. The more people that are in nursing homes, the more it is costing the state. Remember, there are also the pregnant women and the children. There are a lot more of them, but they're basically healthy, so they're not that expensive, although there are more of them. Medicare you've got the old people who are costing a lot.

It used to be that states spent about 10 or 12-percent of their budget on Medicaid and education was about

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25-percent. Now education for k-12 now, they're spending about the same; Medicaid spending is about equal to education. Why is this important? The state I know best is California, but this is going to happen elsewhere. California has a huge immigrant population, which is very young. People already living in California, a lot of them are growing old; let's say more in nursing homes and Medicaid goes up. The young immigrant population, the Hispanic population, has young kids; they're interested in the schools. So you have the young population that wants the tax money to go to schools; the old population wants the tax money to go to Medicaid. That will become a big political issue. It already is, but it will be an even bigger issue all around the country. So when you think of health policy, you should think of these clashes.

Okay, so that's Medicaid versus Medicare. Now Part D. Part D is the way it is because of the political struggle in this country. Medicare was created under a democratic administration and reflects a democratic philosophy, which is basically that government programs are good, government programs are worth the taxes, and people can be helped by government programs. That's the Democratic Party philosophy and I'm over-simplifying it. The Republican Party philosophy is that the individual is best left to make his or her choices as to what is to be done with the money. High taxes

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are bad; government programs are bad. Therefore, the democrats would have liked a drug program under which you simply take your Medicare card and go to the drugstore and get the prescription filled. President Bush wanted to capture this issue for the Republican Party. Say, if we give people Medicare coverage for prescription drugs, we will have a permanent majority, because a lot of people that would have voted democrat would vote for us. So they offered a Part D benefit and the democrats said never, don't do it, wait for us to get back into power. The AARP, which was pivotal in this, had to decide what they were going to do. AARP threw it's support behind the republican approach, which was to do it through the private sector and their reasoning was this: This is 2003; we have a big budget deficit. We just went to war in Iraq. The White House is saying, "We're putting \$400 billion on the table for our drug benefit." The democrats are saying to AARP, "Don't you guys touch this. It's terrible. You're selling out. Wait until we get back into power." And AARP said, "Well, we don't know when you're going to get back into power. We'll take the \$400 billion now because we think people need the drug benefit now." So that's why we have Part D. This battle will continue. Marilyn said, "'The future of Medicare certainly means tax increases.'" But we have two stark philosophies. The republicans say, "Don't you ever raise my taxes." And the

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democrats say, "Don't you ever cut my benefits." So that's what we will fight elections about for many years to come.

I've been writing about this for a long time; Part D will give you headaches like nothing I've ever seen in health policy because it requires people to almost have a master's degree in policy. You have to go on the internet, you have to choose among health plans, you have to put your medications; it's very difficult. The issues that will arise are that lots of people don't know that they have the right to appeal. They don't know that if the drug plan says, "We're not covering your drug," you can appeal it. You can ask your doctor to appeal for you. The doctor may or may not have the time and the desire to do that. There are certain drugs that are not covered my Part D like benzodiazepines, which are anti-anxiety mental health drugs. So that means another problem. People have to search out a plan that voluntarily will cover those drugs, which are otherwise hard to get. People in nursing homes who are on Medicaid were automatically assigned to a Part D plan, which may or may not be a good one for them, so the nursing homes have to scramble, as do the families of people in nursing homes, to make sure that they have the right coverage.

