

Testimony of  
Patricia B. Nemore  
Attorney  
Center for Medicare Advocacy, Inc.  
United States Senate Special Committee on Aging  
“Helping Those Who Need it Most: Low-Income Seniors and the New Medicare Law”  
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Good morning. My name is Patricia Nemore. I am an attorney with the Center for Medicare Advocacy.

The Center is a national, non-partisan education and advocacy organization that identifies and promotes solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. Staffed by attorneys, paralegals, nurses, and information management experts, the Center represents thousands of individuals in appeals of Medicare denials and responds to over 6,000 calls annually from elders, people with disabilities and their families. Based in Connecticut, with offices around the country, the Center is part of Connecticut’s CHOICES program, the statewide program providing health insurance assistance and counseling to Medicare beneficiaries. CHOICES is Connecticut’s State Health Insurance Program (SHIP). Through telephone and email contacts, as well as extensive training and speaking engagements, Center staff is in daily contact with both Medicare beneficiaries and those who assist them.

My own work at the Center focuses on Medicare and Medicaid issues affecting low-income older people and people with disabilities; I have spent much time during the last fifteen or so years focusing on this population. I am, therefore, especially grateful to the Committee, and to Senators Craig and Breaux, for this invitation to testify today on what are *potentially* the most helpful aspects of the Medicare Act of 2003 -- its provisions for financial assistance with drug coverage for low income Medicare beneficiaries.

The Center did not support the Medicare Act of 2003. Based on our years of experience representing Medicare beneficiaries, we believe that, on balance, the Act does not serve Medicare beneficiaries well. However, our disagreements with the law were not primarily with the drug benefit and, in any case, are not the subject of this hearing. We serve our clients not only by advocating for the passage of good laws, but also by working hard to assure that the laws we have are implemented and administered to best serve the needs of the Medicare population.

Today I would like to discuss the areas of the law that need further attention given what we know about low-income Medicare beneficiaries, their prescription drug use and the challenges of providing public benefits to low-income individuals:

\* Issues regarding implementation of the Medicare-endorsed discount drug card and transitional assistance, and

\* Issues that arise under the 2006 drug benefit and low income subsidy.

While my remarks will focus on those areas where the Secretary has authority and discretion to act pursuant to regulations or other guidance, I will also point to areas of the law itself that will result in hardships to beneficiaries if not amended.

**Low-income Medicare beneficiaries: Who are they and what are their drug needs?**

The Secretary of Health and Human Services (HHS) and the Administrator of the Centers for Medicare and Medicaid Services (CMS) know a great deal about low-income Medicare beneficiaries that should inform their exercise of authority and discretion in implementing the Medicare drug law.

They know, for example, that about 40% of Medicare beneficiaries have incomes under 200% of the federal poverty level, with about 37% under the 150% poverty threshold required for a Part D low-income subsidy.

They know that low-income Medicare beneficiaries are disproportionately over 85 and under 65, and that those under 65 have significant disabilities. Low-income beneficiaries are twice as likely to report their health status as fair or poor but less likely to have supplemental insurance to cover costs of needed health care. Low-income beneficiaries have high out of pocket costs for health care, spending more than a third of their income compared with 10% for wealthier beneficiaries.

They know that those who are the poorest among low-income beneficiaries, the nearly 7 million individuals dually eligible for Medicare and Medicaid are, as a group, probably the highest users of health care in the country. They are 10 times more likely to be in nursing homes than other Medicare beneficiaries and have a higher prevalence of chronic conditions, such as diabetes, stroke and Alzheimer's disease.

They know that these dually eligible individuals are high users of prescription drugs and thus will have great need for the Medicare benefit to work smoothly for them. Prescription drugs account for 14% of state Medicaid expenditures for dual eligibles; of the \$21 billion states spent on prescription drugs in 2000 about half was for dual eligibles, although they comprise only about 14% of the total Medicaid population. These high drug users need a broadly defined benefit in a program that works well.

They know that high and complex prescription drug use among low-income Medicare beneficiaries will make it essential that beneficiaries have access to comprehensive information about what drugs are covered by each plan, how the formulary is designed, what their co-payment requirements are and how they can appeal eligibility and coverage decisions with which they disagree.

