>> Marshall McBean: Okay, structure and content of the Medicare program. I want to talk about eligibility, enrollment, benefits and coverage. So, the Medicare program was created as Title 18 of the Social Security Act back in 1965 and in July of 1966 the program started. And I would say that in October of this year the Medicare program is a success. I'm frequently criticized by my colleagues and sometimes by participants for telling bad jokes. You notice I told no joke this morning, so there are no jokes and for my enthusiasm for the Medicare program, for which I will not apologize. I think it's a program that worked.

I was the house officer at Boston City Hospital in 1968 and so I know what it was like when the elderly were not covered or when Medicare had just started and you did not want to be elderly and uninsured. Now, you are elderly and insured and to me that's an improvement. And I suppose a sign of its success is that people are trying to kill it. But, we'll talk a little bit about the program as we go through and I will try not to show my biases.

Okay, there are four types of Medicare beneficiaries: they're the elderly, the disabled and then those with end-stage renal disease and those with Amyotrophic lateral sclerosis. There was one person here from the Chronic Disease Center or Chronic Disease Research Group, which is the group that is related to the USRDS, the United States Renal Data System. If you want to study end-stage renal disease they are really good. They've got a contract with CMS and NIH and they out an annual report on kidney disease and stage renal disease and their website usrds.org is the place to go. So, if you like end-stage renal disease, work with USRDS.

But, backtracking here to the dominate group or the predominant group in Medicare, the elderly of which 85 percent of beneficiaries are elderly, 65 years of age or older. One of the things that the epidemiologists love is that approximately 98 percent of elderly Americans are Medicare beneficiaries. So, the good news is that almost everyone who is elderly is enrolled in Medicare and we can begin to start thinking about doing population based studies. However, in about 10 minutes I'll tell you the bad news, but that's the good news.

In addition to the elderly a major component of the Medicare program are the disabled. I think I heard one maybe two people interested perhaps in that group and about 15 percent of the Medicare beneficiaries are entitled to Medicare because of their disability.

Here's a figure that shows the growth of the Medicare program since inception really and you can see now that the combined elderly and disabled are approaching 50 million. And in fact I would think right now as a percentage increase the disabled are in fact increasing slightly faster than the elderly.

So, here's the percentage distribution by age in Medicare, again numbers I've already showed you, 65-- less than 65 years, about 15 or 16 percent. Then something that people often forget is that almost half of the elderly are the young elderly. Lots of you love to study post-acute care or the

oldest old. Well, I'm not there yet, so like to study the youngest old. You know we're pretty good. You know we're not so bad. You know if you have a benefit, you know you've got hopefully 10 or 15 years of good life, whereas in the oldest old you know you're really working up against a wall. So, I encourage you to-- encourage you to study the youngest old as well as the oldest old where of course we tend to spend more resources. Then you can see the other age group, 75 to 84 are about 30 percent and then 10 percent are the 85 year old and older.

Gender distribution: More women than men and here for the distribution by race. One of the things that Beth will talk about in segment D is the race variable and I won't say too much right now except to point out that the number of Hispanics is increasing, now 7-1/2 percent as well as Asians, Asians alone about 4 percent. So, blacks make up 10 percent and whites 77 percent.

Here's the distribution by gender in the two age groups, elderly and disabled and in the elderly again women the predominant group, but amongst the disabled men being the dominant group. Pause, any questions, comments?

Pretty basic stuff; okay, what is this? It is your Medicare card except none of you has a Medicare card, one, one Medicare card out there. Okay, I actually became familiar with it when we were doing a study of pneumococcal vaccination in Baltimore County many, many years ago. And so, there it is and what's on it. Tell me, tell me about the card. What do you see? And in particular tell me about this thing right here, the Medicare claim number. Does it look like anything you've seen before?

>> [Inaudible background answer]
>> Marshall McBean: Okay, Social Security number, is it someone's Social Security number? Does anybody's Social Security number have a letter in it?
>> No.

>> Marshall McBean: No, so it's not somebody's Social Security number, but it looks a lot like it, right. Okay, anyone else want to make a comment? Okay, note-- let the video recorder note no comments. Okay, as a clue or as an answer this Medicare claim number also called the Health Insurance Claim Number and again this issue of things get called different ways by different people. Health Insurance Claim Number or HIC is actually made up of two components, the CAN and the BIC. Now, the CAN, Claim Account Number is actually an SSN. So, the first digits are the SSN. At the end there's a two position field called the BIC, the Beneficiary Identification Code and it can either be a letter, can be alpha or it can be alphanumeric or just plain numeric.