As Marilyn said, a lot of plans are going to drop out, which means people will have to make yet another choice of plans on how to do this. You will, after we finish

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talking, get exercises, which will put you in the position of finding a plan for a hypothetical person, and then you will see how tough this really is. One of the things to keep in mind is that drug consumption among the elderly is heavily concentrated in a handful of medication. There is something called the Agency for Healthcare Research and Quality, which is AARQ.gov and which is a very good web site, and they have all sorts of studies. Anyway, they have a statistical brief which points out, if you look at the top 10, Lipitor, Zocor and others, they account for about a quarter of all the money that's spent on drugs by people over 65. So in choosing a plan, you have to be sure that it covers these very popular drugs. The other thing, and this is just sort of advice, if any of you are helping parents, grandparents, relatives to do this and you find a plan that has three of the four drugs they take and one that doesn't, for some reason and I can't explain this, go to the COSTCO web site. COSTCO has great prices on prescription drugs. They're cheaper than almost all the pharmaceutical chains. I don't know why that is, but COSTCO is always—this sounds like a commercial but [laughter]—worth checking out, which is yet another illustration of nobody really understands how this business works. So that is sort of linking back to Part D. Remember, again, this comes down to money and politics. So, despite what your economics and statistics professors say, at the end

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of the day, this is going to be about values and the clash of values in our political system. Thank you. [APPLAUSE]

MODERATOR: Thank you, Bob, for breaking that down for us to understand it in layman's terms. Now we're going to turn the program over to the part where you can ask questions. In the essence of time, we're going to take two questions at a time, and then have the panelists to field them. Okay? Anyone have any questions? Okay, we'll take you and you and then just go in that order. Wait for the microphone; make sure that you state your name and your university. First one over here?

LISA SULCHER: Hi, Lisa Sulcher [misspelled?] from Wellesley College. I actually just had a question about the donut hole thing. In your slide you had showed how much people are paying out-of-pocket. My impression was that for over like 5,100 people, Medicare is paying 95-percent of the out-of-pocket expenses; could you just clarify that a little bit?

FEMALE SPEAKER: The slide I was giving you was telling you what happens in terms of the cumulative impact. So if you spend, let's say, \$5,500 on prescription drugs and you have a Standard Plan, they can vary, but according to the

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sort of basic rules, you would pay the first \$250 yourself. Then you would have 75-percent of the cost covered for the next \$2,000. Then you go into the donut hole where you would pay fully out-of-pocket. So you would pay \$3,600 when you hit \$5,100 spending. You would have already paid that. After that, you only pay 5-percent. So when you calculate, on the basis of \$5,500, it's \$3,600 plus something else that you pay for, for example, before you get full coverage. So the point is that it's like the marginal tax rates. When someone says, "I'm in a 45-percent tax bracket," don't feel too sorry for them because they're not paying 45-percent of their income in taxes, because they started out paying nothing and then 10-percent and so forth. So this calculates, for somebody with that level of expenditure, what the average is, recognizing that at different points in time they'll be paying different amounts. So somebody who hits the catastrophic limit is helped, but if they're just barely over the catastrophic limit, they've paid a lot of money out-of-pocket first.

SONYA: My name is Sonya and I'm from UC Berkley. I have heard Part D described as a sell-out to big pharma, mainly because the government can't use their purchasing power to negotiate lower prices. I attended a meeting from people from Australia, the UK and Canada. They were talking

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about their ability to negotiate lower prices from the very same drug companies, and you mentioned the top 10 accounted for 25-percent of all prescriptions. With the federal deficit, with the cost of Part D escalating, with potentially new people being elected come fall, do you think there's a chance that negotiations might happen, particularly with so many people ending up in Humana and AARP's plans?

FEMALE SPEAKER: It turns out to be a very complicated question to answer. A lot of people would say, "Yes, just turn it over and let the government negotiate prices and everything would go down." Now, first of all, if that happened, we would never see prices go down to the level that Canada and the UK and so forth pay because essentially, when you give everybody a discount, nobody gets very much of a discount. So if you're giving 30-percent of all the prescription drugs to Medicaid beneficiaries, that discount is going to have to be adjusted so that drug companies will not give as much as they would give to a small sort of take-it-or-leave-it negotiation. So that's one thing.