**Low-income beneficiaries: The challenges of outreach and enrollment**

The Secretary and the Administrator also know about the significant challenges of providing information, reaching out to and enrolling low-income beneficiaries in assistance programs. In the late 1990s, for several years, CMS identified as one of its government performance and review goals the increased enrollment of low-income Medicare beneficiaries in the Medicare Savings Programs that pay some or all of Medicare's cost-sharing through state Medicaid programs.

From that effort, CMS learned about the barriers to enrollment that result in participation rates for the Medicare Savings Programs of about 50% overall, after parts of the program have been in effect for fifteen years. Barriers include lack of clear, understandable information, lack of knowledge of programs by agencies charged with their administration, complex enrollment processes that require in-person interviews, lengthy applications, onerous verification processes, difficulties with language and transportation and restrictive assets tests. The Secretary and the Administrator know that the participation rate for Medicare Part B, which has automatic enrollment with the opportunity to decline coverage, is above 95 % while enrollment in programs requiring affirmative action on the part of the beneficiary that includes engaging in a complex enrollment process range from about 40-70%.

With this knowledge of who low income Medicare beneficiaries are, awareness of their complex prescription drug issues and of the challenges of outreach to and enrollment in programs for this population, the Secretary and the Administrator should look for all opportunities under existing law to provide the fullest coverage possible of needed drugs, to provide information and assistance necessary for accurate decision making and to ensure the most streamlined enrollment processes possible.

### **Transitional Assistance and the Drug Discount Card**

**Need for individualized assistance to choose a card.** The Medicare-endorsed drug discount card program relies on comparative information available via the internet and phone service. Only about 20% of older people are using the internet to get information, and, according to the Kaiser Family Foundation, only about 3% use [www.Medicare.gov](http://www.Medicare.gov), the website that includes the prescription drug assistance program for choosing a discount card.<sup>1</sup> Beneficiaries can get some assistance by calling 1-800-Medicare, but the need for individualized help – to understand the distinctions between this program and the drug benefit in 2006, to navigate the comparative data and to enroll for transitional assistance - cannot be overstated. Medicare beneficiaries have traditionally relied on the State Health Insurance Counseling Programs (SHIPs) for assistance in sorting out insurance options. But the labor intensive and time consuming nature of the decision-making process with respect to choosing a drug card, together with a tremendous amount of work SHIPs have to do to get up to speed on other aspects of the

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<sup>1</sup> Andy Schneider, "The Medicare Prescription Drug Discount Card Program: Implications for Low-Income Medicare Beneficiaries." Kaiser Commission on Medicaid and the Uninsured. April 2004

new Medicare law put great strain on their budgets. After public outcry, the administration offered additional funding to SHIPS to help beneficiaries understand the discount card. In Connecticut, that additional funding totaled \$.17 per beneficiary, increasing overall funding for the program to \$.52 per beneficiary.

**Recommendation:** CMS should provide additional resources to SHIPs to support their work on the drug discount card as well as the additional work they will do with respect to the Part D benefit in 2006.

CMS has just announced a request for proposals for community-based organizations to undertake outreach and enrollment activities related to the discount drug card and transitional assistance. This \$3.7 million will provide much needed additional resources at the community level to help beneficiaries enroll, but it remains a drop in the bucket: about \$.50 per eligible beneficiary.

**Automatic enrollment of Medicare Savings Programs (MSP) beneficiaries in drug discount card and transitional assistance.** The Secretary has exercised his discretion to deem individuals who receive MSP benefits as income eligible for Transitional Assistance, but to date has expressed unwillingness to create a process to automatically enroll MSP beneficiaries in a drug card. We know the importance of automatic enrollment, as nearly two thirds of the 3.7 million beneficiaries who have, to date, enrolled in the discount card have been automatically enrolled either by their Medicare Advantage plan or by their State Pharmacy Assistance Program. The Secretary himself authorized states to auto enroll their State Pharmacy Assistance Program beneficiaries, but he declines to offer the same opportunity to MSP beneficiaries not served by a state program. The Administration claims it does not want to interfere with choice, but fails to acknowledge that voluntary Medicare Part B operates as an auto-enrollment, with beneficiaries provided the opportunity to decline coverage.<sup>2</sup> The Secretary could randomly choose a card for individuals, inform them where to get assistance if they want to choose a different card and inform them they can choose not to participate at all. If this were done in the next few months, each person automatically enrolled would still have the opportunity to choose a different card for 2005 during the open enrollment period beginning in November.

