>> Marshall McBean:
Okay Introduction to Medicare, to use of Medicare Part D, Data for Research. Educational Objectives, you know I always start by saying this is the University of Minnesota so we have Educational Objectives and so here they are. So we want to understand the program and its benefits and that will be this first talk. Then I want to talk about the demographic information that's new in the Master beneficiary Summary File in the second bullet here. Many of you know about the Denominator file and your colleagues will have worked with the Denominator file but now we have our enrollment information in this MBSF, the Master Beneficiary Summary File. I want you to become familiar with how these data are processed and notice here I say processing of Part D Event Data. They're not claims data. Barb will try to explain the black box that goes into events versus claims so if you want to be a purist, call them Part D events, not Part D claims, we make the mistake, sometimes, but just we will talk about how they are created, processed. Then we'll talk about the content of the Part D Event file and that begins the real fun part. Then the characteristics files on something that's new with the Part D data, are these characteristics file which describe things related to the actual prescription so the prescriber, the pharmacy, and what are their characteristics as well as the plan characteristics.

Many, many variables that I must confess I still don't totally have in my brain and I'm not totally sure of their utility so I think that's a bit of a moot point. Maybe getting way ahead of myself is when you're doing your regressions or trying to explain things, doesn't matter whether this drug is in a three tiered formula. I don't know but we've got all these things out there and how many of them do you stick into your equation? How many do you worry about if you're a doctoral student do I put into my explanatory model? So there's a lot of new stuff there and Kyoungrae is really our expert on that and we'll talk about the Plan Characteristics files and Barb will talk about some of the others.

Then how we can use Part D data for research, I think you already have given me lots of clues already and I just keep my mouth shut. Then there are some new variables that have been created by, we'll talk about them, the Chronic Conditional Warehouse people down in Iowa, welcome the people from Iowa, but certain variables that indicate, for example, in what benefit phase the beneficiary was in when he or she received a drug so there are these derived variables and Barb will talk about those. Then finally again a little bit more about the research. We'll talk about some stuff that we have done. Some of you mentioned the magic word statin. We'll talk about some stuff we did with statins here at the university.

And then finally understanding some of the more stringent requirements about obtaining Part D data. When things are past you forget all of the hullabaloo, whatever that means, hullabaloo in other languages, all the angst, there's a better word, all the angst, over who would be allowed to have part D data. But there was a long history there. And finally once Obama was elected we were able to write the rules, we didn't, but CMS wrote the rules, that allowed us to get the CMS data, although under much tighter restrictions.

Okay so let's talk about the program. Here are some of the acronyms that I'll be using. I've already used some of them. We always split CMS up here because one time we got halfway through the first day and someone asked what's CMS? You know, things like that happen. So you know about ResDAC, CMS, the CCW again, let me go through that a little more slowly. The Chronic Condition Warehouse, all the data that you researchers will receive will come from the Chronic Condition Warehouse in Iowa. Even though you're not studying a chronic condition it's still called the Chronic Condition Warehouse and just try to remember that. And the people who actually have the contract to do all of that work are called Buccaneer Computer Systems and Services. I love to say how would you like to be a government contractor called Buccaneer? Does that instill confidence or what? But they're very good.

Then the Medicare Modernization Act and then two acronyms we'll use many, many, many times, PDP and MA-PD. Most of you know these two but to repeat, the prescription drug plans are the fee for service plans and then the MA-PD plans are those that are affiliated with Medicare, the manage plans. Perhaps some new terms for you, LIS, TrOOP, ICL, Low Income Subsidy, first one, TrOOP, out of pocket spending and we'll talk more about these. The ICL which is the initial covers limit, which is the point at which you enter the gap. And then other ones would be catastrophic coverage limit where you get out of the gap and then others that I've mentioned before. So the program was implemented as part of the Medicare Modernization Act of 2003 so we now have data beginning in 2006.

Reading my text here it's a competitive model with beneficiaries voluntarily purchasing drug coverage offered by private plans. It is so different from A and B, okay? A and B is public, one plan fits all. Here you've got all these plans and all these plan characteristics and people making choice and blah blah blah, in or out, vastly different. And it doesn't matter whether you're a single payer fan or not. Single payer would make our life a lot easier, although all the economists wouldn't have anything to study. So the plans though, and this is important both for understanding and then for research, have tremendous flexibility in what they do and we'll perhaps highlight some of those later in the course but depending on the plan you'll see very wide differences in what's in the benefit package. So some have no deductible. Some have a deductible. They all have formularies and the formularies will vary so that the drugs in which you indicated or interested as a patient may not be available in certain plans, okay? Did anybody see that in the exercise? Yeah, okay so you better be careful what diseases you have because you may not be able to join a certain plan. Then there's prior authorization and other things so huge variability and again, if I'm honest, I just don't know what that means when I'm trying to study certain outcomes.

