



CMA Weekly Alert – April 27, 2006

PART D PROBLEMS FOR LOW-INCOME PEOPLE

According to a White House Fact Sheet issued on March 14, 2006 and titled “The Medicare Prescription Drug Benefit: Helping Seniors and Reducing Costs,” the new drug program is working well for most seniors (sic) and pays nearly all of low-income beneficiaries’ drug bills.

What the fact sheet does not say is that many of the beneficiaries encountering problems are dually eligible for Medicare and Medicaid (dual eligibles). The barriers to their getting drugs that were previously paid for by their Medicaid programs are not temporary glitches but result from the very design of the Part D program.

Problems and recommended solutions include:

Dual eligibles have been randomly assigned to average-cost prescription drug plans, most of which do not cover all drugs commonly used by this population.

To ensure no gaps in coverage when dual eligibles transition from Medicaid drug coverage to Medicare drugs coverage, the law provides for them to be randomly assigned to plans if they do not choose a plan on their own. Random assignment benefits plans by guaranteeing them an equal portion of the enrollment of the dually-eligible population, without burdening them with too large a portion. Random assignment does not, however, benefit beneficiaries.

The Inspector General of the Department of Health and Human Services has determined that nearly one-third of dually eligible beneficiaries - a high drug using, highly vulnerable population - were assigned to drug plans that included less than 85% of the 178 most commonly used Part D drugs. Some of the drugs excluded from a substantial number of plan formularies (lists of covered drugs) are drugs for high blood pressure, high cholesterol and pain relief.

Only 18% of beneficiaries were assigned to plans that covered all 178 drugs, but this does not mean that even these plans cover all drugs needed by each beneficiary – only that they cover the most commonly used drugs. Moreover, even plans that cover all drugs may have quantity limits, prior authorization and other barriers to immediate and full coverage of an individual beneficiary’s prescription drug needs.

Recommendation: In assigning beneficiaries to plans they have not chosen, more attention must be given to matching individual beneficiaries’

drug usage and pharmacy preferences with the formulary and pharmacy networks of individual plans.

Getting coverage for drugs that are not on a plan's formulary involves engaging in one of several complex processes. The frailty of this population, including a high incidence of cognitive impairments, makes navigating those processes more difficult than for other beneficiaries.

Applying for an Exception: Each plan must have a process for enrollees to ask for an exception to non-coverage. Each plan's process is different and although the Centers for Medicare & Medicaid Services (CMS) has posted a model form, it is not required to be used by the plans. An exception request must include a doctor's statement that all drugs on the formulary are either less effective or harmful to the beneficiary or both. Some plans are requiring the submission of clinical notes verifying such assertions. Because each plan's process is different, physicians must deal with multiple processes to serve all their patients. Some doctors are charging for completing prior authorization and exception request forms. Dual-eligible beneficiaries who cannot pay even nominal fees for this service cannot avail themselves of the exceptions and appeals processes.

Changing prescriptions: Plans encourage enrollees to change from an uncovered drug to one on their formulary. Such a change presumes that there is a drug on the formulary that would work as well as the uncovered drug. Making such a change may involve multiple visits to a doctor's office, each of which may cost money in terms of transportation and office visit co-pays, for the doctor to first prescribe, and then monitor, use of the alternate drug.

Changing to a plan that covers the drug in question: Unlike most Medicare beneficiaries, dually eligible beneficiaries are allowed to change plans whenever they want to, with their new coverage effective the month following their action to change. Changing plans, however, is difficult and not without risks. First, the number of average cost plans in each region ranges from six to eighteen and the systems available to help beneficiaries know what each plan covers require access to high speed internet service and a printer. Few dual-eligibles use the internet, so to make use of these decision supports, a beneficiary must generally get help from someone else. The programs that are funded to counsel beneficiaries are overwhelmed by people needing such assistance and by the many difficulties that have arisen during the first months of the program.

Moreover, processing new enrollments in a plan is complex, requiring communication between the old plan, CMS, the new plan, and another government contractor. The information takes days to weeks to run through the system; a change made toward the end of the month will not show up in the system until later the following month, making it difficult to purchase drugs in the first part of the month.

Finally, plans can change the drugs on their formularies at any time, with 60 days' notice to individuals taking the drugs in question. Even an intelligent choice of a plan covering all of a beneficiary's current drugs could be for naught, if the plan removed some or all of

those drugs from its formulary two months later. (An April 27 memorandum from Abby Block of CMS to Part D Sponsors, "Formulary Changes During the Plan Year," *suggests* that plans continue to cover a drug for any plan enrollee who is currently taking the drug even after the plan removes the drug from its formulary for other enrollees. This guidance to exempt current enrollees from formulary changes involving their current drugs is, of course, *not binding on any plans.*)

Recommendations: Exceptions processes should be uniform for all plans, with a single form made available to all physicians and pharmacists. Plans should be prohibited from removing drugs from their formulary during the plan year. More money should be made available to programs that provide individualized assistance to beneficiaries.

