CONGRESS HAS THE POWER TO FIX MEDICARE PART D

The Center for Medicare Advocacy is a twenty year old non-profit organization committed to helping older people and people with disabilities gain access to the health care they need. Our work focuses almost entirely, though not exclusively, on the Medicare program. Every year, we assist tens of thousands of Medicare beneficiaries with appeals of denied claims for service and answer thousands of questions from callers to our hotline.

The Center fervently believes in the original Medicare program that was enacted in 1965 and works diligently to make it work for beneficiaries. We did not support the Medicare Act of 2003 that created Medicare Part D because much of the Act, including Part D, directed Medicare toward privatization and away from the uniform national benefit that Congress enacted in 1965 and that has gained considerable confidence and respect from beneficiaries. Our concerns about fundamental problems with the MMA have been confirmed in the early days of implementation.

We have three points to make concerning implementation of Part D:

1. The problems with Part D are fundamental and systemic and derive from the structure and language of the MMA. These problems are not small “glitches” that will be worked out in time. Problems with Part D will change over time and they will get worse.

2. Blame for the MMA rests primarily with Congress, which enacted this complex, unworkable system. While staff at CMS have in some instances added unnecessary complexity and have chosen to give plans greater leeway than necessary, it is Congress that wrote this legislation to privatize Medicare and it is Congress that must fix the law.

3. Congress needs to replace Part D with a comprehensive prescription drug benefit in the Medicare program. The drug benefit needs to be part of the Medicare program and uniform and consistent throughout the United States. In the meantime, CMS should slow down plan enrollments and Congress should suspend existing late enrollment penalties and plan lock-in indefinitely.
Although the Center did not support the law, since its passage in November 2003, Center staff have studied it, analyzed it, written about it and trained hundreds of advocates across the country in its provisions in an effort to assure that those who could possibly benefit from Part D might do so. Sometimes we have felt that the more we learned about the law and implementing guidance from the Centers for Medicare & Medicaid Services (CMS), the less we understood it. But we have persevered in our efforts to prepare ourselves and others to help beneficiaries. Now, the moment is here and Part D is up and . . . well, not exactly running.

**Early Reports confirm that Part D is a failure.**

The first three weeks of Part D have been an unmitigated disaster. According to the *New York Times*, California reports that 200,000 poor and sick individuals, nearly 20% of its low-income Medicare beneficiaries who are also eligible for Medicaid, had trouble filling prescriptions in the first two weeks of the benefit. If California’s experience reflects that of the whole country, more than one million of the nation’s poorest and sickest older people and people with disabilities had similar trouble, in many cases resulting in life-threatening situations.

One legal aid lawyer writes:

*I have a client who had not had a seizure for approximately four years. She is 24 years old and receives SSDI and SSI benefits. She is a dually eligible person. She was not able to get her anti-seizure medication for 4-5 days and ending up having a grand mal seizure at Walgreens.*

In Connecticut, the state in which the Center’s home office is located, the Department of Social Services is regularly meeting with beneficiary advocates because they are so anxious to get this right. In the first two weeks of Part D, CT spent close to the entire $5 million the legislature appropriated to "wrap around" Part D; this money was intended to supplement Part D for an entire year, not to pay for services required to be provided by Part D plans. As you know, CT is one of now about two dozen states that have recognized the public health crisis created by Part D. More states are doing so every day. The pace at which so many states are responding to this crisis is strong evidence of its magnitude. But how these states will be reimbursed is not yet determined, and they have not been relieved of their clawback obligation.

Our telephone lines and those of every other organization with which we work have been flooded with calls about problems:

Initial calls and reports in the media have focused on dually-eligible beneficiaries – those receiving both Medicare and Medicaid - not being auto-enrolled in plans and, even when enrolled, not receiving their non-formulary prescriptions during the transition period. Failure by CMS or plans to record a beneficiary’s subsidy status has resulted in incorrect charges of hundreds of dollars for prescriptions for which the person should only pay a few dollars. Beneficiaries and pharmacists trying to help them have been unable to get
through to 1-800 MEDICARE or to plan help lines, or have received incorrect information from the Customer Service Representative at the other end.