The other is that these prescription-management companies do try to hold down costs; they do negotiate. The problem is that there is a fear that they do it often in poor ways. That is, by denying people access to drugs that may actually be better for them than another drug. The way that

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they get discounts from pharmaceutical companies is to say to them, "We'll take everybody off of Lipitor," which is one of the popular anti-cholesterol drugs, "and put everybody into a different prescription drug for cholesterol. Therefore, we'll increase your market share and we'll get you savings that way." So there are discounts that these people get. How it would turn out to be different is very hard to know. My own view is that what you could do if you were negotiating on prices is that you could do it more readily on the basis of evidence; "This is the best statin drug to lower cholesterol and, therefore, we're going to negotiate with them. Everybody else can come in if they want, but they can't go above that price." There are a lot of things like that that you could do that would be creative, but if we see the federal government take over and negotiate for prices, we'll not see the prices that people in Canada pay for the drugs that everybody is hoping will happen. It just is a much more complicated market than that. So I guess what I'm saying is that it's not the easy answer; it would give you a different kind of an approach and allow you to do certain things better, I believe, but it makes it difficult. It is also the case that it's not necessarily a give-away to big pharma, but there are certainly big-time winners from this because people who couldn't afford drugs before now have more access than they did, and these prescription drug companies

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are pretty savvy about negotiating, so I don't feel that any of them are going to lose. They also lobbied very hard for that to be the kind of mechanism that would be used.

BOB ROSENBLATT: I have a different answer, basically a political one. This is the system that was produced right now. If the democrats win control of the House, if the democrats won control of the Senate, if a democrat becomes President in 2008, wins in 2008, then the system will be changed and the legislation will call for negotiations. Unless that happens, there's not going to be any change in the current system. I want to emphasize that I'm not saying that is a desirable or undesirable result, I'm merely observing what I think is the reality of it. You make your own conclusions as to whether you think that should or should not happen.

EMILY: Hi, my name is Emily. I'm a graduate student at the University of Wisconsin in Madison. I'm just wondering why the anxiety-reducing drug is not covered in Part D, and if there are any other important classes of drugs that are just completely left out and why?

BOB ROSENBLATT: Do you remember the history of it?

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MALE SPEAKER: Well, part of the reason that it ended up that way was because several classes of drugs had been excluded in federal legislation on the Medicaid program, and so when they went to write the Medicare legislation, they basically carried those exclusions over. Some of the exclusions are for things that seem more sensible like drugs that are for cosmetic purposes only or some weight-loss drugs and some other things like that. For some, like the benzodiazepines for anxiety, it is less obvious why it's on that list. I should say that there are other classes of anti-anxiety medications that are covered, so it's not the only type of medication for anxiety, but one of the things is that the states and the Medicaid programs in many cases did cover, so people at least who have dual coverage with Medicare and Medicaid do have an opportunity to get those drugs covered by their states, but regular Medicare beneficiaries who are not on Medicare end up paying for those out-of-pocket, unless a particular plan chooses to cover it as an extra.

BOB ROSENBLATT: Maybe Bill Vaughn remembers from his time on the Hill, but I vaguely think that there was some question of whether the anti-anxiety drugs were being abused, and that might have been why Congress—is that right?

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BILL VAUGHN: I think that's right, Bob. The old name for these things is uppers and downers, and you had a whole lot of abuse in this, so they put them off the Medicaid list and then they transferred that when they wrote the Medicare Law.

BOB ROSENBLATT: All right, so it was a carry-over from days when people were abusing uppers and downers, which, of course, no one does anymore. [Laughter]

MODERATOR: Okay, we'll have one here in the front and on this side of the room.

MALE SPEAKER: I have one question about parallel importation; do you think it's going to affect Medicaid Part D? [Inaudible] that some states are already implementing or they're taking advantage of parallel importation with Canada, so do you think this will have some impact in Part D in the future?

FEMALE SPEAKER: Importation of drugs is exactly the same as this whole negotiation, and that is Pfizer is not stupid. If Canada orders twice as many of a particular kind of drug that Pfizer owns as there are people in Canada, they simply won't supply it. So when it's a small-scale and it's

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on a small-scale basis, it's not a problem. It's not going to work on the large-scale basis because essentially, these are companies that get to decide whether they're going to sell or not, and they don't have to sell 100 million doses to Canada, for example, or a particular drug.