So, back to my question, is this an SSN? Yes. Whose SSN is it? Let me say that clearly. Whose SSN is it? Is it the SSN of John D. Doe? That's a pretty dumb question right, answer why not. It's-- the real answer is it may be okay. This is the SSN of the person under whom John Doe receives his Social Security benefits. So, if John Doe were a stay-at-home dad okay and his wife or if he had a spouse and his wife worked, this SSN would

actually be hers okay and he would be receiving benefits under her SSN. Now, I know that's not true because way back when there were no stay-at-home dads right. But, secondly it ends in an A, and A signifies that this is the beneficiary under whom or for whom benefits are being received, under whom benefits are being received. If this were Jane Doe and that-- she were a spouse of John Doe and she were receiving benefits under his work history this would be the SSN, but it would be a B okay. And if John Doe died what happens? You don't know the answer. The B becomes a D okay. And if Jane Doe marries again she could have another SSN and another BIC.

Now, some of you are taking notes and the nice thing I can say to you now is don't worry. Twenty or 15 years ago and 10 years ago and five years ago when we started this workshop this was a major part of our discussion. The SSN has-- I hope I made clear, for any individual can change over time. So, like you folks are trying to rationalize claims and information from different datasets, we had a problem within Medicare of rationalizing all the Health Insurance Claim Numbers for each person and that took actually several steps between the researcher and CMS. Now, as I said you don't have to worry about it, the people at Buccaneer, the CCW when you get the data there is an encrypted beneficiary ID. Number one: It is unique to your study okay, but for each beneficiary it is constant through all of your data.

The question is if you come back for a second helping, if you're so happy with your data that you would like more and you're continuing the same study under the same DUA, the answer to this question is yes. The people at Buccaneer will retain the initial population and they will know the encrypted IDs for your DUA and you will get the same encrypted ID on your new data. Any other comments, questions?

So, I wasn't trying to confuse you in the initial discussion of the Medicare card, but the most important message is not to worry that you do have this encrypted ID that will be consistent within your data request and in any subsequent data that you get for that DUA.

Okay, other things that are on the card real quickly that I might point are, it does indicate whether the person has the hospital insurance or Part A, again multiple terms for the same thing. People at CMS sometimes like to call it hospital insurance rather than Part A and often they like call Part B supplemental medical insurance. So, you'll see HI and SMI okay. HI and SMI, Part A, Part B. One thing that's interesting to me is of course the card as far as I know still doesn't include any information about Part D coverage. Can anybody say that I'm wrong on that? Have you seen a more recent card with Part D? No, okay. Alrighty, this slide just repeats what I've said.

Here's another one and then we can go on-- whoop, to talking more about the program. So, there are four parts. I already mentioned Part A or the hospital insurance portion. Part B or supplemental medical insurance or SMI. Then there's Part C. I've heard maybe four or five times the word Medicare Advantage. That's the most recent incarnation of the what was known as HMOs or managed care okay. It's now called Medicare Advantage.

So, if you want to be modern Part C is called again Medicare Advantage. And in order to be enrolled in a Medicare Advantage plan you must have both Part A and Part B coverage. Part D is the prescription drug program, which began in 2006 and I will say a few words about that.

But first, Medicare Part A and its benefits, the one that most of you will look is hospital care. I heard the word MedPAR again several times, so I know many of you are working on hospitalizations, the mention re-hospitalizations was out there also. Part A also covers skilled nursing facility or SNF care, home health agency care and Hospice care. If you're receiving home health care its skilled care and it is supposed to be or rehabilitative care and presumably the patient is confined to home, but I think that requirement is relaxed, although the Inspector General is here to tell if that's true or not. Eligibility for Part A, first of all going to the elderly, a person is eligible if they or their spouse worked 40 or more quarters in their lifetime and paid the Medicare tax while working. How many of you were told by your mother, dad, aunt or someone work your 40 quarters?

>> Me.
>> Marshall McBean: Yea. For about the last 10 years nobody is being told that. When I graduated high school that was one of the first things I was told. You know get your draft card and then be-- make sure you work for 40 quarters. Why would people say that? Medicare wasn't in existence. I should tell you when I graduated from high school in 1960 Medicare didn't exist, so why would someone like my mother say work your 40 quarters?

