Senate Democratic Policy Committee Hearing

"An Oversight Hearing on Implementation of the Medicare Prescription Drug Benefit"

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My name is Tim Westmoreland. I am a visiting professor of law and a research professor of public policy at Georgetown University.[1] During the latter part of the Clinton Administration, I was the director of the Medicaid program for the Federal government. I am here today to discuss the Dual Eligibles—usually referred to simply as "the Duals."

So far the treatment of Duals under Medicare Part D has been an acute problem, in some instances approaching an emergency. And, because of the structure of Part D, the treatment of Duals in the future shows signs of being a serious chronic problem. As one local health officer who has helped Duals through Part D recently testified to his State legislature:

> "Drug plans can change their formularies every month, pharmacies can move in and out of networks, and states must continually send lists of vulnerable low-income patients for enrollment. Medicare Part D as currently constructed guarantees a never-ending transition."[2]

Today, I will briefly discuss five questions:

- Who are the Dual Eligibles?
- What was Part D supposed to do for the Duals?
- What has Part D actually done for (or to) the Duals?
- What will Part D likely do for (or to) the Duals in the future? and
- What should the Congress do to make Part D better for the Duals?

[1] The views I express in this statement are my own and do not necessarily reflect those of past, present, or future employers.
[2] Joshua M. Sharfstein, Commissioner of Health, Baltimore City, Testimony before the Committee on Health and Government operations, Maryland House of Delegates (January 24, 2006).

I. Who are the Dual Eligibles?

Most simply put, Duals are those Americans who are eligible for both Medicare and Medicaid. There are about 6.4 million Duals.

But that makes too simple a very complex and very vulnerable group of people. When compared to other Americans on Medicare, Duals are substantially—between two and three times—more likely to have chronic illnesses and disabilities, to have mental impairments or illnesses, and to have less than a high-school education.[3] They are also much more likely to be very old (over 85) and to live in nursing homes or other institutions. This all means that these people are very likely to need prescription drug coverage and very unlikely to be able to sort through the complexities of Part D letters, forms, websites, and rules.

And, when compared to other Americans on Medicare, Duals are substantially—six times—more likely to have incomes under $10,000 a year.[4] This last point is particularly important for understanding the problems that Part D may pose, because these people are not only very vulnerable, but they also do not have the cash to do what others might do when they encounter an insurance problem: They cannot pay for their drugs and fix the problem later. If their drug is not covered, and they don't "work" the system, they are out of luck. Combined with their poor health and their education levels, they are also much more challenged when it comes to working through the grievance and appeals process.

It bears noting that the Duals are, so far, the largest group enrolled in Part D. So when I talk about what's happening to the Duals, it's mainstream, not a backwater. What's happening to Duals is fundamental to Part D.

II. What was Part D supposed to do for the Duals?

When Part D began, Duals were to be automatically cut off from their Medicaid drug benefits and made automatically eligible for Part D. They were to be randomly assigned to a prescription drug plan in their State that was at or below the average premium cost (the so-called "auto-enrollment"). They were to be allowed to choose a different plan than the one to which they were randomly assigned. They were also, in theory, to be automatically protected from the deductible, the doughnut hole, and large copayments.

III. What has Part D actually done for (or to) the Duals?

First, be aware that the problems that Part D has posed for the Duals and their families are not surprises. Medicaid directors were warning a year in advance that the transition for the Duals was a "trainwreck waiting to happen" and a "disaster."[5] One recently summed up that what has happened was "predictable and predicted."

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[3] Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries" (February 2006).
[4] Id.
[5] Vernon Smith, et al., "Implications of the Medicare Modernization Act for States: Observations from a Focus

Also, the Government Accountability Office (GAO) has reported that CMS discovered many of the data system problems that have plagued Part D when it implemented the preliminary Discount Card program, beginning in June 2004.[6] And the GAO warned as recently as December 2005 that "potential problems may leave some dual-eligible beneficiaries facing difficulties in immediately obtaining necessary drugs" and that CMS's contingency systems and information were not finalized until late November and even December, not in time for the GAO to assess them[7]

So what happened was what was predicted to happen—given the needs of the beneficiaries and the complexity of the program and its implementation

1. Part D lost the Duals

Many Duals showed up at pharmacies that, using all the information available, could find no information about their enrollment or coverage.

