CALIFORNIA HEALTH ADVOCATES

MEDICARE PART D: IMPLEMENTATION OF THE NEW DRUG BENEFIT
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Committee on Energy and Commerce
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Written Testimony of California Health Advocates

I. INTRODUCTION

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California. Separate and apart from the State Health Insurance Program (SHIP), we do this in part by providing support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAPs) with which the SHIP contracts to assist California's Medicare beneficiaries and their families. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare. Our experience with the implementation of Medicare Part D is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting Medicare beneficiaries.

It is clear that the new Part D prescription drug benefit can provide needed prescription drug coverage for those who previously had none, and individuals eligible for the low-income subsidy (LIS) will receive the new benefit at very little cost. But the first two months of the program demonstrates many of the structural defects in the design of the new program that relies solely on commercial companies to provide the new benefit in widely varying ways. By Secretary Leavitt's own admission, the roll-out of Medicare Part D has been a "difficult transition" and, although the Centers for Medicare and Medicaid Services (CMS) has worked hard to make some incremental improvements, many problems with Part D will not go away due to flaws in the basic design of the benefit and its operation. In this written testimony, we first describe the problems Part D enrollees now face –and will continue to face – as the Part D program progresses. Secondly, we use our experience with current implementation problems to analyze broader structural flaws with Part D and propose some recommendations to make the benefit work better for all beneficiaries.

II. IMPLEMENTATION OF MEDICARE PART D -- ONGOING PROBLEMS FOR BENEFICIARIES

As widely reported by Medicare beneficiaries, advocates, pharmacies, physicians and the media, there have been myriad problems with the implementation of Part D. While many individuals are getting their prescription drugs, and some improvements have been made to correct problems in regard to data issues and Part D plan phone accessibility, beneficiaries still face numerous problems that will not get better without fundamental changes made to the way the program is designed and administered. Without addressing the issues outlined below, Medicare beneficiaries will continue to face problems navigating Part D and getting the medications they need at the lowest cost.

Overview

The HICAP network and other advocates around the country report that their clients are overwhelmed by the sheer number of choices and complexity of Part D plans. Some were auto assigned to a plan without regard to their pharmaceutical needs while others were faced with the complexity of choosing a plan from dozens of different designs. Once in a plan many have been unable to obtain their prescription drugs or have had to pay full retail prices when their subsidy status was inaccurately recorded by CMS or the plan. Advocates report that those who are dually eligible encounter the most dire problems, but many of these problems can and do affect Medicare beneficiaries regardless of their economic status.

Over 6 million dual eligibles had their drug coverage switched on a single day from Medicaid to Medicare, resulting in massive systems failures at the pharmacy level, the plan level, at 1-800-MEDICARE and the Medicare website. The sheer volume of dual eligibles, combined with their generally poorer health status and inability to pay for their own medications, swamped the resources of most local programs designed to help Medicare beneficiaries navigate this new benefit. Many Part D enrollees simply did not get their prescription drugs, and continue to experience difficulty due to a number of problems, including:

- CMS and contractors' databases fail to reflect correct eligibility status.
- Consumers, advocates, and pharmacists are unable to get through to Part D plans.
- When reached, 1-800-MEDICARE and Part D plan customer service representatives are often unable to provide accurate information.
- Dual eligibles were auto-assigned to Part D plans without regard to their pharmaceutical needs or their ability to pay premiums for Medicare Part A and B benefits in MA-PD plans.

- ¬ CMS' "backup" point of service system (Anthem/Wellpoint) fails to provide prescription drugs to dually eligible beneficiaries.

- ¬ Widespread system failures result in pharmacies charging the wrong cost-sharing for drugs, causing duals to go without critical medications when they are unable to pay.

- ¬ Part D plans and contracting pharmacies fail to honor transition plan "first fill" obligations, and

- ¬ Consumers of all economic circumstances are unable to file exceptions and appeals with Part D plans to get the drugs they need.