Plans' transition policies have been difficult to get and difficult to enforce at the pharmacy level.

Each plan is required to have a transition process to address the situations of new enrollees who are taking drugs not on the plan's formulary. The transition policies include special focus on the needs of dually eligible beneficiaries. While issues with transitions have been prominent in the early months of Part D because the entire program was "transitioning" into existence, transitions will occur every month as new enrollees join plans, and especially every January, after major plan shifting has occurred during the annual enrollment period in November and December.

CMS has asked plans to extend the transition coverage of non-formulary drugs through the end of March, so that beneficiaries could get a 90 day supply. Such an extension is voluntary on the plans' part. And, even after the extension request, dually-eligible and other beneficiaries are coming away from the pharmacy with no prescription, or with just a few days' supply of pills.

Moreover, the transition is merely to allow the beneficiary to change drugs, change plans, or request an exception so that her drug can be covered even though it is not on the formulary. But many beneficiaries are not receiving the notices they are supposed to get telling them what they should do next.

Recommendation: Transition policies should be uniform across plans and easily made known to beneficiaries and pharmacists. Plan call lines, for pharmacists to get instruction to override codes, should be required to operate 24 hours a day, seven days a week. CMS should enforce contract requirements of plans.

Dually eligible beneficiaries using long-term care services are treated differently depending on where they receive the services.

Dually eligible beneficiaries are provided the best subsidy available under the law. They pay no premium (for an average cost plan) or deductible, have no coverage gap

(doughnut hole) and no cost-sharing at all after they reach the catastrophic coverage threshold. Their copayments vary from \$0 to \$5, depending on income or place of residence.

Dually eligible beneficiaries residing in nursing homes and certain other institutions have no co-payments, since they pay all but a very small amount of their income over to the institution that is caring for them. Dually eligible beneficiaries who are getting their long-term care services in assisted living facilities, however, are treated differently and may have co-pays as high as \$5 per prescription (for typically, more than 10 prescriptions), even though they, too, must pay most of their income to their care provider and even though their care needs are similar to those of nursing home residents.

Recommendation: All dually eligible beneficiaries receiving long-term care services should be treated similarly and should have no cost-sharing obligations, since most of their income is given over to the provider of service.

Dually eligible beneficiaries have lost Medicaid as secondary coverage.

The most common interrelationship between Medicare and Medicaid is that Medicare is the first payer for services and Medicaid picks up where Medicare coverage stops. This is not true under Part D. Medicaid is prohibited from paying for drugs that are covered by Part D. For a state to provide the kind of “wrap around” coverage that is typical for other services, it must use its own money, without any federal contribution. According to the Inspector General of the Department of Health and Human Services, only four states have indicated they will provide some kind of coverage for drugs that are not on a Medicare plan’s formulary.

Recommendation: Amend the law to provide dual coverage for prescription drugs, just as exists for other health care services, including federal matching funds for state expenditures.

Individuals with Medicaid will experience a gap in prescription drug coverage when they first become eligible for Medicare.

Individuals with Medicaid lose their Medicaid drug coverage on the first day of the month that they become eligible for Medicare, even if they have not enrolled in a Part D plan. The state will transmit information about them to CMS when the state becomes aware of their new dual eligibility status. It is unclear, however, whether and when states will have that information. In addition, states often send information to CMS about new dual eligibles only once a month, generally at the end of the month. CMS may not be able to enroll a new dual into an eligible plan in time for drug coverage to begin the following month.

New dually eligible individuals can use the Point of Service (POS) option at the pharmacy that facilitates enrollment into the point of service contractor. The contractor

will then inform CMS so that the individuals can be enrolled into a plan. Under the POS option, the pharmacy distributes a 14-day supply of medicine to the individual, with the possibility of an additional 14-day refill. Individuals who try to get prescriptions under this option at the beginning of a month may not have sufficient medicine to last until they are enrolled in a Part D plan.

Recommendation: Identify Medicaid recipients who are about to become Medicare eligible sufficiently in advance to auto-enroll them in a Part D plan before they lose Medicaid drug coverage. Alternatively, continue Medicaid drug coverage for these individuals until they are enrolled in a Part D plan.

Overall recommendation: Create a single, standard Medicare prescription drug benefit administered by the Medicare program and uniform nationwide.

Many of the problems and issues described above arise from or are complicated by the number of plans available and the fact that each plan has its own design, including formulary, transition processes, exceptions and appeals processes. Virtually no uniformity is required.

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