>> [Inaudible background answer]
>> Marshall McBean: Right. If you pay-- I'm sorry Social Security yes. If you worked for 40 quarters and you and your employer pay the Social Security tax then you will receive Social Security benefits. So, for people of my age and those who are currently in the Medicare program working the 40 quarters was almost a no-brainer okay. Most of us had jobs and most of those jobs did pay under Social Security. And then when the Medicare program came along then with the Medicare tax you have the same requirement of the forty quarters that make you automatically eligible for Medicare.

Now, as it says up here on the slide for those who do not work the full 40 quarters you can actually buy into the program. The premium, you know you can judge whether it's high or low, but its 450 dollars, 51 dollars a month if you want to buy into Medicare Part A this year. As I said earlier 98 percent of the people over 64 are enrolled in Part A. Then the disabled who I mentioned earlier are also eligible for Medicare after they have been receiving SSDI or Social Security Disability Insurance benefits for 24 months. End-stage renal disease, as soon as you get the disease or documented with the disease and ALS will make you Medicare eligible.

Okay, Part A deductibles and coinsurance, both Medicare Part A-- now that I'll talk about, and in a few minutes Part B have deductibles and coinsurance. Deductible for Part A, for hospitalization has always been one day of hospitalization, so you pay for the first day now estimated to be 1156 dollars. And then after that first day Medicare will cover all

of your hospitalization until day 61 and then as you can see up on the slide you have to pay one quarter of the deductible and then after 90days up to 150 half of the deductible and then you pay all costs after 150 days. And for SNF care after the 20th days, so days one through 20 are essentially free, paid for Medicare after day-- starting on day 21 then you pay a coinsurance of 144 dollars. Anybody figure out real quickly where the 144 dollars comes from? Any math whizzes out there? It's 1/8 of 1156 okay. So, you're paying 12-1/2 percent of the one day stay in a hospital as your coinsurance for SNF care.

One thing to note though there's no cost sharing for either home health or Hospice. The last time I gave this talk someone reminded me and actually I didn't even know the difference. What's the difference between co-pay and coinsurance? A little quiz, are they interchangeable words? What's the difference between co-payment and coinsurance?

>> [Inaudible background answer]
>> Marshall McBean: Yes, the answer from the audience, a co-pay is a fixed amount and coinsurance is a percentage. To me when I looked that up and I reaffirmed it last night and before I started talking today seems a bit of nuisance, okay, but if you pay a 15 dollar payment when you see your primary care physician that's a co-payment because it's 15 dollars. If you pay-- if 20 percent of your prescription drug that's coinsurance okay. So, for the people who like to worry about words a little bit of extra knowledge. How many knew that already? Let the record show three people, oh four, sorry four people. Even Phyllis knew it from last April.

Okay, payment of Part A bills. The providers and we often call them institutional providers as distinguished from non-institutional providers. I don't know if that helps you or not and buildings are institutions, hospitals are institutions.

Okay, so providers of Part A services use the UB04, which is also called the CMS 1450 form-- uniform bill is what UB stands for. But again, this is the form they use and all claims for Part A services-- I'm sorry period. Let me show you the form quickly. Here it is. There's one in your notebook, pretty boring and we won't go anymore into it.

But again, the Part A providers will submit this form and what they do is they submit to somebody who pays them the money okay. The claims don't go directly to CMS and Barbara will describe that whole process. And in the past the Part A claims use to go to something called fiscal intermediaries and they were the old Blue Cross plans basically when Medicare started. And there was a fiscal intermediary or FI in each state, so there were 50.

Now, Medicare has changed and there's something called MACs. And if you did the homework assignment before coming you began to see that there are no longer 50 MACs and that some of the MACs have several states within their network. And so, again these claims are sent to the Medicare Administrative Contractors or MACs. Then the last point is that the Part A services are paid for out of the Medicare Trust Fund and we'll talk more

about that in a very apolitical way in about 10 minutes. But, how did we build the Medicare Trust Fund? What creates that Trust Fund?

^M00:20:07
[Silence]

^M00:20:13
>> No answers. Oh you know, it's the Medicare tax right. You and your employer pay a tax on all of your wages and that goes-- and that's what builds the Medicare tax, the Medicare Trust Fund sorry. In preparing and reading last I noticed that in the Affordable Care Act there's going to be a new tax that will then help fund the trust fund. So, any dividend or unearned income, dividend income or unearned income in people making 200,000 or couples making more than 250,000 will have a 3.8 percent additional tax that will go into the Medicare Trust Fund okay. So, for those of you on the right side of the political spectrum that's a no-no, that's a bad thing. But anyway, it's a way that the Affordable Care Act is trying to increase the Medicare Trust Fund. Here's that form and then we can move onto Part B or SMI benefits.