Understanding the Benefit

California HICAP counselors and their counterparts nationwide have been working tirelessly to help educate Medicare beneficiaries about the new Part D benefit and assist them in exploring their enrollment options. In addition to the unprecedented volume of demand for their services, the nature and structure of the Part D benefit injects a level of complexity that requires significantly more time, effort and expertise in counseling each consumer. Program managers estimate that most people choosing a plan require several hours of counseling time and often multiple counseling sessions (each of several hours in length) to collect information about their drug usage and research plans that cover those drugs at an affordable copayment and at the pharmacy of their choice.

The sheer number of drug plans available presents an overwhelming choice for most beneficiaries. Each plan differs in structure, benefits, and costs and some are sold by multiple entities under co-branding agreements with the plan sponsor. One Part D sponsor's product in California, for example, is being sold (or "co-branded") by 14 different insurance companies; another sponsor co-brands with 12 different companies. In California, 18 sponsors offer 47 stand-alone prescription drug plans (PDPs). In addition, beneficiaries can also choose from varying numbers of Medicare Advantage plans, both with and without prescription drug benefits. In Los Angeles, for example, there are approximately 70 different PDPs and MA plans from which to choose. Tiered formularies, utilization management tools (such as prior authorization) and price differences between contracting pharmacy networks further complicate the decision-making process. In addition, this information is not always available and accurate on the Medicare website.

Medicare beneficiaries are unable to differentiate between PDPs and the various MA plans such as HMOs, PPOs, Private Fee for Service Plans, and Special Needs Plans. Some MA plans include prescription drugs (MA-PDs) in their package of Medicare Part A and B services and others don't. Consumers are understandably baffled by the complexity and number of choices and can't be expected to understand the myriad of details necessary to choose the most appropriate plan for their needs.

Enrollment and Eligibility Issues

Unlike enrollment into Medicare Parts A and B, which is handled by the Social Security Administration, individuals must choose a Part D plan from a vast array of choices and purchase a particular Part D plan in order to get the new prescription drug benefit. Computer exchanges of data between Part D plans, the Centers for Medicare and Medicaid Services (CMS) and its contractors complicate beneficiary enrollment and disenrollment and lead to gaps in coverage. Multiple levels of communication and data exchanges must occur before medications can be dispensed by a pharmacy contracted with a Part D plan.

The pharmacist must electronically query the plan to determine whether a beneficiary is enrolled in that plan, whether the drug is on the plan's formulary, whether a deductible applies, and what copayment responsibility exists for the particular drug covered by the plan. If that data is not readily available the pharmacist must phone the plan to obtain this information. The plan cannot confirm the beneficiary's enrollment and copayment responsibility with the pharmacy until CMS has confirmed the beneficiary enrollment and subsidy status, and whether the person is enrolled in another plan or covered by an employer plan receiving the federal subsidy for employers. Any data flaw along this chain will result in medications being withheld or beneficiaries paying the wrong price, if they can afford it, for their medications.

Data flaws affect all Medicare beneficiaries regardless of their status, but they affect those who are dually eligible for Medicare and Medi-Cal (Medicaid) most acutely. While both consumer advocates and California's state Medicaid Agency (Department of Health Services - DHS) report incremental improvements in CMS data systems reflecting eligibility and enrollment, there are continuing data problems that lead to gaps in coverage for dual eligibles. The current "back-up system" for dual eligibles who are not assigned to a plan – the Point of Sale system run by Anthem/Wellpoint – allows many duals to fall through the cracks. Instead, they must rely on the state's temporary emergency funding in order to obtain their prescription drugs. Unless California takes further action, however, this emergency funding will run out in a matter of weeks, possibly months. More than half of all states have had to assume responsibility for the poorest of their residents to make up for the failures of the national program.

