Ok. So then let's go ahead and move on to the next segment which is looking at the PDE cost information in the PDE event record. I always start this out by stating that researchers really cannot determine the true cost of Medicare or the plan for these prescription drugs. And I'll explain that a little bit more. But you can determine what that point of sale cost to the beneficiary was. So you do know what the gross drug cost was and you do know what the patient-pay amount was at that point of sale. But what it really cost Medicare or what it cost the plan, researchers really will not know. The reason why, again, is to protect the commercially sensitive plan data, the final rule addresses that only certain elements of the PDE data are released for a researcher. But that plan--that information does not extend to any plans specific big data, any rebates, drug rebates that the plan is getting, any risk sharing or reinsurance that there is between the plan and Medicare, and any payment information that's collected outside of the Part D event.

So just to give you an analogy of what I'm saying when you're looking at the cost information in the PDE file, the--inpatient hospital claim information, you know that this is what the hospital was going to get paid for that particular hospitalization. But at the end of the year, the Medicare is still going to look at their cost report information and maybe adjust what did that hospital get paid overall. So again, you know what some of the information is at that point of sale for this bill but you don't know in the end what did that plan get paid for their drugs for Medicare, what was some of the cost to them personally as well because of their drug rebate information, so on and so forth. So again, if you're trying to say, "This is what the Medicare Part D program cost," you can look at gross drug cost, but is that really what the plan--what they actually had to pull out of their pocket to pay?

So the very first variable that I told you about is a derived variable. It is the gross drug cost. If you look at the variable name, it looks like it's also the total drug cost. So that's the variable name as well. And again, it's derived from either three or four variables that are submitted by the plans to CMS but not available to you. So prior to 2010 or, excuse me, 2011, the ingredients cost were the ingredients, the dispensing fee. And again, that's always the fee that's negotiated between the plan and the pharmacy, and then if there's any sales tax. And again, beginning in 2010, you will also find a vaccine administration fee that is included in this total gross drug cost.

When you're looking at the data, again, these means and medians and the information I've given you can vary slightly from year to year. I believe this information was based on 2008 information. But the mean gross drug cost was 65 dollars and 20 cents and then the median was 21 dollars and 70 cents.

So if you're looking at what the variables are, this next slide is--if you ever need a slide to print out, print this slide out and tape it up because this is going to give you the highlights of what you need so that you have a total gross drug cost, what does that mean? That total gross drug cost equals the following six variables. It includes the patient-pay amount,
the low income cost share, subsidy amount, the other two out-of-pocket amount, the patient liability reduction due to other payer amount, and the covered D plan paid amount, and then, lastly, the non-covered plan paid amount. So when you sum those six variables, that will equal the drug--gross drug cost. Now, the first thing you do if you go home and do this, you'll say, "I had all these records that don't equal." Well, they're usually off maybe less than a dollar and usually it's only like one or two cents that this doesn't equal simply because when you're slicing up that piece of the pie, the rounding will not always necessarily equal. But again, this is really the key to know when you're using the cost variables is this formula that these six variables will equal what the drug--gross drug cost is.

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>> You have access to all this--

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>> Yes, yes. All these six variables as well as the gross drug cost are in the PDE file for you to select. So again, the gross drug cost, there is one other limitation now with this. Now, I've just stated that these six variables will equal this gross drug cost. There's now a limitation to that formula. Because beginning with the 2011 data, this gross drug cost will still continue to be the full cost of the drug but as we know that the benefit changed in 2011 where there is now a gap discount for drugs. And so, it is not reflect any coverage gap discounts that may have applied to that fill. So therefore, that--those--the sum of those six variables could potentially be less than that gross drug cost or the variable total of gross cost. So if it's less than what it is and by a significant amount, then you can assume that the difference is what was attributable to the coverage gap phase benefit. So what their discount amount was.

So what does that mean? So again, we had this beneficiary that had a total gross drug cost of 65 dollars and 20 cents, but this BENE is now in the coverage gap. So the patient paid five dollars and 53 cents. Again, the rest of the variables, if he happened to have LICS, if he had some other pocket amount or some other third party contributing to it, what the plan was responsible for or what was non-covered. Again, now, you sum all of these up and it only equals 59 dollars and 67 cents. So this difference of the five dollars and 53 is assumed to be that gap discount to the beneficiary. So you still know what the true drug cost is. But in this case, there was a 50 percent discount in the gap to that--what the patient had to pay. So it's going to really reduce the patient-pay amount or, you know, potentially someone else picked it up for the patient.

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[ Inaudible Remark ]

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Yes, 2011 will be the first time that it no longer equals and what doesn't equal will--if it's significant amounts, will be considered apart of the gap discount. So what happens? They do look at the TrOOP when they're adding up, you know, the--to get through the different phases. However,
if the TrOOP is less, lower than the out-of-pocket threshold, they use the gross drug cost. So it won't hurt them to be in the discount. In other words, that discount is still a benefit. It doesn't keep them in the gap longer. It still continues to move them through the gap, so excellent question.