Okay, the major part of Part B are physician services although remember there are other kinds of health providers besides physicians. I know it hurts the doctors when we say, but you know other people do good things for Medicare beneficiaries and so Medicare needs to pay them and those are generally Part B services.

One thing though that you need to remember is in these next two bullet points. The facility charges for a hospital outpatient service and also ambulatory care, surgery centers and things like that are Part B services okay. They're Part B services, but because the-- particularly the outpatient hospital is an institution or dealt with as an institution they will actually use the Part A form okay. The UB0 form to submit their claim for a Part B service. I know it's a little confusing the first time. So, person goes to a hospital outpatient, they receive a Part B service, the hospital the institution when billing for that service, their part of that service will put it on the same form they use when they bill for Part A services. Meantime the physician or other provider who is also part of that outpatient visit will submit a claim, and I'll show you in a minute, the CMS 1500 form and that will go into a different file; we'll talk about it, the carrier file. So, people with hospital outpatient visits will have two claims and each of those claims will appear in two different files. And tomorrow we'll talk about how you work to make sure you don't double count for example or which might be the more efficient way to find cases or procedures when you have this situation.

So, let me just read this, so it perhaps is clearer than I was just saying. A person who is seen in a hospital outpatient setting will generally generate two claims, one from the facility and one form the physician. Now, reading that reminds me of what I should have said perhaps initially that if you're hospitalized, I don't want to say of course, but you will have hospital claim and then the attending physician and the consulting physicians will also submit claims and they will be again coming on the

CMS 1500 form into the carrier file. So, when you're trying to look at costs of care in a hospital you need to again consider more than one data file. Finally Part B services are also there to cover any durable medical equipment.

Now, Part B enrollment isn't quite as easy as Part A entitlement. Somebody or your-- someone or some agency or yourself have to pay in order to be enrolled in Part B. And for most people there is a deduction of the premium payment made in the monthly Social Security check. And then I've got some numbers here just to show if you track through there how the Part B premiums have in fact increased in my mind quite a bit over the last decade. So, here in 2000, 45 dollars, now the minimum payment is almost 100 dollars. As it says here you don't have to enroll in Part B when you first are eligible for Medicare, but then if you don't enroll at that initial time you have to pay a premium later on, an initial premium. And one other thing to note is that the payment arranged in 2012 is between 99 or 100 dollars basically and around 319. I think all of you found that in your assignment. Further-- interestingly that premium is actually less than 2012 and 2011.

Okay, in addition there are co-deductibles, co-deductibles-- deductibles and coinsurance so that the deductible has been increasing, also is now 140 dollars in 2012 and then there's coinsurance of 20 percent for all of the Part B payments. There are some exceptions though. For laboratory tests there's no coinsurance, for influenza and pneumonia vaccination as well as PSA, prostate specific antigen, there's no coinsurance and it doesn't count or you don't need to have met your deductible to have Medicare pay for it.

And then finally one of the great things of 2010 just after Ted Kennedy died was finally the passage of the Mental Health Parody Act. For those of you who concerned about mental health and mental health services there's been a bias since forever that people who require mental health services should have a coinsurance of 50 percent whereas if you have physical illness the coinsurance tends to be and in Medicare is just 20 percent. But, with the Parody Act passed in 2010 beginning in 2011 this 50 percent coinsurance will gradually decrease over, I believe its five years down to 20 percent, so parody with physical illness.

Okay, now this top bullet states the basic that the physicians and other providers in those-- including those who provide durable medical equipment use the CMS form 1500 and submit their claims to the same Medicare Administrative Contractor for their geographic area. And then this repeats what I said earlier. Let me read it because if I try to say it I get all confused. So, hospital outpatient facilities and home health agencies use the UB04 form submit claims for Part B services okay. So, the first thing that's maybe a little bit of a disconnect there is just remember that hospital outpatients and home health provide both Part A and Part B services okay. So, when they are providing a Part B service they still use that form they use when they provide Part A services okay. And these forms used to be committed-- submitted to the fiscal intermediary.

Now, with the MACs that process both the Part A and Part B claim the hospital

outpatient and the home health agency send their Part A and their Part B claims to the same organization. So, that makes it sound a little simpler, but again the organization is receiving things on two different forms and ultimately that information winds up in different files okay, at least for the hospital outpatient. For the home health agency it all appears in the home health agency file. Okay, here's the Part B form or the CMS 1500 and we'll talk about that in great detail tomorrow.