Enrollments for the calendar year so every October through early December you'll have all these people doing what you were doing, typing in, my drugs, trying to figure out which plan is the one for them. To me it's interesting because initially about 6% of the people switched year to year and so that was kind of a ho hum, okay don't worry about the switchers, just throw them out. It's only 6%. Well the MEDPAC report, and I would encourage you every

March, or maybe it comes out in April, but it's dated the March MEDPAC, okay Medicare Payment Advisory Commission, MEDPAC, does an annual report on lots of things in Medicare and one of the chapters, usually it's 13 or 15, is about Part D. And I'll show some of their information later. But it's a good place to be caught up each year on what's changing. And one of the things they had in the report this year is for the last two years the number of switchers is now 13%. So to me that's now at a point where somebody's got to study it and I suggested to Jean that in fact maybe she wants to do that as part of her doctoral work. Because 13% to me means something. I don't know what it means but it is a change.

The one thing that's always been fascinating about the whole process is the number of plans that are available to beneficiaries and the number 2013 around 25 PDP's available for every beneficiary. I think Alaska is at the low end but it's amazing how many plans you may choose from. An interesting fact, while everything seems to be increasing in price, monthly premiums actually have held pretty stable, in fact they've gone down a little bit. So you know $30 is a good number to keep in your head as what the monthly premium is. The other thing that's happened, again kind of sneaking up here, is the percent of all beneficiary's enrolled in Part D. The first year it was 54% and now it's gone up by 9 percentage points and I did the math real quickly. Nine over 54, 1 and 6 that's 16% you know so that's, yeah?

[inaudible audience question]
No. This is all Part D. I will try to repeat all the questions and do feel free to intercede any time. No, this is any of the Part D plans.

Okay, so I guess I'm pausing to say as an epidemiologist I'm beginning to feel better. At least the generalizability you know what's going on here as opposed to saying well I only have data from half of these people and in fact we'll see when we're working with the PDP plans we have data on only about 30% of the people. I'll talk about that in a few minutes. But it does seem for whatever reason that the program is gaining in popularity and I think in my notes to myself I said this may be due to tax changes. It may be less desirable for employers to be covering their retiree.

Then a reminder that as with part B, because it's optional, there's a penalty if you choose to enroll later but don't have credible courage for the period you're not enrolled. Extra help, we'll talk about that, largely from a perspective of how you might identify lower income people and I'm glad there are a number of you from Medicaid because you'll keep me honest and hopefully you'll have a comment. But there is this low income subsidy and if you read the literature that I read anyway there seems to be a lot of interest in getting people to have this extra help. Okay, comments, questions?

Alright so here's the enrollment. It answers your question about were they all in PDP? So this is the Part D enrollment looking at the entire Medicare population so Al asked me to describe the pie chart, okay so there's a pie chart here that shows that there's 10% of the population that don't have any coverage so that will be there in all the estimates of what's going on. Then there are 26%, and this is in 2012, who had credible coverage.

So these folks are outside the box, if you will. And then you've got MA-PD and PDP so 25% of the total population in MA-PDs, a little over 40% in PDP's.

[inaudible audience question]
Credible coverage, the question was how do we know? Well I have faith. [laughter] How do we know? Yes, you know I really don't know how all the data flow and I'm not sure I've ever pursued it enough. For example you'll see a pie chart right here that shows how many people have federal employee health plan, okay, and who have other VA benefits, okay or in eye care or still employed. And as a person in that last category, they've never asked me. Okay they've never asked me why did you not sign up for Part B and why are you not in Part D? So I don't know how they know?

The question was am I going to talk about Medicare Advantage Plans? Not very much, okay but they are there. And one of the things to remember is that while for A and B studies you're really limited to the fee for service population, you can do some Part D examination of drug utilization etcetera by
[inaudible audience comment]
Yeah, okay, questions coming faster than I can think. [laughter] The answer to the questions was yes, you may compare them.