This surprised no one who has worked with the Medicaid and Medicare programs. The planned transition was dependent on a seamless exchange of real-time data between State and Federal agencies. But State and Federal data systems have a long record of difficulty "talking to each other." State data systems for Medicaid have had years of individual problems in being accurate and keeping current.

As a result of these problems, the workload and paperwork was in some part passed to pharmacists, state and local advocates, and families.[8] They were, in effect, drafted to do the eligibility and enrollment work that the Federal government had not done.

2. Part D sent the Duals to inappropriate plans.

Auto-enrollment was done without regard to the Duals' diagnosis or current drugs. Their drugs may not be on the approved list of what the plans will pay for or the plan's limits may require a new visit to the doctor to get past the restrictions. This is especially difficult for people with chronic illnesses and disabilities.[9]

In the transition confusion, CMS started to require 30 that plans provide for up to 30 days of a Dual's current drug; since the confusion has continued, CMS is now requiring 90 days. But this is a temporary policy—and to get that, the Duals must go to a pharmacy that is in their plan's network. If their drugs are not on the formulary and they cannot work the grievance and appeals

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Group Discussion with Medicaid Directors," (Kaiser Commission on Medicaid and the Uninsured, January 2005).

[6] Government Accountability Office, "Medicare: Sponsors' Management of the Prescription Drug Discount Card and Transitional Assistance Benefit," (January 13, 2006).

[7] Government Accountability Office, "Contingency Plans to Address Potential Problems with the Transition of Dual-Eligible Beneficiares from Medicaid to Medicare Drug Coverage" (December 16, 2005)

[8] For one example among many, see Melissa McGrath, "Half of Medicare Patients Still Without Drug Coverage," Idaho Statesman (February 25, 2006).

[9] E.g., Bob Moos, "Mentally Ill Facing Snarls in Rx Plan," Dallas Morning News (February 23, 2006).

procedures, the Duals may go without their medications or be subject to very high out-of-pocket costs (that are not simply a mistake). [10]

I would also note that even if their drugs are on the formulary, the price for these drugs may be much higher than in other Part D plans in the State. There are no data yet, but since the Federal government is paying these drug prices for Duals, this cost created by random selection will likely mount up to a significant new expense for Medicare.[11]

3. Part D has sent the Duals to pharmacies that are inconvenient to the beneficiary.

I think the most obvious of these is the auto-enrollment of Duals in Hawaii to plans that were not licensed to do business in the State of Hawaii.[12] It's hard to imagine how such a beneficiary could easily find another, in-network drug store.

But it's not just being on an island. For many other elderly and disabled people throughout the Nation, rural and urban, being randomly assigned to a new pharmacy poses barriers that may genuinely interfere with their access.

And remember that refill policy that can be done only in the plan's network? If the Duals are not at a pharmacy that is in the plan's network, their only option is to pay full retail price of the drug and then claim reimbursement from the plan later. Even CMS has acknowledged that the Duals are unlikely to be able to afford that.[13]

4. Part D has overcharged the Duals.

There are widespread reports of Duals being charged deductibles and high-copayments that they were to have been protected from.

To protect their residents who are Duals, most States have stepped in to help with emergency payment. CMS says that they will pay for that with a "demonstration project," but that is only for a short while. Supposedly all these additional costs will be eventually paid for by the plans to which Duals were to have been auto-enrolled. But it is unclear in this demonstration what the "pay-and-chase" rules will be for getting payment back from plans. Without details, CMS has said that it will provide for processing the paperwork and reconciling claims and has recently announced that it will make States whole if the payment by the plans is less than what the State paid.[14]

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[10] Jocelyn Guyer and Jeff Crowley, "Medicare Modernization Act: An Early Look at Medicare Drug Plan Options for Connecticut's Medicare Beneficiaries," (Connecticut Health Foundation, December 2005).
[11] Id.
[12] Helen Altonn, "Drug Plan Troubles Force Third Extension," Honolulu Star Bulletin (February 26, 2006).
[13] GAO, cited in note 5, at page 4.
[14] Center for Medicare and Medicaid Services, "Fact Sheet: State Reimbursement for Medicare Part D Transition," January 24, 2006; See also, BNA, "HHS Announces Reimbursement Demo to Help States Pay for Transition to Part D," Health Care Daily Report, February 21, 2006.

5. Part D has made drugs unaffordable for some Duals.

Some Duals have found the copayments that they are legally charged according to the law to be unaffordable. Even low copayments are out of reach for many Medicaid beneficiaries.

