

Senate Democratic Policy Committee Hearing

**“An Oversight Hearing on the Implementation
of the Medicare Prescription Drug Benefit”**

Robert M. Hayes
Medicare Rights Center

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Good afternoon, Mr. Chairman and members of the Senate Democratic Policy Committee.

We appreciate your commitment to the health security of the American people and we understand your concern over the public health emergency that is being caused by the bungled, if inevitable, mismanagement of the new prescription drug program for people with Medicare. We are grateful to bring before the Committee – and to anyone else in the government who will listen – our day-to-day experiences assisting people with Medicare.

We will focus this report from the trenches on the most critical of humanitarian crises arising from Part D: the barriers people with Medicare face in accessing life-saving drugs since January 1, 2006. Looking ahead, we will also share with you the overwhelming challenges organizations like the Medicare Rights Center are confronting in our efforts to provide the one-on-one counseling and assistance needed to make any sense of what indeed is the largest and most complex consumer benefit program ever launched in the nation’s history.

The Medicare Rights Center (MRC) is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities obtain good affordable health care. Every day we help people with Medicare access necessary services. Tens of thousands of callers use our help-lines annually. We help people with Medicare navigate the health care system, enroll in programs that may help them pay for health care, and overcome barriers to care.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington, Chicago and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent, relying on a small staff and hundreds of deeply committed volunteers to carry out our mission. We are neither supported nor controlled by the pharmaceutical or insurance industries. Our sole and non-partisan mission is to serve the 43 million men and women with Medicare.

Through national and state telephone hotlines, casework and professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. We are also bringing Medicare Interactive, a web-based counseling tool to counselors and consumers across the country. We bring to many levels and branches of government policy recommendations rooted in the real needs of people with Medicare.

The issues under consideration at today's hearing are critical in assessing whether the Part D drug benefit passed by Congress furthers Medicare's fundamental goal: providing health security for our nation's older adults and people with disabilities. By act of Congress and submissive regulation by the Administration, Part D plans have broad leeway to decide which drugs they cover, what they will charge for those drugs, and what impediments will be placed before people seeking coverage of medicines their doctors prescribe.

What does this mean to far too many people with Medicare? Fear, anxiety, and uncertainty: exactly the opposite of what Medicare has offered for some 40 years, and exactly the opposite of what the American taxpayer should be purchasing with their hundreds of billions of dollars flowing into the insurance and drug industries.

The fear and anxiety of many people with Medicare is not unwarranted. It is not the product of negativists. It is the reality forged from a program that, I say regretfully, cannot and will not work. Two months into the new program, the casualties are apparent.

Consider Ms. S, a 76-year old widow from the small town of Sinclairville, New York. Ms. S is a dual eligible and until January used New York's Medicaid program to fill her prescriptions. Like over 6 million others with Medicare and Medicaid nationwide, Ms. S was switched from Medicaid to Medicare drug coverage on January 1, 2006. Unlike many, Ms. S was successfully auto-assigned a Medicare drug plan. In January, armed with both her Medicaid card and her new Medicare drug card, she went to her local pharmacy to get her blood pressure medicine. Her pharmacist informed her that that medicine was not covered by her assigned Medicare plan and advised her to switch to an alternative drug that was covered by her plan. Ms. S left the pharmacy that day empty handed. A week later, she was taken by ambulance to the hospital—after seven days off medication, her heart was beating too slowly for her to stand up.

The litany of start-up problems with the new benefit is by now familiar. Here are the two most common: the poorest people with Medicare were charged high, unaffordable co-payments and deductibles because they were not entered into plan computer systems as eligible for low co-payments; drug plans did not provide temporary fills for drugs not on their formularies, a transitional protection they had promised when they bid to serve the Medicare population.

Pharmacists, people with Medicare, and consumer advocates found it difficult, if not impossible, to get through to the plans' toll free numbers to resolve these problems. When they did get through, poorly trained customer service representatives often were unable or unwilling to help.

Most states stepped in to provide stop-gap coverage through their Medicaid programs to people who receive both Medicare and Medicaid benefits – a step vehemently and curiously

fought by the Bush Administration throughout 2005 and the early days of 2006. This temporary coverage has doubtless prevented much more widespread access problems.