Stories abound about people leaving with 2-3 days of prescribed drugs at best, more often with nothing. How does a beneficiary enforce the Transition allowance even if she knows there should be one and even if she knows what it is?

CMS’s point-of-sale process, for “guaranteeing” that low-income beneficiaries not enrolled in a plan can get their drugs, requires too many steps by both the beneficiary and the pharmacist. Overwrought pharmacists do not have time to complete the many steps required of them.

Systemic problems with Part D will become more visible as implementation continues.

Some of the early implementation problems, horrific though they are, may be resolved in time. Low-income beneficiaries may be auto-enrolled. Plans may begin to honor the transition periods, as they promised CMS in CMS-approved contracts. But what happens once beneficiaries, both dually-eligible and others, are enrolled? How will Part D work for them? We anticipate that problems will be worse than they are today as systemic problems in Part D become increasingly visible.

For example, people are already being stymied by Prior Authorization requirements. How does a beneficiary challenge a Prior Authorization request or refusal? One plan requested a physician to fill out its PA form but once that was done, required more documentation within 3 days; without it the prescription was not filled. When calls were made to the plan to pursue this problem on Monday, January 16th, the automated message said they were closed all day for Martin Luther King Day and advised the caller to call 911 if this was an emergency. Prior Authorization requirements are not a matter of transition or start-up problems; they are built into plans’ formulary structures and apply to different drugs on each different plan’s formulary.

Many beneficiaries will find out that their PDP does not cover all of their prescriptions. They will have to change drugs or, if their physicians are willing to help, pursue exceptions and appeals. Drugs that are covered at the beginning of the year may be dropped by the PDP, or the PDP may initiate new utilization management tools that make it difficult or impossible for beneficiaries to get the drugs. Some beneficiaries who develop a new medical condition during the year may need a new prescription and find that it is not covered by their PDP. Other beneficiaries will learn that their PDP does not include their pharmacy in its network, and that they have to go elsewhere for their drugs. Some beneficiaries with high drug costs will fall into the doughnut hole and will be responsible for 100% of their drug costs. They will not have the money to pay for their prescriptions. None of these problems will be solved by enrolling beneficiaries in plans or by fixing the so-called start up “glitches.”
The unique problems of beneficiaries who live in institutions will also become increasingly visible as Part D implementation continues. While long-term care pharmacies have, apparently, generally honored transition plans and provided non-formulary drugs to nursing home residents, they will be unable to continue without payment from plans. Problems with limited and inappropriate formularies, prior authorization, utilization management, and doughnut holes will restrict residents’ access to medically necessary drugs.

**CMS has made only timid responses to the health care crisis created by implementation of Part D.**

While half of the states have taken various actions to address the health care crisis created by Part D, CMS responses have been too little, too late. Last year, in creating its transition guidance, CMS refused to require plans to have a specific transition process, merely suggesting to them that they *might* provide a 30-day supply or *might* take other similar measures. Each plan’s process is different. Even CMS’ most recent guidance, issued two weeks into the program after unrelenting press reports of problems throughout the country of people being denied drugs at the pharmacy, requires only a “temporary supply,” not a specific amount.

**But ultimately, the fault lies with Congress.**

While it is possible to enumerate countless failings of CMS in implementing Part D, ultimate responsibility for this disaster lies with Congress. The problem with Part D is its impossible design. That is why individuals are going without necessary medications and states are scrambling to fill the void for our most vulnerable citizens.

It was Congress that ended Medicaid drug coverage for the more than 6 million Medicare beneficiaries who also have Medicaid, among the poorest and sickest of all Americans. Prior to January 1, these dual eligibles, their advocates, and their pharmacists had only one system state-wide to navigate to get drug coverage; now they have about 13 in most states. Instead of retaining Medicaid drug coverage as a wrap-around and safety-net, Congress chose to eliminate it totally and immediately, without even any transition of overlapping coverage to allow for the inevitable start-up problems of Part D. Congress’ answer to assuring coverage for those losing their Medicaid was to direct the Secretary to randomly auto-enroll all dual eligibles into low cost plans. This random enrollment results in individuals being assigned to plans that do not cover their drugs. It benefits only plans, by assuring them a fixed percentage of the low-income beneficiaries in their state as guaranteed enrollment.