LAURA: Hi, I'm Laura [inaudible]. I'm a graduate student in health policy at GW. My question is about people who have to spend down because they're not covered by Medicare, so they have to spend down until they're eligible for Medicaid. To what extent does that person's family have to chip in? How much can they reach the money of the children?

BOB ROSENBLATT: It doesn't. It's the money of the person that's on Medicaid. The children do not have to contribute. There are also cases where people may give away assets in anticipation of possibly going in a nursing home, but there's a look-back period where the government can say, "Did you give it away within X years of going to a nursing home? We're going to make a claim on it." But basically, no, the children are not responsible.

FEMALE SPEAKER: Also, just so that you understand, you can be on Medicare and still qualify for Medicaid, but if

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the co-pays and deductibles and so forth that you pay on Medicare are so large that it essentially puts you into poverty or your income already is very low, you get Medicaid coverage that supplements Medicare. So Medicaid was always intended as kind of a wrap-around and, in fact, originally it wasn't even necessarily viewed that it was going to be a long-term care program, which has turned out to be a very big expense for the Medicaid program.

MODERATOR: You can go ahead, and then pass the mike up to this gentleman in the front.

MALE SPEAKER: Thank you very much. My name is [inaudible]. I'm a student at George Washington University of Public Policy. I have been thinking on a way to solve the problem of the increasing costs on Part D. I was just curious that there is a policy—we have been looking at the problem with the program and the customer's side, but why don't you look at the producer's, the drug maker's, side? What I mean is for decreasing the cost of the prescription drug, how about this way for government to give the prescription drug companies tax benefit to reduce the drug cost to give the old people and the beneficiaries a better deal for the prescription drugs? So I just wondered if there is any policy or lobby or any political action for that, just

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rather than controlling or touching the companies or the making more eligibility difficult, so rather than just reducing the beneficiary coverage of a population or decreasing the benefit coverage, how about reducing the origin of price by giving the companies a tax benefit or incentive?

FEMALE SPEAKER: I think the key issue here is the question of whether or not you want the prescription drug companies to be deciding who is deserving of getting the lower price and who is poor. While it is cumbersome to have it done by the government, most private companies aren't equipped to and don't want to. They have done it to some extent in the past, but it's usually been also a cumbersome process. I think that this would be just a very indirect way of doing it, unless you tried to lower the prices for everyone. Again, that would mean then that the government would have to get involved in determining what a legitimate level of profit is, for example. How much is too much profit for the drug company to have and when they were subsidizing. As an economist, it would really mess up a lot of the incentives and create a lot of problems, I believe.

MIMI SCOTCHMORE: Hi, my name's Mimi Scotchmore [misspelled?]. I'm at the University of Chicago studying

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social work. This whole last year I was working with older adults in an independent residential facility. One of the biggest challenges for us was to learn Medicaid Part D, like you were saying, it almost takes a master's degree to even understand it, but also then to explain it to the population it was really affecting. It was really hard because you're working with older adults who are kind of set in their ways, have gotten their prescription drugs in a certain form for a long time. To explain to them that this was going to change and it was going to affect them was really difficult. So I guess my question is what was set out to be the outreach and the implementation process for something so large that was going to affect so many different people, because from my perspective, we really had a hard time learning, doing the training, and then also explaining to people what this really meant for them on the ground.

