



CMA Weekly Alert, November 23, 2005

TO ERR IS HUMAN, BUT CAN WE FORGIVE ALL THESE MISTAKES?

Advocates, including the Center for Medicare Advocacy and our colleagues, have received a steady stream of communications from beneficiaries regarding problems with the www.medicare.gov Personal Plan Finder, the Formulary Finder, 1-800 Medicare, and the 2006 *Medicare & You Handbook*. Beneficiaries should be aware of the issues outlined below when trying to select a Part D plan.

Problems with the Web Tool

- At times, entering multiple drugs at once produces a result that says no plan covering all of the drugs is available in the area, even when this is not the case. Entering each drug separately may, in fact, produce results showing that all of the drugs are covered, even though entering them simultaneously does not. Information has also been generated by the Plan Finder showing that a drug is not covered, though the hard copy of the plan's formulary shows that the drug is covered.
- We have learned that some plans are *not* covering all of the drugs in the classes of drugs that should have all, or substantially all, drugs in six categories: anticancer, anticonvulsant, antidepressant, antipsychotic, immunosuppressant, and HIV/AIDS. However, drugs that are not supposed to be covered - barbiturates, benzodiazepines, weight loss/gain - *are* covered in some plans that have supplemental benefits for higher premiums.
- Plans' utilization management tools are not explained in the Plan Finder. While it may say that prior authorization and step therapy are required, there is no explanation as to what these terms mean. There is also no reference to the Transition Process – the ability to obtain medications during the time a drug is taken off the formulary.
- The “Important Notes” section for particular plans is not consistent from plan to plan. One national plan may state it is national and another national plan may not indicate it is a national plan. Also, some plans indicate that a beneficiary will pay more for an out-of-network pharmacy while other plans do not mention this at all.

Problems with Results

- Co-payment amounts are inconsistently reported. It would be easier to use the Plan Finder if all plans structured the information in the same manner, particularly by listing it in tiers. Instead, some use confusing descriptions by listing, for instance, that there are injectable and non-injectable versions of the drug, but without indicating the tiers on which they appear.

- The printing options once you have entered a zip code do not work correctly. The only way to print more than one page at a time is to ignore the “printable version” and print directly from the screen after selecting “view all” at the bottom.
- If you enter information about a beneficiary that is on Medicaid, the results will give you plans that are over the benchmark premium.
- The tool does not warn you if one of the pharmacies you entered is not in the network or has higher costs.

Problems with the Formulary Finder

- The Plan Finder used to list several plans that could be accessed by clicking on the particular plan name. Now, clicking on a plan sends you to the Formulary Finder and several plans come up, even after you have selected information about one particular plan.
- In some instances, the Formulary Finder states that no plans in the entire state cover a particular drug when we know that this is not the case.
- When using the Formulary Finder, one receives results for both PDPs and MA-PDs. Many people will not know the difference, and could find themselves looking at the wrong type of plan and selecting a plan that will require them to get all of their health coverage from a Medicare Advantage plan when they never meant to select that type of plan.
- Users have found that the Formulary Finder automatically changes brand name medications to the generic equivalents, even when the option to search for a lower priced generic drug is unselected.
- When a drug is found, the Formulary Finder indicates which tier the drug is on, but it does not give the cost-sharing amounts for that tier. It also does not indicate whether the cost sharing exceeds the cost of the drug.

General Misinformation

- Humana’s 1-800 number on the Plan Finder and in their printed materials is wrong. The correct phone number is 1-800-851-1768.
- There is no information about long term care pharmacies on the web. We have heard from a State Health Insurance Assistance Program (SHIP) in Ohio that a 1-800 Medicare operator did not know what a long term care pharmacy was.
- We have heard from several SHIPs that 1-800 Medicare customer service representatives are telling people to call SHIPs, even for the most basic information which the customer service representatives should have been able to provide.
- During a test call to 1-800 Medicare, the customer service representative gave out erroneous information. The hypothetical beneficiary was told that her information would all change because she was “dual-enrolled”, because she had Medicare A and B, and

would therefore have little or no premium, no deductible, and lower costs per drug: “probably around \$1 or \$5 per prescription.” The operator said that she could not enter the caller’s Medicare number or parts A and B status because she was not sure the computer would get that specific, but she seemed certain that having parts A and B would make most, if not all, of both the premium and deductible go away. The customer service representative was terribly confused. She appears to have known something about low income subsidies, but only enough to confuse the issue. Having both Medicare Part A and Medicare Part B does not qualify an individual for a low income subsidy, which is “extra help” for premiums, deductibles and co-payments. The full low-income subsidy is, however, automatically available to Medicare Beneficiaries who are truly dual eligible; that is, those who have Medicare Part A and/or Medicare Part B *and* full Medicaid (Title 19) coverage. This call, which resulted in only dangerously inaccurate information, took 31 minutes.

- Customer service representatives are also redirecting calls to the local SHIPs regarding dual eligibles who have called because they have not yet received their autoassignment letter. Dual eligibles who want their autoassignment letters in Spanish are also told to call the local SHIP.
- Customer service representatives have been unable to identify which plans are below the benchmark premium.
- At a CMS Long Term Care Conference in early November, Charlotte Yeh of Boston Regional (CMS) explained that the penalty would be based on 1% of the cost of the monthly premium for the plan in which the individual had enrolled. We know that the 1% penalty is based on the national average for 2006 - \$32.20.

The Handbook

- It has been much publicized that the 2006 *Medicare & You Handbook* has mistakes in it. In the handbook, the list of plans indicates that all of the plans with premiums below the benchmark for the region will be fully covered by the low income subsidy. In fact, the low income subsidy will only fully pay for *standard* plans that are under the benchmark premium. The subsidy will not fully cover enhanced plans, even if they are below the benchmark premium. Moreover, some beneficiaries eligible for the subsidy will only have part of their premium subsidized. The Handbook makes no mention of partial subsidies.
- Another mistake on page 58 of the handbook states that Medicare Savings Program (MSP) recipients can only change plans once until December 31, 2006. In fact, MSPs can change plans every month, just like dual eligibles.

Beneficiaries and advocates are urged to keep in mind that Medicare Part D is still a work in progress. Information sources, and even the information itself, will change daily. Double and triple check all facts when making any decisions about Part D plans.

For further discussion of information access issues, contact Rebecca Ganci (rganci@medicareadvocacy.org) in the Center for Medicare Advocacy’s Connecticut office at (860) 456-7790.