**Recommendation:** The Secretary should create a process to auto enroll MSP beneficiaries. If he fails to do so, Congress should act quickly on S.2413, the Medicare Assurance of Rx Transitional Assistance Act and its companion, H.R.4437, legislation requiring the Secretary to do so.

**Counting of \$600 benefit in other federal programs.** The law prohibits the counting of either the \$600/year Transitional Assistance or the value of the discounted

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<sup>2</sup> The Secretary's promotion of choice in this situation contrasts with the reality of the situation of Medicare Advantage enrollees, who have no choice with respect to a discount drug card if their MA plan offers a card.

price of drugs purchased with a discount card in determining eligibility for or the amount of assistance under other federal programs. We applaud CMS's decision to reverse its earlier interpretation of the law so that it now requires that the \$600 should count toward an individual's spenddown for medically needy Medicaid eligibility. We encourage CMS to advise states that individuals should have freedom to use their \$600 when it is most advantageous to them during the year, rather than having to spend it all before receiving Medicaid coverage.

**Recommendation:** In developing guidance concerning the medically needy spenddown, the Secretary should permit beneficiaries the freedom to use their transitional assistance when it is most advantageous to them. The Secretary should work with HUD and other agencies to assure that they, too, interpret this law so that beneficiaries get the full value of the Transitional Assistance credit, without losing other benefits.

**Problems for Medicare Savings Program beneficiaries in several states.** We have received reports from advocates and others in the field that in several states, MSP beneficiaries were erroneously told they were ineligible for a discount card because they had Medicaid. As best we are able to determine, this resulted from CMS combining two separate files sent by states, one listing their full Medicaid beneficiaries and one listing their MSP-only population. While staff at CMS is aware of the problem and claim to have resolved it, we remain unaware of how beneficiaries were informed that, indeed, they are eligible and they can use their card. That this problem arose at all raises the importance, to beneficiaries, of smooth data sharing between states and CMS concerning the Medicaid status of individuals. This will continue to be an important issue in 2006 and beyond.

## **2006 Prescription Drug Benefit and Low-income Subsidies**

### **Loss of Medicaid prescription drug coverage by dual eligibles as of January 1, 2006**

The significance of loss of Medicaid drug coverage for dual eligibles in 2006 cannot be overstated. Medicaid, generally, requires some access to all medically necessary drugs, even where the state has implemented a formulary or requirements for prior authorization for certain drugs. The Medicare Act, by contrast, gives plans broad discretion in defining therapeutic classes and categories and in designing their formularies and cost-sharing structures.

Medicaid law limits permissible cost-sharing to nominal amounts, defined as no more than \$3. In Connecticut, Medicaid beneficiaries and their advocates were recently successful in getting prescription drug cost-sharing requirements repealed; thus, dually eligible beneficiaries in Connecticut will have heavier cost-sharing burdens under the Medicare Act. This will be true in other states as well.

The Medicare Act's prohibition on Medicaid wrapping around the Medicare drug benefit

is a dramatic departure from the Medicare/Medicaid relationship that has existed since the programs' inception in 1965. To address the serious and extraordinary health needs of those who are elderly or disabled and are also poor, the programs operate together with Medicaid serving as a Medi-gap policy with respect to Medicare. Medicaid pays for Medicare's cost-sharing and for non-Medicare covered services, such as prescription drugs and non-skilled long-term care. The loss of drug coverage from Medicaid will leave some dual eligibles worse off than they are under Medicaid. It will leave others lacking the extra help they might otherwise get from Medicaid wrap-around coverage for cost-sharing and drugs that their Part D plan does not cover.

Moreover, as noted, the Medicare Act affords great discretion to plans not only in creating their formularies, but also in defining therapeutic classes and categories of drugs they will cover. Therapeutic classes and categories will not be comparable across plans, unless all plans adopt the non-mandatory model guidelines developed by the United States Pharmacopeia. Moreover, plans need not cover all drugs within the classes and categories that they themselves design. While this limitation will affect all Medicare beneficiaries, it will most affect low-income beneficiaries, who do not have the resources to pay for drugs out of pocket. The example of Dan Cusick, an HIV positive dual eligible is instructive:

Starting in 1995, Dan was on a drug regimen that included 3 anti-HIV drugs: Indinavir, Lamivudine, and Zidovudine, as well as Acyclovir to treat his PML [Progressive Multifocal Leukoencephalopathy]. Under the Medicare prescription drug law, it will be up to individual prescription drug plans to decide whether his three HIV drugs would be considered to be in the same class, and whether to cover only two (or all) of the anti-HIV medications, of which there are currently 20. If there ever comes a time when he cannot take any of the HIV medications and a new drug is approved, he would not be able to count on having access to the drug (security that he currently has through Medicaid), because each prescription drug plan can decide whether or not to cover new drugs.<sup>3</sup>

Similar issues will arise for beneficiaries with Multiple Sclerosis (or with many other diseases) who may need one or two specific drugs from four or more different options.

