



CMA Weekly Alert – January 11, 2007

IT'S JANUARY, AND MEDICARE PART D ISSUES ABOUND

When the Medicare Part D program went into effect in January 2006, millions of older people and people with disabilities who tried to get their prescriptions under the new Medicare prescription drug program encountered a wide variety of problems. Despite some reports that the prescription drug program is running more smoothly in 2007,¹ beneficiaries continue to experience difficulties. Some of the problems are the same as in 2006. Others stem from the complexities of a prescription drug program that is run through hundreds of private companies, and that requires the drug benefit to change every year.

Among the issues that arose in the first 10 days of 2007:

Dual eligibles and others whose status has not changed are told that they are not eligible for the low-income subsidy (LIS): By law, individuals who are dually eligible for Medicare and Medicaid (dual eligibles), people who are eligible for Supplemental Security Income (SSI), and people who are eligible for one of the Medicare Savings Programs (MSP)² are deemed eligible for LIS. Yet some beneficiaries who experienced no change in their Medicaid, SSI, or MSP eligibility status, and hence in their LIS eligibility, have been told at the pharmacy that they are no longer eligible for assistance and that they have to pay the \$265 deductible in order to get their medications.

Individuals whose LIS status is in dispute have not been informed of their option to establish their LIS-eligibility: Beneficiaries have been denied the low-income subsidy at the pharmacy for a number of reasons. Some beneficiaries have changed drug plans and information about their LIS-eligibility has not reached their new plan. Other beneficiaries' names were not on the list of LIS-eligible individuals that the Centers for Medicare & Medicaid Services (CMS) sent to the plans in December. Still others may no longer be deemed eligible for LIS and may need to file an application for the subsidy. CMS indicated in December that, where conflicting information about LIS-eligibility exists, plans are to rely on the best evidence available, and they may rely on evidence submitted by the beneficiary at the pharmacy. See, the Center for Medicare Advocacy Weekly Alert, "Low Income Subsidy Matters," (12/21/06) http://www.medicareadvocacy.org/PartD_06_12.21.LISMatters.htm. Unfortunately, many

¹ See, Julie Appleby, "Medicare drug plan's 2nd year less bumpy," USA Today, Jan.5, 2007, http://www.usatoday.com/money/industries/health/drugs/2007-01-05-medicare-usat_x.htm; "Part D starts more smoothly in second year," McKnight's Long Term Care News, Jan. 8, 2007, [http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews\[tt_news\]=3521&tx_ttnews\[backPid\]=3&cHash=a023bef6d3](http://www.mcknightsonline.com/content/index.php?id=24&tx_ttnews[tt_news]=3521&tx_ttnews[backPid]=3&cHash=a023bef6d3).

² The Medicare Savings Programs are the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiaries (SLMB) program, and the Qualified Individual (QI) program.

beneficiaries report that they are not informed at the pharmacy or by their plan's customer service representatives of the option to present evidence of their LIS eligibility or of a pending LIS application at the pharmacy to receive their prescriptions at the subsidy amount. As a result, many have gone without needed medicine or relied on limited funds from charities, friends, or family to pay for their drugs.

The Point of Service Option continues to work only sporadically: CMS indicated at the end of December that it would continue to contract with WellPoint to provide the Point of Service/Facilitated Enrollment (POS/FE) service for dual eligibles to ensure seamless drug coverage for duals. See http://www.cms.hhs.gov/States/Downloads/backgrounder_3final.pdf. Advocates continue to report, however, that not all pharmacies know about POS or are willing to use the option. Beneficiaries again leave the pharmacy without their medicine and sometimes must wait substantial periods of time before their drug coverage is established.

The POS facilitated enrollment process also does not work if a beneficiary is “technically” enrolled in a plan but coverage in that plan is not yet activated. This problem occurs for newly-granted dual eligibles who find themselves unable to get their medications for weeks or months when they transition from Medicaid-only to Medicare and Medicaid.