BOB ROSENBLATT: Well, a lot is spent on paying for drugs; relatively little it spent on educating people. The burden had fallen very heavily on some really skillful people, the HICAPs. Every state has one and they're really good. These people basically get federal and state funding to work with folks on Medicare. They got some extra money, but not much. I'm trying to remember. I think the last time I checked with CMS, the budget for education/outreach was

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about \$300 million. So \$300 million spread over 40 million people on Medicare is not very much money. Other private groups like the drugs companies and various advocacy groups also set up training programs. Once someone who is reasonably proficient on the computer can sit down with a person, it can usually be done probably in an hour, but it requires the Medicare beneficiary to know all of the drugs that he or she is taking and to know the dosages and to know the pharmacy that they usually shop at. So with that information, it can be done, but it probably takes at least an hour in the easy cases, and in the hard cases it can take a lot more. If someone doesn't know the drugs they take, if they don't speak English, if the pharmacy they use is in an ethnic neighborhood and that pharmacy is not part of the chain that the Part D plan is signed up with, it can get really complicated. But the burden has fallen on the HICAP people, basically everyone refers folks to them.

FEMALE SPEAKER: It is a SHIP program, it's called HICAPs in California.

BOB ROSENBLATT: You're right, thank you. SHIP everywhere else.

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FEMALE SPEAKER: I would also add that CMS, I think, tried very hard to do the outreach. I think that before we sort of point fingers and say they didn't do a good job, I think the important thing is that this was just an incredible, formidable task because it's such a complicated program. So I certainly don't fault the people who were trying to do this, but I do think that we also misled some people by implying they go on the web site they do all due diligence, that they can know what it's going to be. But if you do that and you go on the web site, there are these little asterisks that saying things like "prior authorization required," and that could be something as simple as having your doctor fax in a form, or as complicated as having the doctor make three or four call, which they're not totally excited about doing in many cases, to get you on that list. So it may be, in some cases, that what looked like drugs that were covered ended up being very hard to get at for some people. So even with the best intentions and with your master's degree and all the training, you might not steer people to the plan that actually turned out to be the best for them. I think one of the things that people are going to find disappointing is they're going to be comparing notes with their neighbors over time and say, "Wait a minute. That plan would have been better for me. I didn't know about that." And they're going to be unhappy about some of that.

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But we tried to sort of imply to people that you could go on there and you could find the very best plan, and it would save you \$1,000 more than another plan, and I think that may come back and kind of bite us as well, because I think that in many cases people who did all the due diligence still got into some problems with this.

BOB ROSENBLATT: Let me add one brief anecdote to that. Health and Human Services Secretary Mike Leavitt presides over this. He's a very smart guy, was governor, and he had it well publicized in his speeches saying how he had sat down with his parents and they got all their drugs together, only took an hour, it was great. Well, it turns out that his dad had worked for a company that offered retiree coverage, so he should not have signed up for a Part D plan. [Laughter] And as I say, Mike Leavitt is a really smart guy and he's in charge of all of this, so if he couldn't get it right for his parents, than its tough, it's tricky.

MODERATOR: Well, that concludes our question and answer session for this component of the program. Please join me in thanking Bob and Marilyn. [Applause]

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FEMALE SPEAKER: And thank you, Tiffany, very nice. Thanks for our panel for introducing you to the newest benefit, in fact, the first benefit expansion of such dramatic effect in Medicare. We picked it obviously because of its currency, but also because it raises these very practical questions and these very ethical questions and a number of other questions of design. So what we're going to do after a quick break is dig down even deeper now, using this as an example, with two very expert people. In fact, had Jack mentioned his name and university, you would have known that he's going to be your next speaker, Jack Hodley [misspelled?] and Michael McMullan. Let's thank this panel one more time, and then I'm going to give you instructions. [Applause] My staff has decided if I choreograph this right, it'll be a quick break, but also get you all the essentials, so those of you who'd like to get up and walk around, that's still fine; we're not trying to be control freaks here. But we also would like one volunteer at each table to go out, and you can get two plates full of cookies to bring back to your table and not every has to stand in line that way. So if there is one volunteer per table to go get cookies. Those shouldn't be a National Academy intern because National Academy interns, you need to go out and meet with Dan right now to get your computers and your instructions. Dan's out at the registration desk. So if you're not a National

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Academy intern and you can go and get the cookies, please do that. There's water, there's bathroom; you know the drill. And there's also that nice, goldenrod evaluation form for you to fill out. Thank you.

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