But what will happen when states pull back their Medicaid coverage, as CMS is encouraging them to do, in March, the same month the transitional period runs out. Once these safety-nets are pulled away, we expect the formulary restrictions imposed by plans will seriously and impair access to vital drugs.

Many people left the pharmacy with their drugs without knowing that the plan was only covering their medicines on a temporary basis or that the state had stepped in to provide coverage. As a result, they have not taken the steps necessary to obtain coverage from the plan or to switch to a drug that is covered. When they return to the pharmacy for a refill they may find the drug is not covered and be forced to interrupt their drug regimen, a serious prospect for people taking heart medicines, diabetes medications or mental health drugs.

In addition, the process to appeal for coverage is not working. People with Medicare, their counselors, doctors and family members have experienced problems getting through to plans to get the process started and to obtain the forms, documentation requirements and contact information necessary to receive prior authorization or process an appeal. Every plan uses a different form and requires a different level of documentation. Many plans still do not have these forms and documentation requirements available on their websites. Some plans impose confusing or onerous requirements, for example, requiring doctors to forward articles from medical journals to back up their case for a particular drug. The American Medical Association, pharmacist groups and consumer advocates are working to develop a model form for plans, but use of this form will be voluntary – CMS, curiously, will not require plans to accept it.

Many people with Medicare – those with cognitive disabilities or mental illness, who are isolated in their communities – would never, even with an efficient process, be able to appeal for coverage. But this system turns an appeal for coverage into an insurmountable hurdle even for the most savvy Medicare consumer.

Of particular concern are mental health drugs and drugs in other protected classes – cancer medications, immunosuppressants for people with organ transplants, anticonvulsants, antidepressants and antipsychotics. These drugs are not supposed to be subject to prior authorization or step therapy – the requirement to first try a cheaper alternative drugs – if a person is already stabilized on a drug regimen. But plans are imposing such restrictions. Patients forced into the prior authorization or appeals process will at best face delay in filling their prescriptions – a delay that could trigger a life threatening interruption to their drug regimen.

The potential impact of impaired access to mental health drugs is great. One in five older adults and over half of people on Medicare because of disability have a mental or cognitive impairment. Older adults have the highest suicide rate in the United States. Furthermore, nearly forty percent of “dual eligibles” – 2.5 million individuals – have a cognitive or mental impairment. Patient compliance with mental health drug regimens is crucial for the medicines to be effective; restrictions that interrupt treatment or force a switch to a medicine that is less effective or has adverse side effects can prompt patients to abandon their drug therapy.

Among the most widespread complaints is the difficulty and confusion all people with Medicare face in choosing the right prescription drug plan. Until there is a true Medicare drug benefit, this will not change. People with Medicare find themselves confronted with a complex and confusing landscape as they try to select a prescription drug plan that best meets their needs. Plans differ widely in the drugs they cover and impose a range of restrictions on the drugs that are included on their formularies. Deluged with marketing materials, frustrated by inaccurate, conflicting or absent information, people with Medicare and the friends, family members and professionals that counsel them, struggle to find consistent and accurate information for this important choice.

In particular, people with Medicare have reported difficulty in obtaining information on the “utilization management” practices plans impose on certain drugs that would make clear whether these restrictions will be used to deny coverage.

There are three broad types of utilization management. Plans may require prior authorization before they will cover a certain drug, demanding that physicians certify specific diagnoses that are necessary for coverage. They may impose step therapy the requirement that an alternative, cheaper, medicine is first tried and shown to be ineffective or cause adverse side effects before a more expensive drug will be covered. Finally, plans can impose quantity limits on certain drugs. The impact of these techniques varies considerably. For example, quantity limits can specify the number of drugs a plan will cover per month or they can cap the total number of drugs it will cover at a set amount. Similarly, prior authorization can limit coverage of a drug by a wide to narrow set of conditions.

Although plan web sites and the web tool CMS has developed to allow for plan comparisons note which drugs are covered by utilization management techniques, they do not explain how these restrictions work. Curiously, that appears agreeable to CMS. People with Medicare need that information to decide if their drug regimens are compatible with the restrictions a plan imposes. For example, if they can determine whether they meet a plan’s criteria for prior authorization, people with Medicare can decide if they will be eligible for coverage under the plan. Without this level of transparency, utilization management techniques could discourage enrollment in the new Medicare drug benefit and may steer people taking certain high-cost drugs away from the plans that impose them.