While presumably, states can fill, with state-only money, some coverage gaps that might be experienced by dual eligibles, the law is silent as to how that might work. Moreover, as states continue to feel budget pressures, and since they are required to "pay back" to the federal government most of the savings they realize from not covering drug costs for dual eligibles, they are unlikely to want to undertake new obligations that have no federal

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<sup>3</sup> Jeffrey S. Crowley, "The New Medicare Prescription Drug Law: Issues for Dual Eligibles with Disabilities and Serious Conditions." Kaiser Commission on Medicaid and the Uninsured, June 2004, 10.

matching dollars. Thus, dually eligible individuals in many states face the serious threat of losing rather than gaining prescription drug coverage with the advent of Medicare Part D in 2006.<sup>4</sup>

**Automatic enrollment of dual eligibles in Part D plans.** The law requires the Secretary to automatically enroll dual eligibles in a Part D plan, on a random basis, if they have not themselves enrolled in a plan. However, it has neither time frames nor a structure for this process. While automatic default enrollment can be helpful to ensure that dual eligibles do not have coverage gaps beginning in January 2006, the Secretary should promote beneficiary involvement in the process to reduce the need for default enrollment as much as possible. Such involvement will reduce the likelihood of an individual being enrolled in a plan that, for example, does not include his pharmacy in its network. States have successfully reduced their default enrollment of families into mandatory Medicaid managed care by using face-to-face bilingual counseling and making multiple outreach efforts in advance of the default enrollment, among other steps.<sup>5</sup>

**Recommendation:** The Secretary should use part of the \$1 billion designated for outreach and education to engage the states and State Health Insurance Counseling Programs (SHIPS) in this effort. The Secretary's default enrollment plan should also include targeted education and outreach following the enrollment so that the beneficiary understands how to use the plan in which she is enrolled and how to choose a different plan, if she wishes.

### **Enrollment in Low Income Subsidy<sup>6</sup>**

**Deeming MSP beneficiaries eligible for low-income subsidy.** The law requires the Secretary to deem eligible for low income subsidies Medicare Savings Program beneficiaries from states whose eligibility rules are "substantially similar" to those of the Medicare subsidy and gives him discretion to so deem all other MSP beneficiaries.

**Recommendation:** The Secretary should exercise this discretion in favor of deeming MSP beneficiaries from all states eligible for the low-income subsidy appropriate to their income range.

**Application and enrollment for low-income subsidy.** The law requires the Secretary together with the Commissioner of Social Security to develop a model

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<sup>4</sup> Despite the myriad methods state Medicaid programs use to control prescription drug costs, states generally are required to provide access to most medically necessary drugs. See Jeffrey S. Crowley and Deb Ashner, "Medicaid Outpatient Prescription drug Benefits: Findings from a National Survey, 2003" Kaiser Commission on Medicaid and the Uninsured, December 2003.

<sup>5</sup> "Medicaid Managed Care: An Advocate's Guide for Protecting Children." National Association of Child Advocates and National Health Law Program.

<sup>6</sup> For a discussion of opportunities for CMS to improve access to the low-income subsidy, see Kim Glaun, "Ways CMS Can Improve Access to the Low-income Medicare Drug Benefit." (forthcoming)

simplified application form and process to provide to the States. States must make eligibility determinations for the low-income subsidy in accordance with this section of the law.

**Recommendation:** The Secretary should assure that the process does not require face-to-face interviews, that the application form is also made available to community-based organizations that assist low income Medicare beneficiaries, that it is made available on-line in an easy-to-find location, and that states use the process.

**Assets test and documentation requirements.** The law imposes an asset test for low-income beneficiaries who are not dually eligible. Assets tests create barriers to eligibility in two ways. First, the test itself renders ineligible for benefits low-income people who would otherwise qualify and who have no more income to pay for their prescription drugs than another person with fewer assets. The Kaiser Commission on Medicaid and the Uninsured estimates that 1.8 million people are ineligible for the low-income subsidy only because they would “fail” the asset test.