Now, here's a slide I would like to pause on for a second, so let me just ask are there any questions of-- about Part A entitlement services, payment. Okay, a good part of it you'll hear again later today and tomorrow. If you look at this slide and in this I think you can see it pretty well in your notebook. These are the revenue sources for Medicare in fiscal year 2009, probably not too different than currently 2011-2012. And so, you can see first of all that all of Medicare is costing 500 billion dollars, so half a trillion and change. Now, look at Part A okay, so half of all roughly is Part A, so hospitals still get the lion's share. Part B is incredibly large. It used to be maybe a 65-35 split between A and B. But, Part B services at least in terms of total cost have increased quite a bit. And then you've got Part D, which is about 12 percent of the total at 60 billion.

But, what to me is interesting and I think worth pausing as a little bit of a civics lesson on more than something to do with the actual data is to see what the different revenue sources are. So, I went quickly when I talked about Part B and just said where does the trust fund get its money and that's from payroll taxes, 85 percent comes from payroll taxes. They're smaller amounts, six percent comes from taxation of Social Security benefits, which I don't quite understand and then others, so mostly again from payroll taxes. What about these other two? Where does most of the money come from for Part B, which we're talking about right now and then Part D that we'll talk about in a little while? It comes from the general fund. Who is the general fund?

^M00:30:55
[Silence]

^M00:31:01
>> Anybody? That's you and me right. It's the general fund. The revenue raised every year for the Federal Government. So, first of all note that Part B and this is actually required by law that the Part B cost are covered 75 percent by the general fund and 25 percent by the beneficiaries. And so, that's why you see adjustments in Part B premium year to year is to try to first of all figure out how much it's going to cost and then to try to estimate that 25 percent. So, here the beneficiaries if you will, they've paid most of this, but they haven't paid most of this right and that's a question of redistribution, social justice, whatever you want to talk about, but that's what it is. And the thing that-- the reason I bring it up and I don't get too excited because it is just facts is that when people talk about Medicare going broke, what they are talking about I believe, but they never make the distinction is Part A because that's the trust fund that's going broke. The general fund will never go broke. And

so, the-- when people talk about Medicare going broke they're not talking about Part B, they're talking about Part A.

Now, Part D while I've got it up here why don't I just finish. Notice for Part D 80 percent comes out of the general revenue okay. So, have the beneficiaries paid for their Part D services? Well, they only pay nine percent through their premiums okay. So, think about it. So, when people criticize the Part D program as being a burden on the taxpayer, and some people do, it's because it was-- it is funded out of the general fund and not by the people who consume the service okay. And I just say that as a neutral statement. So again, it is a redistribution of income from those of us who are paying taxes to the people who have the Part D program.

Managed care, later called Medicare Plus Choice, now called-- what did I say it was called before, right Medicare Advantage okay. So, we've had few of Medicare since 1966. Medicare Managed Care began in 1985 and as I said earlier you must have both Part A and Part B and continue to pay the Part B premium or have it paid for you in order to be in Medicare Advantage.

Medicare Advantage very briefly described, the MA plan assumes the risk. The plan is paid by CMS on a capitated basis. The capitation is based on something called the CMS Hierarchical Condition Codes or CMSHCC. I don't have time to go into the detail of that, but that's fun reading and understanding that. Initially the capitation was based on 95 percent of the average annual per capita cost. And what that means is that you lived in a certain county and were in Medicare Advantage CMS paid the Medicare Advantage provider 95 percent of what it cost for the average beneficiary living in that county adjusting for a couple of things and that was cool. Except it also made sense right because you were doing managed care right, because you have managed care it should cost less, made sense.

However, in previous recent administrations the managed care plans weren't making enough money. And so, they've changed it so that now the Medicare Advantage plans are basically paid 10-14 percent more than the cost of treating a fever service patient right. Now, that is a political statement on my part. I mean, that's a real change and there are a couple of Kaiser, do you want to-- well you're special. You're in-- Kaiser is special, but the other Medicare Advantage plans are making now more money on every beneficiary than those people-- than it costs to treat someone in the fever service system, end of statement. Okay, however or maybe because of that managed care with or Medicare Advantage has continued to grow particularly once this change took place here in the mid portion of the first decade of the 21st century. And so, here we go we've got almost 30 percent now, over 25 percent of Medicare beneficiaries are in Medicare Advantage okay.