OK. So getting now into this individual of other payment variables or cost variables, the first one is that patient-pay amount. And we consider that this is the amount the beneficiary paid that is not reimbursed by a third party. And I'll be talking about some of those other variables. So basically, we still don't know that if, you know, I am an 83-year-old person that went to the pharmacy but my daughter was with me, she may have written the check, but it's just someone that, you know, I'm responsible for as the beneficiary and not another third party. So, we still don't know whose out-of-pocket is. We don't know, do I have supplemental insurance that I can submit, you know, these co-insurance are co-pays too. So, we just know that's really, again, the patient's responsibility or the patient-pay amount that is not responsible by a third party. And again, the patient-pay amount is one of the variables that contribute to the true out-of-pocket or the TrOOP amount, again, for covered drugs only. So if I am an enhanced plan, it will not contribute to my true out-of-pocket or to my gross drug cost.

Here is where I give you the percentage again of how many fills are in each of these status codes for coverage. Again, over 99 percent of the fills that you will see are covered drugs, less than half percent are enhanced, and then a very, very small amount are over-the-counter. When you look at some of the means and medians in where people are with the patient-pay amount, you see a lot of them that have zero amounts, a lot of the LIS will have no patient-pay amounts. The mean for the total population is around 11 dollars. Even at the 25th percentile, it was still zero amount. And at the 58th percentile, it was only 3 dollars. So again, patients are not paying a lot of out-of-pocket for their fills. However, when you divide that out between the two types of populations, the low income subsidy groups versus those without low income subsidy, again, for those that are LICS, very seldom do they have to put out very much for any co-pays. Again, the mean was just a dollar 71 for them. Even at 50 percent, it was still a little over a dollar. However, the mean for those without LICS supporting them was almost 18 dollars for that.

So that was the patient-pay amount.

I'm now going to move on to the low-income cost sharing subsidy amount. And again, this is the amount that the plan reduces what that patient is responsible for their patient-pay amount because of their LIS status. And again, plans do get paid for the drugs and these payments. However, at the end of the year, they will reconcile with the--what they pay the plan with the actual amounts that were incurred. So there is some adjustments. Again, when I talked about how claims were processed, there was that reconciliation time period that CMS has which is why the file was always delayed in time. So there is some actual adjustments that can be made from the point of sale time.
If you look at the means for this, again, looking at the total population, the mean was 14 dollars and 67 cents. Again, it's not really accurate to look at a mean for the low-income looking at the total population. But if you look at those that are in LICS only, the mean was a little bit higher, again, just supporting the fact that they do have a lot of help with their drugs. The mean was 34 dollars and 69 cents.

The next one is this other true out-of-pocket amount. So what is this? This is an amount that records all qualified, and I want to emphasize qualified third party payments on behalf of that beneficiary. This is not an amount that is responsible for the LIS patient or the patient-pay amount. Examples of qualified are pays program, state assistant programs, other charities. But you have to be a recognized qualified entity in order to have this populated. It's not populated very often. Again, most of the time, even at the 95th percentile, no one has actually had any other true out-of-pocket amounts of populated. There's only about little over two percent of the records that even have it populated. When it is, again, it kind of reflects what the cost of the drugs tend to be or what an LICS may have supported as well. So it's around 23 dollars and 58 cents.

And then the last kind of out-of-pocket cost would--is considered the patient liability reduction due to other payer amount. Again, this is if someone else has some other benefits, examples maybe TRICARE or the VA. These are types of other places that they have that they can reduce what the patient is responsible for. They are not TrOOP eligible. These are types of people who do not then participate in the Medicare Part D. I will say very, very seldom do you ever see this populated. And mostly, because if they are VA, typically, they'll just go to the VA and it's in their system and it doesn't flow through the Part D plan. So again, it can be a little misleading that if you think, "OK, I can then track any VA cost," you can't. It's not very well populated. If it is, sometimes, you know, it just happens to be that they got it and then they try to get reimbursed by the VA later. So, it's not very well populated. But again, depending, if you're looking at cost, it is part of the puzzle that adds in the gross drug cost. But if it is populated, again, the mean is very similar to what we see as far as support for these drugs.

So we've kind of talked about what the patient is responsible for. Those first four variables included the patient-pay amount and then any outside third party that may help--be helping that patient with their out-of-pocket cost. These next two variables that I'm going to be talking about is what the plan is responsible for. So the next one is called the Covered D Plan Paid Amount. And again, this will be populated simply for those drugs that are "covered". When you look at it, the mean is 35 dollars and 32 cents. Now, I want to, again, keep in mind that this is what Medicare has agreed that for this fill, at this benefit phase, based on the cost of the drug, this is what Medicare has agreed to cover to that plan. That doesn't mean that unlike the claim that gets paid, you know, you submitted a claim, we're going to pay you this amount. This may not be the exact amount that that fill actually got reimbursed to that plan because of all the other reconciliation that happens with the information that we don't know about. But if you want to just kind of see it as a whole what is Medicare covering
for Part D drugs, this is the variable that you would use. This is what Medicare basically says, "We're going to pay you the plan for covering this beneficiary for this drug."