The issue becomes how do you then risk adjust or do the proper adjustments for you know the selection of healthier people into MA-PD? I didn't say that, or whatever. What we've suggested, which hasn't happened yet, is we've suggested that CMS provide the CMS HCC score, the Hierarchical Condition Category Score because that's a pretty good risk adjuster, at least for the payment side for where people get reimbursed. Or you could do that yourself, okay, and there's a recent paper attacking one of our papers that actually did that, okay and not bad. You can run the Medicare data and calculate the CMS HCC score and use that as an adjuster but you can't do it, nobody caught me on that, because you don't have the utilization on that, from the MA-PDP. And what they did in this paper are giving much too detail. They used that as switchers so someone who went into PDP data they had prior AMB data. A lot of you are nodding, good. I'm not talking too fast. And so they were able to estimate. But that would be one way to do it. I think our way is better just to get CMS to give it to us. But we've been unsuccessful in that so far.

Another thing would be to set up a risk adjuster based on pharmacy, right? I mean there's a whole literature. We gave up that talk this time because our expert couldn't get back from Korea. But there's a whole set of, well not a whole set, a guy named Farley, Bill Farley, William Farley, actually was a graduate student here. It was a really neat paper looking at risk adjustment using diagnostic codes, looking at pharmacy codes, looking at the mixture and he's got C statistics, blah, blah, blah. So one of the thoughts might be to develop a risk adjuster, what is it called, RXVA? You've got a risk adjuster based on your pharmacy data but you could develop a Medicare RX kind of risk adjuster based on the prior year's pharmacy utilization where they could then use that to study drugs because it's based on drugs.

Okay switching to another topic, just to talk about the standard benefit, and the emphasis here is standard benefit. Remember about four slides ago I said plans can do whatever they want so you might never see a plan that does this. Okay and so I've got two calls here if you will on slide and the other one has something called TrOOP in it, which I'll talk about in a minute. And the other slide on the right talks about total drug spending. So you could either sum how much people actually paid or was paid or their TrOOP and you get to these various thresholds. So first of all we have the deductible which is now $325 and we see that's employee obligation. Then here's the insurance phase which I always find kind of interesting because although this isn't on a real scale, okay, the insurers aren't in there. They don't have much skin in the game. You know, I mean you've got them paying 75% of the prescription drug claims up until this gap or the catastrophic limit, sorry, up to the initial coverage limit or until you get to the gap and that's only about $2,000. Okay so the beneficiary is paying you know about 1/3 once you get to the gap and then of course until the new change in the law they had to pay the whole gap. Okay so there's a lot of beneficiary liability in here, is my kind of take home message. That while Part D is very good and it's great if you can keep your total expenditure below $3,000 roughly, then you're okay but boy don't fall into the gap. And clearly policymakers have responded to that. Although data from the Chronic Condition Warehouse would indicate maybe 12% fall into the gap, 10, 11, 12 so not everybody but those for whom it happens it's very important.

The other comment to make about the gap in this slide is as you know things have changed and so the major drug companies had their arms twisted. They agreed to pay 1/2 of the cost of branded drugs in the gap and in fact that's going to increase as they pay will increase until the year 2020 and enrollees will pay less. Things are not quite so good for generic drugs but again the gap liability of the beneficiary is decreasing over time and I'll show you a slide on that specifically in a minute or two. Once you get to this number $6954.52 then you've reached the catastrophic coverage limit and then the liability really goes to Medicare and Medicare pays 80% of the drugs cost. So for those of you studying biologics you're going to find your drugs you know put a patient often up here and it's Medicare who's paying most of the bill.

Okay so I mentioned that I have this thing called TrOOP and because it will come up and it will be repeated by Barb and others, let me just take a first crack at it, kind of read this to you. True out of pocket costs, oh my goodness, there's a variable called TrOOP, thank goodness I don't have to do any math. Well it isn't really the TrOOP, the TrOOP isn't the TrOOP meaning the TrOOP isn't the actual amount the beneficiary would pay. It has these other things in it and the Medicaid folks are nodding their head, that it includes money that Uncle Charlie paid on your behalf or a state pharmacy program such as PACE in Pennsylvania. Was yours called MACE or something in Missouri?
>> No, MoRx.
>> MoRx, that's worse. Anyway so Missouri drug so if Missouri's paying for your drugs, that comes into the TrOOP, okay so it doesn't sound like the beneficiary paying but if you start worrying about those kinds of things

remember to pay attention to Barb's talk and she'll talk more about these components that go into the TrOOP. But it is important in that the TrOOP amounts are used by Buccaneer Chronic Condition Warehouse to find these transitions. I don't know why they didn't use the total drug expenditure. They could have chosen in my opinion, but I've never asked, they could have chosen these amounts but they chose these amounts and I don't know why. But those are the two reasons to mention the TrOOP.