So, what they notice is first of all their getting more services, 10 percent more, 14 more plus with the advent of Part D a lot of people found that the Medicare Advantage drug programs being linked to the Medicare Advantage plans was something that was attracted to them. And so, you have critically after 2006 this marked increase in beneficiaries joining Medicare Advantage and I think it's been stimulated by the MAPD or Medicare Advantage

Prescription Drug programs.

Now, earlier I said the good news for the epidemiologist was that 98 percent of all elderly beneficiary or all elderly Americans are Medicare beneficiaries. The bad news is that over 25 percent are in Medicare Advantage because we do not get claims data for these people. So, the question of generalized ability-- although no one raises it at the end of their papers, you know it doesn't say Medicare study blah, blah, blah. Weakness only represents 75 percent of the elderly. But, I think you need to know that. Again, somebody someday will start seeing whether there are major differences caused by that leakage if you will in terms of what we can say in terms of the entire elderly population.

So, here we have a couple other points to make in terms of Medicare Advantage as it's distributed throughout the country. If you can see it perhaps better at the table than on the screen there's a wide range in Medicare Advantage enrollment by state. The West Coast, which as you can see a little darker here, Minnesota, Florida, a few other areas, Pennsylvania, very high enrollment, other states as low as four percent, in Wyoming three percent and Vermont. This is 2009. Here's similar for 2011. I couldn't find one that had the actual state percentages, but roughly the same distribution. And here's one we did way back when in 2001, looks the same okay. So, in one sense if you've got a problem you've had it for a long time so don't worry about it, there's variation at the state level.

However, one thing to point out is looking at the county level, so that some of you will go home and you'll do more local studies than I do. I tend to do national studies. And if you're in Florida or California on the West Coast you can see that even by county there's huge variation in HMO penetration. So, by just point this out to remind you that if one of these areas where there's high and low, a mixture of high and low HMO penetration you might want to take that into consideration in your study.

So, in summary what I've said in the last couple of minutes there's been an increase in the rate of enrollment in managed care or Medicare Advantage and I have answered my question why I think that's due to Part D. The enrollment is not uniformly distributed throughout the country. And as I said a few minutes ago these data called encounter data are not available for researchers. We keep hearing it will be available. CMS has data that they could make available, but it is not yet available. They keep putting this next bullet point in here. Back in 1999 we were saying well by the first of January in 2000 we'll have hospital data, has never happened and it's 12 years later.

The good news is that Beth will describe in segment D how you can identify those people in Medicare Advantage and then how you can exclude them, so you can toss them out of your denominator. They're not in your numerator, so you can get rid of them from your denominator. And then we recommend these exclusions being made. Okay, end of Part C or Medicare Advantage, any questions?

Okay, so this a bit of a transition or at least a transition I can make

into Part D because even though I just said you can't get information on Part A and Part B services provided to Medicare Advantage beneficiaries you do know or you can get information on beneficiaries who are enrolled in the Medicare Advantage Prescription Drug plans. So, you can do comparisons if that's your interest in Medicare Advantage, MAPD and D for service drug beneficiaries PDP plan users, so that is possible.

Okay, so Medicare Prescription Drug Program or Medicare Part D, here are some acronyms that you may not have come across in the past, so let me run through them very quickly. PDP is the Prescription Drug Plan related to fever service beneficiaries. MAPD as I've said many times is the Medicare Advantage variety prescription drug event. We talk about events. We don't talk about claims. And it's about a 10 minute discussion, but you'll see in the Medicare Part D data, a 10 minute discussion that I don't have time for. You'll see events. You'll see the PDE files, Prescription Drug Event file as opposed to claim file. Initial Coverage Limit or ICL, I'll talk about that more in a minute. Then there's the catastrophic coverage limit, something called true out of pocket cost, low income subsidy and Master Beneficiary Summary file I've already mentioned and the BSF, the Beneficiary Summary File.

So, Medicare Part D implemented in 2006 as part of the Medicare Modernization Act of 2003. It's based on a competitive model, which as it says here, beneficiaries can voluntarily, voluntarily, voluntarily purchase drug coverage offered by private drug plans, not public drug plans. The Part D plans have a lot of flexibility in designing the plan benefit package, so there could be different deductibles or no deductibles, different co-pays, certainly different formularies, things that are used to encourage efficient use of drugs like prior authorization can vary between plans and premiums vary by plans.

So, when we do our workshop and if you're interested in Part D, I encourage you to come to CMS 106, our workshop related to Medicare Part D. We do an exercise like the one you did before coming here where we asked people to take a-- take me basically and find a plan for me. It's kind of fun. I mean if you want to start learning about the program, just you know call your aunt or your mom or dad or someone and say what drugs are you on and then see if you could find a good plan for them. It's a way to begin to understand the Part D program and you can find that on the Medicare website.