Second, the disclosure of and documentation required to verify the level of assets may discourage individuals from applying. Research suggests that documentation requirements create barriers to enrollment, and that it is possible to minimize documentation without impairing program integrity.<sup>7</sup>

**Recommendation:** The Secretary should act to minimize documentation requirements under the law. He can do that by interpreting the law’s requirement that the application form being accompanied by copies of recent statements from financial institutions so as to put the least burden on the applicant; one month’s bank statement should suffice, with authorization to the entity determining eligibility to inquire further with the bank, as necessary.

**Use of more liberal methodologies.** The law permits the Secretary to allow states in determining eligibility for the low income subsidy to use more liberal eligibility methodologies used in their MSPs if the Secretary determines that to do so will not result in “significant differences” in the number of subsidy-eligible individuals.

**Recommendation:** The Secretary should interpret this authority liberally both to allow the low income subsidy to serve the broadest universe of those in need and to ease the burden on states for enrolling individuals in this Medicare benefit.

**Use of common eligibility rules regardless of location of application.** Individuals may apply for the low-income subsidy either through their state Medicaid program or through the Social Security Administration. The eligibility rules should be

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<sup>7</sup> Kim Glaun, “Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings.” Kaiser Commission on Medicaid and the Uninsured. December 2002.

the same, regardless of where they apply, and should incorporate a state's more liberal methodologies, if any. SSA has experience in applying state eligibility rules in those states for which it administers a state supplement to the federal Supplemental Security Income program; such a requirement would not, then, be beyond SSA's capability. The law includes an authorization of appropriations for the SSA determination process.

**Recommendation:** The Secretary should direct the Social Security Administration in states using more liberal methodologies to use those methodologies in SSA's determinations as well.

**Family size involved.** The law requires that eligibility be measured against the federal poverty level for a family of the size involved. SSA has stated orally that, in its eligibility determinations, it intends to measure against the actual size of the family. We are encouraged by this information and hope it will appear in the regulations; such a standard is essential to take into account the support provided by Medicare beneficiaries with dependent family members other than a spouse.

**Recommendation:** The Secretary should state, in regulations, that the family size poverty level standard used in determining eligibility should reflect the actual family size of the applicant.

**Initial determination.** The Medicare law requires the Secretary to determine the initial period of eligibility, up to one year.

**Recommendation:** The Secretary should exercise this limited discretion to identify one year as the eligibility period so that beneficiaries are not required to reapply before that time.

**Redeterminations.** In fact, beneficiaries frequently lose benefits at the time of redetermination for failure to complete the process due to cognitive or physical impairments, change of address or hospitalization.<sup>8</sup> The most beneficiary-friendly redetermination process is a passive one that requires the beneficiary to act only if some important piece of information has changed since the last determination, or to sign and return a simple form attesting to the validity of pre-printed information. Unfortunately for beneficiaries, the law directs states to use the processes they currently have in place, and few if any states have focused attention on improving their renewal procedures. The law is silent as to the redetermination process to be used by SSA.

**Recommendation:** The Secretary should direct the Social Security Administration to adopt a passive redetermination process to minimize benefit disruption.

**States' duty to screen and enroll eligible MSP beneficiaries.** The law explicitly requires states, but not the Social Security Administration, to screen all

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<sup>8</sup> Id.

applicants for the low-income subsidy to determine if they are also eligible for a Medicare Savings Program, and, if so, to offer them the opportunity to enroll.

**Recommendation:** The Secretary should direct the SSA to screen for MSP eligibility, which would be particularly easy to do if SSA was relying on the state's MSP methodology for determining low-income subsidy eligibility, and to report the results of such screenings to the states.

### **Drug Plan Design**

To the extent Medicare drug plans do **not** have open formularies that cover all medically necessary drugs, low income beneficiaries will be disproportionately harmed. Restrictive formularies, broad class definitions that result in coverage of some but not all drugs an individual is taking, and tiered co-payments that demand a higher amount for a drug that is medically necessary for a particular individual all impose hardship.

**Recommendation:** The Secretary should exercise vigorous oversight of plan design in carrying out his duties to assure that plans are not likely, through their design, to discourage enrollment of Part D eligible individuals.