Conversely, a plan’s failure to adequately explain its utilization management techniques leaves potential enrollees in the dark about how, and under what conditions a drug is covered. As a result, many potential enrollees may believe, incorrectly, that they will obtain coverage of their drug under the plan.

One such enrollee in Minneapolis emailed the Medicare Rights Center: “I am a person with Medicare and Medicaid because of a disability. I was automatically enrolled in a Part D plan that did not cover all of my prescriptions. I then re-enrolled in another plan that did cover my prescriptions. After I received a notice from my new plan that I was enrolled, I went to pharmacy to pick up my prescriptions. I was denied prescriptions three times because the

pharmacist said I did not have the necessary ‘pre-approval.’ I was given the choice of paying out-of-pocket or leaving without medicine.”

Even people with Medicare who do not take exotic or high cost medicines are bumping up against restrictions on their drug regimens under the formularies offered by the new Medicare plans. Because it is private plans, and not the Medicare program itself, which negotiate with manufacturers and craft formularies, those restrictions vary considerably. One plan may cover all seven drugs a beneficiary takes, but impose restrictions on four of them. Another may not cover one or two medicines on the drug regimen but is otherwise free of restrictions.

Without access to a computer and the Internet – the situation faced by some 75 percent of older Americans – making an informed decision is impossible. Even with computer access, the lack of sufficient information, such as about utilization management restrictions, and the presence of errors on plan or CMS web sites, can frustrate informed decision making.

Each year, the Medicare Rights Center receives over 75,000 calls for assistance from people with Medicare. Since January 1, 2006 our call volume has increased 400%--the majority of these calls are about Part D. This increase in volume, coupled with the complexity of the new drug benefit, lack of consistent information, volunteer burnout and the slow progress of client-by-client fixes culminates in many of our clients and, for that matter, counselors as an overwhelming feeling of helplessness. With this benefit, as it is currently structured, there is no one-size-fits all solution. Indeed, for many people there may be no good solution.

Even for those that do succeed in finding that one right drug plan to meet their needs one moment, there is no guarantee that that drug plan will meet their needs in the next moment. Because of the way the benefit is currently structured, Medicare drug plans can change their formularies or alter their provider network at any time. However outside designated enrollment periods (November 15 to May 15 for this year, November 15 to December 31, 2006 for coverage in 2007), most people with Medicare will be “locked in” their Medicare prescription drug plan. Under such a structure there is no way for consumers to make an informed choice. If they find their drug coverage is inadequate or if their provider network changes, individuals could wait up to a year until they are able to change plans. There is no way around it, anything short of Congressional action to prohibit mid-year formulary changes will result in people being harmed.

Consumer dissatisfaction and confusion is causing the low-take up in the drug benefit, despite the widespread need for affordable drug coverage. The latest enrollment statistics provided by CMS show that there are currently about 18 million people with Medicare without drug coverage through the Part D benefit or through a retirement plan that provides comparable coverage. At the current pace of enrollment, that means around 13 million people will still be without coverage when the enrollment period ends on May 15. Remember, 11 months after President Johnson signed Medicare into law, nearly 94 percent of eligible Americans had voluntarily enrolled in Medicare Part B. (And an Administration committed to health security rolled out the Medicare Part A and Part B programs – on its face a far more daunting task than the addition of a new benefit for people with Medicare.

Congress should address the abysmal enrollment rates in the low-income subsidy, the “Extra Help” portion of the benefit. At last count, only 1.1 million of an estimated eight million eligible are signed up. Over half of those who have applied have been rejected because their financial resources exceed the limits imposed – they have insurance policies or other savings that disqualify them. This asset test punishes low-income older adults who have scrimped and saved to have some financial security in their retirement or to pass on a small nest egg to their children or grandchildren. It also complicates the application process, preventing automatic enrollment on the basis of income information already on file with the federal government. We urge you to eliminate the asset test for the Extra Help program.

People with Medicare need and deserve an affordable, secure and intelligible drug benefit through Medicare. So too does the American taxpayer.