According to the state Department of Health Services, an estimated 10,000 Californians will become dually eligible for Medicare and Medi-Cal each month, thus becoming a dual for the purposes of Part D benefits only. DHS anticipates that despite current efforts to alleviate data problems, there will be ongoing delays in CMS auto-enrollment of these individuals into a Part D plan. Other states will have the same, chronic problem transitioning dual eligibles from their state Medicaid program to Medicare for their prescription drug coverage.

In addition, there will continue to be delays in eligibility information when dual eligibles – or any other Part D enrollee during a permissible enrollment period – first enroll in a plan or exercise their right to change plans. Enrolling in or changing drug plans requires complex data exchanges between the old plan, CMS, the new plan, and the plan's contractors and sub-contractors. This information can take many days or several weeks to be accurately displayed in the system. Changes made toward the end of the month often will not show up in the system until later the following month, making it difficult to obtain drugs in the early part of the month after enrolling in or switching plans.

In late 2005, HICAPs and other Medicare counselors helped numerous dual eligibles analyze their auto-assigned plans and find other plans that better suited their individual needs. These duals who "did their homework" however, were penalized in January when they found that their records were in chaos; the Anthem/Wellpoint POS system failed and did not help them.

> Example: Helen, age 86, a dual eligible of Humboldt County, changed her auto-assigned plan on December 15th to one that better suited her drug needs. In January, her new plan had no record of her enrollment in the plan or her status as a dual eligible. She went 3 weeks without her medications because she could not afford to pay for them, until she was able to obtain emergency coverage through the state. She did not receive her new plan's enrollment card until February 10th.

> Example: Dorothy, a Medicare beneficiary from the central coast of California, chose an AARP Part D plan in early November 2005, but days later informed them that she no longer wanted this coverage. Despite confirmation of her request from AARP at the time, Dorothy has had the AARP Part D premiums deducted from her Social Security check for both January and February and it is not clear when that deduction will end or when those premiums will be refunded.

Low Income Subsidy (LIS)

In addition to problems with eligibility and enrollment data, many HICAPs and other consumer assistance programs report that there are still widespread problems with data available to pharmacies and plans that accurately reflect individuals' LIS eligibility status and the correct amount of their prescription drug copayment. This problem is most acute when an enrollee switches plans or enrolls in a Part D plan for the first time, leading to LIS enrollees being charged inappropriate copayment amounts. This problem occurs for all LIS enrollees – not just dual eligibles.

> Example: Mildred, age 86, a dual eligible resident of Del Norte County, changed her auto-assigned plan in December 2005 to one that better met her drug needs. Her eligibility information for the LIS, however, did not follow, and she had to pay approximately 15% of her income on drugs. After 10 phone calls to various entities by the local HICAP, she found that she must wait 6-8 weeks for reimbursement from her plan.

Transition Processes

Despite CMS' request to Part D plans that they extend their transition "first fill" coverage of non-formulary drugs through March, HICAPs report that many Medicare beneficiaries are unable to access such coverage due to lack of information about transition policies at Part D contracting pharmacies and/or the unwillingness of pharmacies to provide such supplies.

Information about these transition processes have been extremely difficult to obtain through the plans; this issue is a recurring one and people will continually become newly eligible for Part D and will find that their new plan does not cover the drugs they are currently taking. The transition process is meant to allow an enrollee to request an exception so that his/her non-formulary drug can be covered or to change drugs or drug plans. Many beneficiaries who have been given a transitional supply of non-formulary drugs, however, are not receiving notices from plans and contracting pharmacies informing them what they should do next (e.g., talk with their doctors about alternate drugs, file an exception request, or change plans).

Language Access

CMS standards require Part D call centers to accommodate non-English speaking beneficiaries. Based upon reports from HICAPs and other advocates, however, non-English speakers in California, a culturally and linguistically diverse state, are not being accommodated.

In our agency's Sacramento office, we answer phone calls from Medicare beneficiaries that for whatever reason are not appropriately routed to their local HICAP program. One of our staff members, Marta Erismann – also a HICAP counselor – has personally assisted over 300 Spanish speakers in the last few months, many of whom have been unable to communicate with their plans.