So here this is again, here's 2012 just to show, if you have instant reading capability, things didn't change very much. Here's where we started covering brand of drugs used in the gap and the deductible changing just a little bit between years.
[inaudible audience question]
The question was is this the same for MA-PD and PDP? Yes, yeah, every plan has to have an actuarially equivalent plan to this, okay and I hope nobody then raises the question and says what does actuarially equivalent mean? And I'm not sure because if a plan has no deductible, many do, many MA-PDs do, does that mean they get you up here? How is it actuarially equivalent? So here are some changes over time. The deductible actually did jump early but then it's been stable. The initial coverage limit and the cash coverage limit again are going up over time.

This extra help thing, some of you are going to get really bored how many times I talk about this but it is a difference in the program. And I get all excited about it because the people who have low incomes, there's this effort by Medicare and advocacy groups to get people into this program where they have help paying the premium. Most often they have help paying for their deductible, coinsurance. They don't have any coverage gap liability and there's no late enrollment penalty. So if you're a poor person, boy you really would like this extra help. And as I will say 15 times, people are trying to get into this program. The thing it does for researchers, and we'll see this in an hour or so, is it gives you smaller gradations of measures of income and assets if you will so some of you, Helen mentioned doing eligibles, and I'll bore you with doing eligibles later, but some of us have always tried to figure out you know who are the lower income people and who are the strata and then maybe try to get multiple strata. And so this low income subsidy variable will allow some of that so that's why I talk about it.

So here is the same pie chart that Jerrod [phonetic] asked about earlier. So this is this pie chart here now with some additional information, although it is 2010 dated, not 2012. So going around the pie chart we have the 10% of people with no credible coverage, okay. And what we added here then is some of this information that you're asking about, although I don't know exactly how they get it. So here are people with federal employee health benefits, Tricare or an active worker, okay? That's 14%. Then there are others who are in the retiree drug subsidy program or Medicare rather than or allotting not to pay for the entire drug coverage. So the person says to a former employee we'll help you out. Keep them in your plan and we'll supplement what you're doing. So the people who are in retirement drug subsidy programs, then there's other credible coverage and this sums to that number earlier, whatever the heck it was. And then we've

got the MA-PDs here and the PDPs. And so for the MA-PD with 21%, 4 plus 17 is 21, and so only about 4 over 20, what's that, 20%, are in the low income category, okay, or at least the low income program. If you go to PDP, 38% or so, almost half are low income subsidy. And I don't know anyone who's really worried about this enough as epidemiologist. I mean if you think about it for a second, when you have A and B data and then you supplement it with D data, that's these people here, okay. And automatically almost half of them are poor and yet you're going to write papers that you're going to implicitly say generalize to the entire Medicare population. No one is worried about that and I just put it out there because we're all a little sloppy, including me, but someone really should look at this. And so also when you're looking at MA-PD and PDP, you know income, somehow it isn't just about health and somehow risk adjusting for health status, but there is an income thing there too. So important things that we as a research community I don't think have really focused on enough yet.

Any questions though about this, yes?
[inaudible audience question]
I asked my friend, now these are 2010's, it will come from the Beneficiary Summary File of the Master Beneficiary Summary File okay so you can get this. It's the banomenator, [phonetic] okay. These are data that you can know easily.

Okay this slide I love, even though it's all, yesterday I was looking up some stuff and the Kaiser Family Foundation has a 2012 version of this but it hasn't changed very much. This one has nice colors so I didn't swap this one for the newer one. If I asked you who pays for Medicare Part A? What's the source of money for Medicare Part A? And now you're looking down at your, [laughter] who pays for Medicare Part A?
>> Federal government.
>> But where did the money come from?
>> Trust funds.
>> Right, the people who are in it pay for it, right? I mean it sounds pretty good, right? It sounds pretty fair, I should say, right? You put in your money and you and I are doing it right now and some day you're automatically entitled to Part A.

What about Part B? Who pays for Part B? These old folks, and they're disabled, but these old folks run around complaining, yeah but they're getting care. Who's paying for it?
[inaudible audience comment]
Yeah but who's paying for most of it?
>> The trust fund.
>> No, not the trust fund and you've got to understand that because the newspaper reporters never point it out. Trust fund, blah, blah, blah or Medicare, they never say this article or this comment should relate to the trust fund and Part A and this should relate to the supplemental medical insurance trust fund for Part B and Part D, they both come out of the same trust fund, but where does the money come from that goes in to pay for part B and Part D?
>> Taxpayers.
>> Yeah, you, me, okay. Seventy five percent comes from the general fund.