And many Duals, especially people with disabilities, take many drugs. A three-dollar copayment per drug multiplied by eight or ten drugs per month is just not possible for people with such low incomes. There are widespread reports of people going without drugs for mental illness, diabetes, and other chronic problems, and concerns have been raised that these people will end up in emergency rooms with illness that could have been prevented. While pharmacies are allowed to waive these copayments for hardship, the reports coming in are that waivers are uneven or not used.

IV. What will Part D likely do for (or to) the Duals in the future?

There will be ongoing problems. As I noted earlier, Part D is a program with a transition that never ends.

Medicaid eligibility will change. People will qualify for Medicaid throughout the year. People don't uniformly become elderly, disabled, or poor on January 1.

Plans will go out of business. There is widespread discussion of how the first year of Part D will produce a shake-out and consolidation of plans, with fewer and different plans being available next year. Any Dual enrolled in the disappearing plans will have to start over.

Plans may raise their premiums above the State average, so that they are not longer eligible to take Duals. When this happens, the coverage of any Duals in the plan will be terminated, and these beneficiaries will need to be auto-assigned to another plan. This will be very disruptive and likely to cause a lot of confusion and anxiety—all over again.

Plans will increase prices. They have already done so, with prices on common drugs up 4% in the first month.[15] These increases in prices will either cost the Federal government money (if the drug is on the formulary or the Dual gets a waiver) or cost the Duals money (if the drug is off the formulary and the beneficiary does not get an exception).

Plans are likely to make formularies more restrictive, and such changes in formularies will pose difficulties for Duals. As usage data comes in, new prior authorization requirements will be established, including the so-called step-therapy/fail-first policies that require patients to fail on an on-list drug before getting permission to use an off-list drug.

Future documentation problems will make establishing eligibility worse. The new documentation requirements of the Deficit Reduction Act require birth certificates, passports, or the equivalent in order to qualify for Medicaid. Many old, poor people simply don't have such documents—even if they were born in the U.S.

[15]Special Investigations Division, Committee on Government Reform Minority Staff, "Medicare Drug Plan Prices are Increasing Rapidly," February 2006.

Duals can shift plans more frequently. This is good and will help protect Duals from all of these other problems. But there will be ongoing confusion among these vulnerable people and their families.

V. What should the Congress do to make Part D better for the Duals?

Provide a standard Medicare drug option available to all that can be a safe haven until they choose another plan. When Duals have to be auto-enrolled, auto-enroll them there until ***they choose*** to go elsewhere. This is not dissimilar to how Medicare works for hospital and physician services. Beneficiaries enroll in Medicare Part A and Part B, unless they themselves choose to join managed care in Part C.

This option should have both an open formulary and prices that are negotiated by Medicare or adapted from another Federal pricing system already in use. (I would note that all other Federal pricing systems get better deals than Medicare Part D has so far provided.)

Provide an ongoing transition payment through Medicaid to allow States to assure that a Dual who is newly enrolled in Part D is truly covered. Don't cut off Medicaid payment for a Dual until it's confirmed that Medicare will pay.

Provide both the Federal agencies and State Medicaid programs with increased money and enforceable (and enforced) requirements to straighten out their data systems. Part D is not the only place where the inability to talk among Medicaid and Medicare and Social Security confuses the systems and mistreats beneficiaries.

Audit the auto-enrollment plans for cost and utilization. My guess is that they—like Medicaid managed care plans that have received auto-enrolled beneficiaries from States—are collecting premiums on a lot of people who don't even know they're enrolled and who are not getting any services. I'm also guessing that these plans, while holding their premiums to an average level, are charging higher prices for those drugs used commonly by people likely to be Duals—at Medicare's expense.

VI. Closing

There absolutely must be a system for paying for prescription drugs for Medicare beneficiaries. Prescription drugs are a much-needed service for people on Medicare. Medicaid has very limited eligibility and does not help many of the people who need help.

Conversely, Medicaid—and the States—have too long been shouldering a burden that should have been Medicare's. (I would note that this problem is not solved by Part D, since the clawback effectively continues this burden on Medicaid.)

But there has to be a better way than this around-your-elbow-to-get-to-your-nose, Rube-Goldberg system of Part D. It serves neither the beneficiaries nor the taxpayers well. And it is endangering the health and wellbeing of some of the most vulnerable Americans.