Many of Marta's Spanish-speaking clients reported that their Part D plans did not have bilingual representatives, or if they did the number of bilingual staff was limited and unable to respond to the demand. Many told her that they were put on hold for many hours waiting for the Spanish-speaking counselor, only to be disconnected after waiting for an hour or more. Many were told numerous times to "call back in one hour" on several continuous days. Numerous callers reported only being able to leave a voice-mail message with their plans, many leaving messages that went unreturned for two or more weeks. On the occasions when non-English speakers were able to talk to plan staff, the staff was not generally knowledgeable about Part D and unable to respond to their questions.

The problems for non-English speakers carry over into pharmacies, as well. Many pharmacists, due to lack of bilingual staff, are not able to communicate to Medicare beneficiaries the reason they are being denied medications. Many of these individuals leave their pharmacies, not understanding why they can not get their medications.

Rural Issues

In several rural counties of Northern California, the local pharmacy is contracted with a single PDP, one with a premium too high for duals and people with low income assistance. Other than a Regional PPO plan, there are no MA-PD plans in these counties. People in all but one PDP must drive many miles to the nearest chain pharmacy over mountain roads that become impassable in bad weather. The nearest chain pharmacies do not provide home delivery services that are provided by the local pharmacy, a serious problem for people who cannot get to the contracted pharmacy. Mail-order prescriptions offered by other Part D plans do not always cover all needed medications, or deliver drugs in a timely fashion.

Marketing Misconduct

Amid the confusion over the new Part D benefit, HICAPs and other Medicare counselors report inappropriate marketing performed by plan representatives. Some HICAP managers describe speaking with clients who leave marketing presentations with no idea what they just had signed up for. Part D plan agents, with little or no oversight, can take advantage of the general confusion surrounding Part D and steer people towards plans that will result in enrichment of the agent, but might not be the best plan for the enrollee.

> Example: The HICAP program in Ventura County reports that a Part D plan agent has apparently switched a group of board and care residents from the plans they enrolled in with HICAP's help, to the plan that the agent was selling, without regard to their individual drug or pharmacy access needs.

Added Cost Burdens for Dual Eligibles

Consumer assistance programs across the country report that many dually eligible individuals have been charged inappropriate cost-sharing for their drugs, including deductibles and copayments. Even when the low-income subsidy (LIS) is correctly applied, however, it must be made clear that most dual eligibles cannot afford the new cost burdens that are permissible under the LIS.

California is one of many states that does not force Medicaid recipients to pay prescription drug cost-sharing. While dual eligibles are automatically enrolled in the low-income subsidy (LIS, or “extra help”) which covers some of their Part D expenses,

dual eligibles in California (and many other states) now face additional cost burdens that are out of their reach. HICAPs and other consumer assistance programs in California are already hearing reports of people unable to pay their rent, grocery and other survival costs due to these increased cost-sharing amounts.

Unlike current Medicaid rules, pharmacies can deny drugs to those who cannot afford to pay the new cost-sharing requirements. The only place where dual eligibles will be exempt from these new obligations is in certain long term care facilities such as nursing homes, but not assisted living/residential care facilities for the elderly. This, unfortunately, creates a perverse incentive towards institutionalization (and goes against the spirit of the *Olmstead* decision).

HICAPs report that most pharmacies are not using their discretion to waive copays for LIS individuals. HICAP programs and other non-profit agencies are receiving many calls from people seeking assistance in paying the copays – for which there is currently none.

> Example: A paraplegic client of the Health Consumer Alliance in California only makes $800 a month. Due to his many complicating medical issues, he is on 35 medications. He cannot afford the $3-5 co-payments for his meds. His delivery man has paid his co-pays the last two months. He says that he will have to choose between paying for his rent, food, and medications.
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> Example: Linda, a client of the Health Consumer Alliance in San Diego, has an income of $842 a month. She takes about 30 medications and cannot afford the $1, $3, $5 co-payments. She says that she will be out of money for food by the end of the month. If she were to move into a nursing home, she would have no copayments.
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> Example: Every HICAP counselor in Humboldt County, CA, reports hearing at least one client report that they will die because of their inability to afford their drug copays.
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> Example: One HICAP manager in the Central Valley, responding to a distraught client who could not afford her copays for her insulin, went down to the client's pharmacy to pay her copays for the month.