### **Nursing home issues**

An estimated 1.6 million nursing home residents are low-income Medicare beneficiaries dually eligible for both Medicare and Medicaid.<sup>9</sup> Additional numbers of residents will qualify for the Part D low-income subsidy for individuals with incomes up to 150% of the federal poverty level. Moreover, nearly all nursing home residents are Medicare beneficiaries and will be eligible to enroll in a Part D plan.<sup>10</sup> Nearly seventy-five percent of nursing home residents have cognitive impairments.<sup>11</sup> Nursing home residents receive, on average, more than 6 routine prescription drugs per day.<sup>12</sup>

Issues related to providing prescription drug coverage in nursing homes are distinct from those relating to the community. Nearly 80 percent of all nursing home beds in the country are served by pharmacies that specialize in long-term care services.<sup>13</sup> Such pharmacies specially pack prescription drugs in unit doses, to reduced medication errors.

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<sup>9</sup> Andy Schneider, "Dual Eligibles in Nursing Facilities and Medicare Drug Coverage." Briefing Note: The Kaiser Commission on Medicaid and the Uninsured, November 13, 2003. (Schneider: Dual Eligibles in Nursing Homes)

<sup>10</sup> See, e.g., CMS Compendium 2001, "Characteristics of Nursing Home Residents" at 54. Available at <http://www.cms.hhs.gov/medicaid/survey-cert/datacomp.asp> (Site visited July 15, 2004)

<sup>11</sup> Id. At 86

<sup>12</sup> Dan Mendelson, Rajeev Ramchand, Richard Abramson and Anne Tumlinson, "Prescription Drugs in Nursing Homes: Managing Costs and Quality in a Complex Environment," NHPF Issues Brief No. 784 (November 12, 2002), [www.nhpf.org](http://www.nhpf.org), as cited in Schneider: Dual Eligibles in Nursing Homes, *supra* note 9.

<sup>13</sup> Id.

They provide 24 hour service and consultant pharmacists to review monthly each resident's drug regimen.

Residents whose coverage is paid for under a Part A currently have their drug costs paid as part of the prospective payment made to the facility. While they must pay co-insurance for their stay after the 20<sup>th</sup> day, they have no separate co-payment for prescription drugs.

Residents whose Part A coverage has been exhausted and who are dually eligible then have their stay paid for by Medicaid, including their prescription drug costs which are most commonly paid for separately from the payment to the facility.

Important questions need to be addressed in regulations including:<sup>14</sup>

Will nursing home residents need to enroll in Part D to have their prescription drugs paid for, even if their stay is paid for under Part A?

How will dual-eligibles, whose Medicaid drug coverage will end January 1, 2006, know that they must enroll in Part D in order to have drug coverage? Who will choose the plan, the beneficiary or the facility? If the beneficiary chooses the plan, who will help those many residents with cognitive impairments?

Must all Part D plans cover the special services provided by long-term care pharmacies now? Will they be required to cover unit packaging, 24 hour service and the services of consultant pharmacists?

How will nursing homes fulfill their legal obligation to provide necessary services to residents if a resident requires a drug not covered by her Part D plan?

CMS has recognized the special circumstances of nursing facilities and their pharmacies in its administration of the discount drug card. Unfortunately, by doing so, it has denied nursing home residents the value of any discounts offered, since it waived the law's requirement of negotiated prices and created a special nursing home card that serves only as a conduit for the \$600 transitional assistance for low-income beneficiaries.

The American Society of Consultant Pharmacists has prepared thoughtful comments on the prescription drug utilization of nursing home residents and what will be needed under Part D to meet their needs. Among their recommendations is that CMS not issue regulations that would affect nursing home residents until after the publication of the Review and Report on Current Standards of Practice for Pharmacy Services provided to Patients in Nursing Facilities.<sup>15</sup>

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<sup>14</sup> These and other important questions are raised in Schneider: Dual Eligibles in Nursing Homes, *supra* note 9.

<sup>15</sup> Letter of March 10, 2004 to Dennis Smith, Acting Administrator, Centers for Medicare and Medicaid Services from John Feather, Executive Director, American Society of Consultant Pharmacists. Available at

**Recommendation:** CMS should immediately convene a work group of nursing home residents' advocates, facilities and consultant pharmacists to further identify the prescription drug issues unique to nursing home residents, including how to ensure coverage for the drug regimens they need, how to inform them of their need to enroll in Part D and assist them in doing so and how to provide coverage for necessary drugs that may not be on their Part D plan. Regulations affecting nursing home residents' use of Part D coverage should be delayed pending the issuance of the mandated long-term care study.