Some beneficiaries were not provided with the information they need to make an informed choice about their prescription drug coverage: The Part D program is premised on the belief that Medicare beneficiaries are better served if they can choose a drug plan that best suits their needs. To accomplish this goal, beneficiaries need complete and accurate information about their options, including information about how the benefit structure of their drug plan changed from 2006 to 2007. At the end of December, news reports indicated that about 250,000 Medicare beneficiaries had not received their Annual Notice of Change (ANOC), originally due October 31, 2006.³ The ANOC describes changes in a drug plan's formulary and cost-sharing. Press reports further indicate that CMS will give these beneficiaries a special enrollment period (SEP) until February 15, 2007, during which time they may choose a different plan. CMS has not provided beneficiary representatives with sufficient information, however, to determine who the affected beneficiaries are and how this process will work. It appears that the same plans that failed to comply with the requirement to send out an ANOC are also responsible for notifying beneficiaries of the new SEP. Furthermore, given the problems with plans generally failing to acknowledge SEPs, it is also unclear whether all drug plans will be willing to recognize the rights accorded these beneficiaries.

Some beneficiaries did not understand that their benefits will change: The overwhelming majority of Medicare beneficiaries remain in the traditional Medicare program. Thus, they are used to a uniform, stable benefit structure and are unfamiliar with the concept of significant annual changes in the benefits that are due them. As a result, some beneficiaries did not read through the ANOC sent by their drug plan. Others found the ANOC too long and complicated to understand. Beneficiaries who did not understand that drug formularies and cost-sharing could change from 2006 and 2007 are now discovering that their drugs are not covered, or are subject

³ 11 BNA Vol 249, “Some Medicare Beneficiaries Will Get More Time to Pick Drug Plans, CMS Says,” (Dec. 29, 2006).

to new requirements, or are subject to higher cost-sharing. Because the annual enrollment period is over, these beneficiaries are locked in to their drug plan for another year. They must remain in a drug plan that no longer meets their needs until the next annual enrollment period, November 15- December 31, 2007, with new coverage not starting until January 1, 2008.

Some beneficiaries are being told that they may have to pay money back to their drug plan: Some drug plans are beginning a reconciliation process and discovering that they may have charged the wrong cost-sharing to some low-income beneficiaries. In one state, a plan with one of the largest enrollments only collected the LIS co-payment from some beneficiaries who are eligible for the state pharmacy assistance program (SPAP) but who are not eligible for LIS. The plan has informed these beneficiaries, who have limited incomes, that the plan may collect the difference in the co-payment amounts for drugs that were covered in 2006. This could result in beneficiaries being asked to repay hundreds and possibly thousands of dollars in 2007 for their 2006 benefit.

Problems from 2006 continue:

- Customer service representatives at drug plans and at 1-800-MEDICARE continue to give incomplete or incorrect information. CMS itself has indicated that the staffers at 1-800-MEDICARE are not regular Medicare employees but instead are temporary staff who are able to provide only scripted answers to simple enrollment questions. They are not able to resolve problems, yet CMS continues to advise beneficiaries who have problems with their plans to contact 1-800-MEDICARE for assistance. Problems that the 1-800-MEDICARE staff forward to the CMS resolutions unit frequently go unanswered. Many Medicare beneficiaries have reported that they contacted advocates for assistance after their calls to 1-800-MEDICARE went unresolved.
- Dual eligibles are not enrolled in drug plans.
- Beneficiaries are enrolled in Medicare Advantage plans, rather than prescription drug plans, or in higher-cost prescription drug plans through misrepresentation by plan agents or representatives.
- Beneficiaries experience problems with premium payments, including incorrect premium amounts being withheld from Social Security checks.
- Beneficiaries are not being told that they should contact their plan for a coverage determination if the pharmacy says their drug plan will not cover their medicine.
- Plans do not meet the time frames for appeals.

The Center for Medicare Advocacy will continue to monitor Part D and to work for a prescription drug benefit that meets the needs of all Medicare beneficiaries.

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