So the last then variable is this non-covered plan paid amount. Again, we've gone over and over yesterday what exactly does non-covered mean. It means that it was a drug that--or an item that was on a beneficiary formulary that say, "We will cover this," but it's not part of the standard Medicare benefit. So that means that the plan is responsible for this whole amount. So when CMS reconciles what they're going to pay the plan at the end of the year, they don't care about the amounts in this field. This is solely the risk that the plan takes to cover these drugs because they can charge higher premiums to offer these drugs. So, they're going to try to recoup their cost or paying for these drugs, non-covered drugs through premium amounts. You can have negative amounts. I'm going to explain that in a minute. So when you look at the non-covered plan paid amount, if you see something negative, it doesn't mean something's going on strange. And I'll talk about that more again. Again, the mean is like 3 dollars and 56 cents but that's looking at the whole population again and that's including covered drugs. So that's why it's so low. When you only look at some non-covered drugs, it looks a little bit lower.

So, there are three patterns that it could--can occur when you look at this NPP variable. That the costs are always--well, there are maps to this if you map them to standard defined benefit. So when the plan pays more for what is covered in that particular benefit phase under the standard benefit, that NPP is going to be a positive amount. If the plan and the standard benefit are the same, it's going to be a zero amount. If the plan pays less than what is covered in a given phase under a standard benefit, the NPP will be a negative amount. And it's usually the negative amount that gives people pause to, "Why am I seeing is negative amounts?" So this is an example. Again, this is why I was talking about the 2010 benefit. I'm not going to read this to you. But bottom line is if you want to, you know, take a second to read this, I'm going to go to the next slide because this kind of explains a little bit more.

So during this, this is a covered drug and the cost for that covered drug was 100 dollars. And we know that given the benefit phase to this person was in that that patient--the beneficiary had a patient-pay amount of 40 dollars. So they always calculate what the patient is responsible for based on their co-pay or co-insurance. So for this 100 dollar drug, this patient was in a benefit phase where they were responsible for 40 dollars of it. And so, what the plan actually paid at the point of service, again, this plan paid at point of service is not a variable that you find in the files. So I don't want to confuse you. C is not a variable you will find. But this is just to illustrate why things are different. So again, with the patient paid and what the plan paid to that pharmacy for that 100 dollar drug still equals the 100 dollars, 40 and 60.

Now, what Medicare says that they're responsible for, they're now in this initial coverage limit where--or the phase where the plan is responsible for a 75 percent of the cost of the drug. So again, what Medicare says
the plan is responsible for is 75 percent of this drug. So that's their covered plan paid amount. They were in that initial coverage gap where the plan paid 75 percent if you want to go back to that one slide. So then what Medicare says your covering is actually 75 dollars of that drug. But in essence, because the plan only had to pay 60 of that given what the patient had to pay, their non-covered paid amount is a negative 15. Why is that? Again, because all of these variables have to equal that gross drug cost. So that's how you get a negative amount.

So again, when you're looking at these and want to divvy up some of what the costs are, all the variables that are related to the beneficiary responsibility of what we talked about is that patient-pay amount, the LICS amount, the other TrOOP amount, and the PLRO amount. So again, those are things that are under the beneficiary's responsibility whether or not it's them or a third party paying for them. And then again, the net amount that a Part D paid for the drug is just the covered drug plus the non-covered paid amount.

Again, just want to reiterate that CMS only looks at that covered plan paid amount in the reconciliation with the plan at the end of the year. Plans take the chance of recouping the cost of those non-covered amounts based on higher premiums for enhanced benefits.

There is no TrOOP variable in the data. So if you're trying to maybe calculate some phases or TrOOP cost yourself, TrOOP is equal to the patient-pay amount, that LICS amount and the other TrOOP amount. That PLRO does not account for TrOOP, so it's just these three. So again, just wanted to reiterate looking at this example of what that gross drug cost was and if this beneficiary happen to have every single variable with a little piece of the pie whereas the gross drug cost would be the 65 dollars, the TrOOP is actually the 26 dollars and then what Medicare covers for that actual drug would be the 35 dollars.

Just real briefly, some people may want to use this variable, you can. It's not always completely consistent with the benefit phase because, again, some of the information. This is calculated by CMS. And when the CCW creates that benefit phase, it is a derived file, so some of the information will be a little off but really isn't too bad because there's about eight percent of the beneficiaries that fall into the coverage--the catastrophic coverage phase. But again, if you wanted to look at this variable just to see how many people went all the way through the phases into the catastrophic phase, there's about--a little about over eight percent of that will actually reach the catastrophic coverage phase.

And I just wanted to close again. We've talked about in the cost of what people are looking at and what they're advertising. If you look at the top 10 drugs by cost, and this is the gross drug cost variable in 2009, I've just given you the top 10. I think you'll notice that a lot of these are brand name drugs. You've got the Plavix, the Lipitor, the Nexium, Abilify, Flomax, so all of these are brand name drugs. And there's a lot of cost to this.