Okay so here in A it's all out of the payroll taxes. People pay for it ahead of time. Here it's paid for with general funds. So every year set by Congress is the amount of money that will go into the supplemental medical insurance trust fund. So this Part D is a great deal for the elderly. And they started this in 2006 and they're kicking in 9%. And that's as good as the banks. I mean the banks, what do they do, 3% reserves and can go play with the rest? Here you give a dollar to the beneficiary and you get $10 worth of benefits. So the point is they're paid out of different sources and that's just so you know that but to realize again that it is the working population that is paying 3/4 of Part D and Part B.

Alright now this part here we're talking about things that I don't know anything about which are the landscape files, although I will show you a bunch of slides developed from that. So our thrust in this workshop is to talk about the research identifiable files, okay the ones that you will use, or have already started using, but there are these public use files known as the landscape files that have these various titles. They sound pretty intriguing, okay. Plan information, basic drug, geography, pharmacy network but they cannot be linked with the beneficiary level files. Okay when we talk about the characteristics files, Kyoungrae will talk about those and Barb, these may be linked. These are out there, okay. Now the kinds of things that are in there are whether or not it's a stand-alone or an APD, the premiums by plan, annual deductibles. And people like MEDPAC have used these data to then describe the program.

I'm just going to show you now some slides that other people have made that help wrap up our discussion of the plan. So if you're interested in this, here's the link to go get those data but I have to confess I've only looked at the slides that others have made. So here from MEDPAC is the number of Part D contracts and plans and so the dark black is the PDPs. They've diminished in time and ADPs have also diminished over the past few years. And then here one thing I haven't talked about very much is this is grey color down here is what are known as diminished plans, plans that allow people who are deemed to be eligible for Part D may enroll without any penalties so those are low cost plans, let me just say that. So there's a certain subset of plans that are low cost for people who are essentially receiving public assistance in their purchase of a Part D plan. But the plan numbers have generally come down a little bit.

The purpose of this slide is to just look at enhancements and so interesting as they say here, don't look at the between year differences, look at the between PDP and MA-PD differences. And you can see that, MA-PDs, 90% plus percent of them are enhanced, whatever that means. Again maybe additional benefits, the formulary is more relaxed, something like that or has no deductible. And in fact if you look at the gap coverage, over half of the MA-PDs will have some form of gap coverage where all these percentages are much, much lower in PDP. So why wouldn't join MA-PD? But again there are differences and they may be important for your research.

Okay here's gap coverage again. PDP and MA-PD, the comparison is between the two types of plans and again by 2008 many, many, many more MA-PDs were having gap coverage then were PDPs.

[inaudible audience question]
Do we know at the beneficiary level if they have gap coverage? Kyoungrae will tell you. I would say yes, we do have the prescription level. If you have a PDE, so you have a prescription drug event, you can go around and figure out, so the plan characteristics, whether or not that plan offers coverage in the gap. And it gets a little complex because you also want to know is the drug being dispensed when the person's in the gap and does it matter, right? Because whether or not they have gap coverage is one thing at an entry level but then whether it influences whether the person uses the drug or not could be another thing. If a person has a prescription drug event then, as Kyoungrae said, I'm just repeating it, you can then use that information to link to the Plan Characteristics File which will then tell you whether or not there's gap coverage.

Okay this is a tough slide. It's from MEDPAC I guess. And again looking at the PDPs versus MA-PDs and we can just again focus on these latter years where again there's very little gap coverage. There's green, for those who are in PDPs a lot more for those who are in MA-PD. And then for those who have gap coverage it's mostly generics. And that was something I was discovering a couple days ago that when it says gap coverage it doesn't mean like universal gap coverage for everything. You might have to look at the fine print because the gap coverage might only be for generic drugs, okay, and not just as complexity too.

Okay so here's the Gap Coverage Reduction Act, if you will. So this is the amount that beneficiaries will pay between now and 2020 in terms of gap, medications that are purchased when they're in the gap, for brand and generic. And so slowly that gap covers liability will drop to 25% for each kind for beneficiaries.