Part D enrollment is by calendar year. You can choose again from a multiple number of plans as it says in the next bullet. In 2012 every beneficiary had at least 25 plans from which to choose. Open enrollment last year was beginning on October 15th, it will be the same this year and it will run through December seventh. Interesting to note though, only about six percent of people switch plans year to year. So, once in a plan people seem to be pretty stable.

The fourth bullet here points out that the premium actually went down in 2012 from 2011. That's an encouraging sign perhaps. The percentage of Medicare beneficiaries enrolled in Part D though isn't the 98 percent or the 75 percent that we've been talking about Part A or fee for service

compared to Medicare Advantage. Only about 60 percent of people are enrolled in Part D. And as I've said Part D is enroll-- is optional, enrollment is optional as with Part B, but also if you join later there is a penalty for not joining at age 65. One of the things I'll talk about a little bit in a few minutes is this extra help for this thing called Low Income Subsidy, the LIS.

Okay, so here's Part D enrollment in 2010. The first thing to think about is whether a person has creditable coverage. So, 33-- 32-33 percent of the people have some kind of drug coverage as deemed to be equivalent to the Medicare Part D. So, if you're a retired Federal employee, if you're retired from an industry that had perhaps a labor union you have a drug benefit as part of your retirement benefits and that's considered creditable coverage. So, if you're in that category and don't join Medicare Part D you don't have to pay a premium on your premium. Sorry for saying it that way, but you don't have to pay an extra premium if you ever do join Part D period. Then there are people who don't have any creditable coverage, so these people don't have any drug coverage as far as we know. Then for those who do have Part D you see the distribution, roughly 2/3, 1/3 not quite, but close enough between the fee for service or PDP drug plans and the MAPD drug plans.

This is an attempt to show the benefit. If you start at the bottom as a person begins to consume drugs and have them paid for most-- the standard benefit, again this is standard benefit and there are lots of plans particularly the MAPDs that have no deductible, but again standard benefit. There is a deductible phase, then after a certain point you go into essentially the insurance phase where the beneficiary is paying 25 percent and insurer is paying 75 percent. Then you reach this line here, which is the initial coverage limit and then you fall into the doughnut hole. The more formal term is coverage gap. So again, repeating you have a deductible you've got to meet, then you have insurance and coinsurance or co-payment. Here's the percentage, so coinsurance, but they are more likely co-payments. And you reach this initial coverage limit, you fall into the doughnut hole and the new news in 2012 was that in prior years this coverage gap period the beneficiary had to pay the whole amount, whereas in 2012 for brand name drugs the beneficiary only paid 50 percent and had a 14 percent reduction in generic drugs. And of course these two numbers will increase over time until they become zero. That's all a part of the Affordable Care Act.

Once we reach this next threshold, which is called the catastrophic threshold, then the enrollee pays a very, very tiny amount in terms of a co-pay. The plans are pretty off the hook and Medicare pays 80 percent. So, in this catastrophic phase Medicare's paying the bill. So, it goes beneficiary, insurer, beneficiary, Medicare. Comments, questions?

There are a couple of things on the side here. Here's this acronym, TrOOP, True Out of Pocket Payments and over here is the actual drug cost. So, the reason I feel compelled to put the TrOOP amount in here is this, the actual dollar amount that are used to calculate these various cut points and are used by the Chronic Condition Warehouse. If you ever start getting

Part D data to describe where people are either just here or here and here, here, here and here etc, but this is just to make it a little bit more realistic. This is the actual amount as it would be translated into the actual drug payment. So, above about 3000 dollars you fall into the doughnut hole and then finally 3700 dollars later you're in this catastrophic phase.

I put here the definition of TrOOP because it so complicated or so long, I guess not complicated. But, when people talk about or Medicare talks about true out of pocket costs this is both out of pocket spending and it's very fun because it says of the beneficiary or family member or official charity, supplemental drug coverage, through a state pharmacy assistance program like the PACE program in Pennsylvania or the Low Income Subsidy, the LIS I've mentioned a couple of times or under demos. So, there's a whole lot of stuff here that-- it isn't just what the person actually pays, but what they pay plus what a lot of their friends can help them pay. And then as I said a couple of minutes ago the TrOOP is important because that's what CCW uses in calculating where someone is along this spectrum of Part D payment.