There are additional unintended consequences and costs faced by low-income individuals due to the problems with Part D implementation. HICAP counselors report that many of their low-income and/or non-English speaking clients do not have land-based telephone lines; instead, they rely on cell phones, sometimes using prepaid minutes. Many saw their minutes drained as they waited "on hold" for hours for a 1-800-MEDICARE customer service representative or a Part D plan representative. Some had their phone service cut off; some had to borrow funds to obtain additional minutes to continue their efforts to contact Medicare or seek information from their plans.

Exceptions and Appeals

Once transition fills and various states' emergency drug coverage run out, many more Part D enrollees will be forced to use the exceptions and appeals process in order to obtain non-formulary drugs. Current Medicare rules give Part D plans broad flexibility in how they administer their exceptions processes, including the form of request (oral or written) and the type and amount of evidence prescribing physicians must submit to prove medical necessity. Although CMS has posted a model form to be used to request a coverage determination, each plan can create its own process. Some plans are requiring the submission of clinical notes verifying that all drugs on the formulary are either less effective or harmful for the beneficiary or both. Because each plan's process is different, physicians must deal with multiple processes to adequately serve all their patients. Many doctors are unwilling to go through this process because they say the plans require too much information. Some HICAPs report that some local medical groups are establishing policies requiring scheduled office visits with physicians in order to assist with patient exceptions, in order to receive some type of compensation for their time.

Overall, Part D enrollees and those that are assisting them are having difficulty navigating the exceptions/appeals process. We fear that the volume of exceptions (along with the need to assist with these requests) will increase exponentially once current transition first fills run out (if available/accessible) and California's emergency drug coverage for dual eligibles expires.

> Example: Mr. H., a 23 year old Medicare beneficiary in El Dorado county, was stabilized on an anti-psychotic drug prior to joining a Part D plan in January. Although his new plan covered his drug, it did not allow for the amount and quantity prescribed by his treating psychiatrist. Mr. H's family began contacting his plan in early January and his psychiatrist wrote two separate requests to the plan to cover his drug in the requested dosage amount. When the HICAP program later intervened towards the end of the month because neither Mr. H. nor his psychiatrist had received a written response from the plan, a plan representative replied that the plan had not responded because the physician had not used the correct form. Mr. H. changed plans in February.

III. STRUCTURAL PROBLEMS -- PART D BENEFIT DESIGN

As referenced above, HICAP counselors and their counterparts nationwide have been working tirelessly to help educate Medicare beneficiaries about the new Part D benefit and assisting them in exploring their enrollment options. The nature and structure of the Part D benefit, however, injects a level of complexity that requires significantly more time, effort and expertise in counseling each consumer. Trying to both decipher and navigate the range of Part D plans, drugs covered on their formularies, applicable cost-

sharing based upon which tier a drug is in, assessing any utilization management tools that might apply to a covered drug, and investigating which pharmacies contract with a given plan are all challenging, at best.

For further analysis of issues relating to enrollment/disenrollment protections and choices, as well as access to plan information about utilization management tools and transition plans, see our website for issue briefs we have co-authored with the Medicare Rights Center (www.cahealthadvocates.org).

Lack of Standardization

The sheer number of drug plans available that differ in structure, benefits and cost, make informed choice on the part of beneficiaries difficult to achieve. Tiered formularies, utilization management tools (such as prior authorization) and contracting pharmacy networks further complicate decision-making. In addition, the flexibility Part D plans are given in designing their exceptions process, including determining the form of request along with the level and type of medical evidence required, hinders beneficiaries and their prescribing physicians in obtaining needed drugs.