Here's something that's a little interesting I think, how formularies have changed, and again not something I used to think about very much but the take home message here is these blue bars have increased such that if you look down here most plans, be they PDP or MA-PD, have a generic preferred brand and brand type formulary. And those of you who are looking sometime at your pharmacy benefits that's probably what the plan that you are in has also so just a trend in terms of having three tiers as the general offering.

This is mainly to show between MA-PD and PDP what the cost sharing is. There's some exclusions made down here but let's just take it at kind of face. It says if for generic drugs in 2011, looking here at the far right, you know the copayment on average is $6 or $7, preferred brand $40, nonpreferred $80 and not really much difference between MA-PD and PDP. And then the other point to make in this slide is if you look at the specialty drugs, these are not dollars down here, these are percentages. So when you get into specialty drugs, if they're in that tier, the beneficiary is paying about 1/3. Okay so there's biologics in special drugs.

Finally, looking at utilization management, which is a tool that's become increasingly popular, so there are different types of utilization management, for those of you who know it well, prior authorization, so you

can't have a certain drug unless your prescriber does something to advocate for yourself, step therapy, you can't have a second line drug without going through the first line drug and then quantity limits, which to me always seem stupid, but only a 30 day prescription let's say rather than a 90 day prescription. And so again, for all of these types of utilization management techniques things have generally gone up over time.

Question was, Jerrod phrased it as, can you capture all the generic drugs because people go to Wal-Mart, you know, $4. Some of you are from Arkansas, down there, go to Wal-Mart to get your drugs, and we can't capture that. And when people, when Wal-Mart started doing that and some of the other pharmacy or even drug companies offering rebates, there was a bit of a shudder. You know we wouldn't be able to study complete utilization. And I don't know anybody who's tried to answer that question empirically. In other words looking at different people. So let's say if you're in LIS, I don't know if this is going to be true or not, you might not go to Wal-Mart because your drug subsidy program gives you a really low copay, lower than $4. Whereas if you're paying yourself, okay, and you might be hit with a higher copay for a branded drug, you might go to Wal-Mart, get the generic at Wal-Mart. But I don't know anybody who's looked at let's say prescription fills over the calendar year because the Wal-Mart phenomenon would probably take place in November and December when you hit the coverage gap. You're not just paying the copay, you're paying the whole freight. And I don't know if I'm making any sense or not. But it's a question that was raised, what about these drugs that are purchased at Wal-Mart? And people have just I think left it open for now. No one's really answered the question, what is the impact? And what will be the impact on research? Drawing false conclusions about drug use, medication, prescription ratio or things like that so I can't answer your question but it did strike fear in the hearts of researchers about two years ago but I haven't seen an answer.

Okay this, as I said, there was a great deal of concern about ever getting the Part D data. Finally in June 2008 the rules were written and public comment, etcetera, blah, blah, blah and so we now can get the Part D data but it has some restrictions in terms of commercially sensitive plan data, prescribers and pharmacies. So a lot of encryption there that isn't in the Part A and Part B data. And the other thing that I've underlined here is there is much more implied then minimum data necessary. Okay when you ask for Part A and Part B data, sure, Medicare is not going to give you data that's totally irrelevant to your study. Okay but they're not going to ask you to pick variable by variable what you should get. Okay it's really by file. Okay whereas in the PDE data you need to justify every variable. Okay so more restrictive because of the legislation ultimately and then the rules that derived so just be prepared to be more explicit in what you need.

Okay now what you came for, beneficiary level data, okay now you know all about the plan and there's this information out there about the plans and we'll now jump in to the beneficiary level data. I'm going to talk about the denominator or enrollment information and then we'll go into the numerator data. The most important thing, not the most important thing,

but one thing to remember is that when I talk about the denominator data it's about all beneficiaries. Okay so some of these things that are there that are new because of the Part D program that is information that's available for all beneficiaries. So when we want to find duals we can find all the duals whether you're in Part D or not, okay we can categorize the duals, which is what we couldn't do before. And then we've got of course all the numerator data and lots of claims. So although I don't see it here, maybe we'll see it in the next slide, you'll never get 100% Part D data because there're too darn many. That's the same comment we make about Part B data so you're largely getting a 5% sample.

Those of you who need help even after these great lectures, call Ben and his colleagues at the assistant's desk. You know where we are and we're here to help you. I'm just rushing through because most of you have seen these already. Know about our workshops some of you have been too, CMS 101 and somebody that I mentioned, Cost Effective Research. We've done a CER Workshop a couple of times. And then here's how to contact us.