Here is some data now and they'll be a few slides like this showing how things have changed over time. Things have gotten a bit more expensive under Part D for the past 7-2-4-6 years. You can see the deductible has gone up as has the ICL, the TrOOP in the total drug coverage or expenditure, total drug expenditure coverage. So, things are getting more expensive. Here's that slide I showed earlier and again to remind you that most of the payment for Part D comes out of the general fund or the general revenue.

This extra help I mentioned, Low Income Subsidy there is this program to help beneficiaries pay for their deductible, their coinsurance and possibly co-payments depending on what their income level is. People who have Low Income Subsidy or who qualify for the Low Income Subsidy have no liability in the coverage gap and there's no late enrollment penalty. Over the last couple of years if you can imagine there is this benefit people at CMS and number of advocacy groups are concerned that the beneficiaries who were eligible for this subsidy actually get it. And so, there have been a lot of efforts to encourage people to know about this subsidy and to sign up for it.

Here's the Medicare Part D enrollment, again slightly different pie chart where I've included now the LIS people and I'll go through this kind of close-- slowly. So, here's the 10 percent with no creditable coverage, then here 14 plus 13 plus 3, these are the people with creditable coverage, but broken down into groups like the Federal employee workers, the retired benefits-- beneficiaries, people who have Tricare or active workers like me, then there's other types of creditable coverage. Okay, so here's primary if coverage through retirement plans, this group 14, then others-- there are employers who actually get something called a Retiree Drug Subsidy, which means that CMS was trying to encourage people who had drug coverage from their labor union or from their employer to continue having that coverage rather than falling completely into Medicare Part D. So, Medicare will pay part of that drug plan for those people and then here

are others with creditable coverage, so that's the creditable coverage group. And then here are the MAT-- MAPD people, the 21 percent and four percent of those, so about 25 percent of the MAPD people are LIS, which tend to be low income people. The PDP folks though, that 38 percent almost half okay are LIS.

And so, again as we begin to think generalize ability if we have Part A and Part B data only on those who are on PDP and half of those people who are on PDP or in LIS then the people on whom you really have a lot of data A, B and D, half of them are poor. So again, you have to start worrying about the generalize ability of what you're doing. This is more about the Low Income Subsidy and here are a couple of slides that show the details. I won't go into them now more than you need to know, bingo.

Just a couple of comments on the Part D data itself, I've broken it down into denominator data if you will and numerator data. The denominator data base in the Beneficiary Summary file segment of this Master Beneficiary Summary file I've mentioned several times that Beth will talk about. And the information in this Beneficiary Summary file segment is there for all Medicare beneficiaries. And so, whether not you're in Part D you still will know obviously whether they're in Part D or not, whether they're in a PDP or MAPD and you also know the LIS status. So, it gives you some clues for beneficiaries as to their income and then you also can know about their dual eligible status, more about this later.

Finally, the numerator data in Part D is in something called the Prescription Drug Event records or PDE file and a couple of facts about this PDE file. There are about a billion claims in it annually. This again is the name of the file and it's linkable to something called characteristics files, which contains information about the medication so you can know whether it's a generic drug, a brand drug, you can know how many days prescription they received. You can also know about the drug plan. You can know some things about the prescriber, the physician as well as the provider, the pharmacy although this information is quite limited. And again, if you're interested in Part D we encourage you to come to our Part D workshop.

So, if you haven't understood things I've said there's help out there called The Research Data Assistant Center. Again most of you or all of you know about-- some of you have actually used the assistance desk, briefly to describe it we've had a contract now for 17 years with the Center for Medicare and Medicaid Services to provide services and help CMS increase the number of researcher skills and accessing and using CMS databases for studies of the Medicare and Medicaid programs and beneficiaries and I like to add in order to improve the health of these beneficiaries. And we have the assistance desk, which is staffed by masters level trained technical advisers and they're happy to answer any of your questions regarding Medicare and Medicaid, the data, data access and availability, record layouts, information about the program.

So, if you have any questions please feel free to contact the assistance desk and we will work you from-- work with you from your first inquiry until

you actually submit incomplete data requests to CMS. The technical assistance desk supports the ResDAC website and our website was revitalized and modernized in August, so if you haven't visited since then you might want to do that.

Here are the workshops while you are currently in CMS 101 as you know. I mentioned earlier CMS 102, Introduction to the Use of Medicaid Data for Research and then we have a few other specialty workshops. There's one on cost reports for those of you who are interested in that, our Part D workshop and we have been running on comparative effectiveness research, which we may or may not continue. Here's the way to contact ResDAC, again most of you know these, but they are there for your reference.