Part D plans are required to cover all medically necessary drugs within the scope of drugs that are coverable under the Medicare statute. Many Medicare beneficiaries with chronic conditions and who take multiple prescriptions, however, are having difficulty finding plans that cover all of their prescription drug needs. Even if a particular drug is covered, plans can put higher-cost drugs in higher cost-sharing tiers, limiting the benefit of having a particular drug "covered" by a plan. Further, plans do not adequately explain the restrictions they impose on certain drugs, leaving potential enrollees uncertain whether or not the drugs would be covered for them. In other words, even if a drug is covered by a plan, it can be both unaffordable – due to its tier placement, or unavailable – due to onerous prior authorization requirements.

The Medicare program should provide a limited number of standard, uniform benefit packages, and standardize the benefit, cost sharing, and procedures provided through private plans. CMS should consult with the NAIC, industry representatives, and consumer groups to standardize the Medicare Part D benefit in the same way Medicare Supplement insurance (Medigap) products were standardized in 1990. In addition, exceptions processes should be uniform and standardized among all plans, with a single form made available to all physicians and pharmacists.

Lack of Safety Net Coverage for Dual Eligibles

When drug coverage for dual eligibles was switched from Medicaid to Medicare on January 1, 2006, dual eligibles lost much more than drug coverage administered through their state program, they lost more comprehensive coverage, with less restrictions, less cost-sharing and more due process protections. As discussed above, data exchange issues will continue to leave them with gaps in coverage and protection from high costs.

The best way to protect dual eligibles who are unable to access their drugs due to data system problems reflecting eligibility, enrollment and LIS cost-sharing, is to continue Medicaid coverage (and federal matching funds) to serve as a true payer of last resort. Absent a Medicaid extension, we recommend that the Anthem/Wellpoint system be redesigned and expanded to serve as a payer of last resort as a means of addressing all eligibility and enrollment problems that dual eligibles face (as has been recommended by California's DHS).

Expand Enrollment into Low Income Subsidy (LIS)

Many Medicare beneficiaries who are eligible for the low income subsidy have failed to apply. While as many as 8 million beneficiaries are estimated to be eligible, only 1.4 million have actually applied and been found eligible. Of those that applied, over 60% were denied not because they did not meet the income test, but because their resources were too high.

Elimination of the asset test for the LIS would greatly expand eligibility to a benefit that can truly help needy individuals with Part D costs.

Minimal Oversight and Regulation

A great deal of flexibility is given to Part D plans throughout virtually all aspects of Part D. Even during the early roll-out of Part D, when it was becoming clear that there were major problems with beneficiaries accessing their drugs due Part D plan failures in honoring transition policies and providing adequate lines of communication with beneficiaries and pharmacists, CMS continued to "request" and "recommend" that the plans extend their transition periods and provide more accessibility rather than demand it.

The Medicare program should impose more strict requirements on Part D plans, including the following:

- Stricter formulary requirements (require the plans to cover more drugs)
- Stricter transition policies (requirements, rather than recommendations, for longer "first fill" periods)
- Standardized forms and procedures for exceptions and appeals
- Accessibility standards
  - availability of plan-specific information (e.g. required posting of plan materials, including transition plans and exception and appeals processes on plan websites and/or CMS website)
  - broader language access for non- and limited-English speakers
  - greater availability of alternative formats (e.g. for individuals with limited/no sight)
- Enforce existing pharmacy access requirements for Part D plans, especially in rural areas, or provide alternatives

IV. CONCLUSION

Medicare beneficiaries deserve a prescription drug benefit that they can understand and easily access. While many individuals are successfully getting their prescriptions filled and there have been some improvements in data issues and Part D plan responsiveness, many problems encountered by Part D enrollees will not go away without further attention and intervention.

Thank you for the opportunity to provide these comments. For more information, please contact CHA. Respectfully submitted by:

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