It was Congress’ design of Part D that allows there to be over 2,000 plans operating throughout the country. Due in part to the overwhelming confusion created by the number of plan choices and the complex decision-support systems offered to help make that choice, only one million people voluntarily enrolled in the program by the end of the year.
Because of Congress’ interest in privatizing Medicare, each of these more than 2,000 plans has a different formulary, a different transition process, a different exceptions and appeals process, a different network of pharmacies. Moreover, a beneficiary in California may not be able to fill a prescription through Part D when visiting her daughter in Maryland, though she could use her Medicare Part A and Part B in either state without problem.

The potential for problems is increased exponentially by the number of plans. For Part D to “work,” data must be shared among CMS, the Social Security Administration, 50 states and the District of Columbia, over 2,000 plans, the TrOOP (true out-of-pocket costs) contractor, thousands of pharmacies across the country, and, for those who are institutionalized, the institutions in which they reside. To help their patients, physicians and pharmacists must become familiar with formularies and exceptions and appeals processes for more than forty plans in most states. CMS’ enforcement of plan requirements is rendered exponentially more difficult by the sheer number of plans it must monitor.

To ask for an exception to the plan’s formulary, a plan member must use a form designed by the plan itself to ensure meeting all plan requirements, not a universal form that could be easily made available to every Medicare beneficiary. Moreover, each beneficiary must learn of her plan’s exceptions and appeals processes, how to access it, what standards (designed by the plan) must be met to prevail, and what documentation is needed. This situation is the result of Congress’ action.

The doughnut hole, also created by Congress, will significantly mitigate Part D’s benefit to individuals just outside the scope of the low-income subsidy. Its impact will be felt most by African-American and Hispanic beneficiaries, who experience a higher prevalence of multiple chronic conditions which, in turn, are associated with high out of pocket drug spending.

**What happens next?**

What will happen when the hue and cry of the first month of Part D dies down? What will happen when the press loses interest and the states are no longer willing to pay for drugs that are the responsibility of private Part D plans that are receiving millions of federal dollars each month for their enrollees?

What will happen when a 30-day transition supply is no longer the issue, but step therapy or prior authorization or dosage limits are in effect, and plans continue to require physicians to provide more and more documentation of the need for a specific drug? Or when beneficiaries discover that their drugs are being removed from their plan’s formulary? Or when they are told at the pharmacy that their plan does not cover the drug but are not given information about seeking an exception or otherwise getting into the appeals process? What will happen when no one is looking anymore but drug plan call centers continue to be open only during “regular business hours” as required by CMS’s
regulations, but the call center is on the west coast and the beneficiary is on the east coast, or the beneficiary needs an emergency drug on a holiday?

**In the short term**, CMS must:

Alert all pharmacists who fill prescriptions for dual eligibles that they will be reimbursed, regardless of whether or not they can verify coverage or subsidy eligibility through the plan or through CMS pharmacy help line.

Assure states that they can continue Medicaid coverage for their dually eligible residents and be reimbursed for such payments.

Assure that all individuals who identify themselves at the pharmacy as eligible for the full low-income subsidy pay co-payments of no more than $1 for generic drugs and $3 for non-preferred brand name drugs.

Assist beneficiaries who have paid out-of-pocket more than they are required by law with getting reimbursed by their plans.

These emergency systems and assurances should stay in place for at least six months, or as long as necessary to assure that the system is working effectively. CMS should use its enforcement authority to fine plans that do not follow its requirements.

**In the longer term**, CMS should slow down new plan enrollments until the immediate start-up problems are resolved. Congress should suspend enforcement of both the lock-in provision, which precludes beneficiaries from changing plans even when their plans change formularies, and the late-enrollment penalty. Congress should also ensure that for 2007, Medicare beneficiaries have the choice of coverage through Medicare, rather than through a private plan, as they do now for hospital and other medical care.

Finally, and most importantly, Congress should enact a real Medicare drug benefit that is administered by Medicare, not by private plans, and that is uniform throughout the country.

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