### **Information needs of beneficiaries**

**Information prior to enrollment.** Since the law gives plans great latitude in design, it will be critical for beneficiaries, and more so for low-income beneficiaries, to have clear comparative information on which to base their decision to join a plan.

**Recommendation:** The Secretary, pursuant to his mandate to make comparative information available to beneficiaries prior to the initial enrollment period, should require plans to provide information concerning the structure of their formulary, drugs covered by the formulary and which drugs are covered in which tier of co-payment, to the extent the plan uses tiered co-payments.

**Information needs of enrollees.** Unfortunately, the law is extremely confusing as to the plans' obligation to provide information to enrollees. Generally speaking, the law appears only to require that plans inform enrollees about how and where they can get detailed information about how the formulary works, cost-sharing requirements, drugs covered and how enrollees get access to their covered drugs. The law requires plans to have a toll free number and to post changes in their formulary on the internet. Apparently, they are not even required to notify directly individual plan members when they remove a drug from formulary or make changes in their tiered cost-sharing; they merely must "make available notice." Unless enrollees check the internet or call their plan each time they seek to fill or renew a prescription, they may arrive at their pharmacy and be told their plan no longer covers the drugs they are taking.

**Recommendation:** The Secretary has discretion to determine appropriate disclosure concerning benefits the plans must provide; he should exercise this discretion to afford beneficiaries the maximum amount of clear, understandable information about how their plans operate. Plans should be required to mail information to enrollees regarding changes to formularies and prices and should be limited in the number of such changes allowed each year.

**Information concerning initial coverage limits and annual out-of-pocket threshold.** Although many low income beneficiaries are not affected by the initial

coverage limit, some are, and all are affected by the annual out-of-pocket threshold, after which their cost-sharing requirements are reduced or eliminated.

**Recommendation:** The Secretary must specify how often such notices must be provided to enrollees by plans; he should require them to be sent shortly before the initial coverage limit is reached and shortly before the out-of-pocket threshold is reached.

### **Determinations, Reconsiderations and Appeals**

If drugs are not on formulary, if they are removed from formulary, or if they are subject to tiered cost-sharing at a high tier, beneficiaries must pay the extra costs out of pocket. Low-income beneficiaries have little disposable income from which to pay for uncovered or under-covered drugs.

Moreover, the cost of a drug not covered by the plan does not count toward meeting any of the beneficiary out-of-pocket spending requirements of the benefit. A speedy informal system for challenging coverage determinations is therefore critical for all beneficiaries but especially for those who cannot afford to carry the costs pending a lengthy appeal process. Moreover, even with an expedited review system, beneficiaries need access to a short-term supply of the drug for which they seek coverage.

The law is not clear about requirements for review of various coverage decisions. While there must be a determination and reconsideration process for “covered” benefits, it is not clear that such process must be available to request coverage for drugs not included at all on the plan’s formulary. Nor is there any mention at all of a process to seek continued coverage of drugs that have been removed from the plan’s formulary. Moreover, there is no mention of how an enrollee would get notice of her right to engage in whatever process the plan has.

**Recommendation:** The Secretary should clarify the ambiguities in the law to make clear that the internal determination and reconsideration process, including expedited process, apply to questions of non-formulary drugs as well as drugs removed from the formulary. The role of the physician should be as it is in Medicare Advantage; that is, if the physician requests expedited review, it must be granted. The Secretary should also require that a plan enrollee is entitled to a 72-hour emergency supply of drugs pending the outcome of an expedited process.

### **Conclusion**

The task before us is daunting. The Medicare Act creates an extremely complex set of processes required to be followed for a Medicare beneficiary to enroll in a Part D plan with a low-income subsidy, to ensure that the drugs she needs are covered by her plan and to seek coverage for those drugs that are not. At every step of the way, beneficiaries

will need clear, reliable information, counseling and assistance. The Administration must take all steps possible to make systems beneficiary-friendly, to minimize burdens and to maximize participation.

We appreciate the opportunity we have had today to share ideas on these points. The Center for Medicare Advocacy will continue vigorously to advocate for policies that promote the health of all Medicare beneficiaries and especially that recognize the special needs of low-income beneficiaries.

Thank you.