THE HENRY J. KAISER FAMILY FOUNDATION

THE MEDICARE DRUG BENEFIT

Early Experiences of Medicare Beneficiaries in Prescription Drug Plans

Insights from Medicare State Health Insurance Assistance Program (SHIP) Directors

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Notes and Acknowledgements

This paper is based on a moderated discussion with directors of State Health Insurance Assistance Programs (SHIP) that took place June 27, 2006. The discussion was moderated by Julia James, an independent health policy consultant. Most participants were the SHIP directors for their states; in some instances another individual, such as a former director or interim director, attended. Our thanks go to the meeting participants who came from SHIP programs in California, Colorado, Delaware, Florida, Georgia, Iowa, Louisiana, Maine, Michigan, Minnesota, New Jersey, Pennsylvania, and Tennessee.

EXECUTIVE SUMMARY

The magnitude and complexity of the new Medicare prescription drug benefit, with its relatively short implementation period, created an enormous need for education and counseling services for Medicare beneficiaries. At the front lines in this effort were the State Health Insurance Assistance Programs (SHIPs) that offer free one-on-one counseling and assistance to Medicare beneficiaries, among other services. The SHIPs have been a key partner to the Centers for Medicare and Medicaid Services (CMS) in assisting beneficiaries with the new Medicare prescription drug benefit.

The purpose of this research is to gain insights into Medicare beneficiaries' experiences with the new drug benefit and to understand challenges that some beneficiaries are facing, rather than provide an overall assessment of the new program. SHIP directors were convened for a structured, focus group discussion because SHIPs are a key resource for beneficiaries who have questions or issues to resolve related to their Medicare prescription drug coverage. Representatives, primarily executive directors, from the SHIP agencies in 13 states participated in the focus group discussion on June 27, 2006 which covered a range of issues facing beneficiaries, including: plan enrollment, premium payments, cost sharing, access to medications, Medicare Advantage plans, marketing, and issues for special populations, such as dual eligibles and retirees in employer plans.

It is important to note that SHIPs are a resource for people who need help and seek out assistance. People who do *not* have questions or experience problems are unlikely to contact SHIPs. Of course, some who do encounter problems may not seek assistance from their SHIP. Therefore, the problems described in this report are examples of problems encountered by a number of beneficiaries, but should not be construed to apply generally to the Medicare population.

KEY FINDINGS

All SHIP directors participating in this discussion reported that their programs engaged in extensive beneficiary education and counseling efforts around Part D during the last year. Given their work with Medicare beneficiaries, they were able to offer a number of observations regarding their experiences with the new Medicare drug benefit.

Enrollment

Because beneficiaries must be enrolled in a Medicare drug plan in order to receive the Medicare drug benefit, the enrollment process is critical. All of the meeting participants reported that they had experienced significant casework related to problems resulting from data system errors, time delays or inadequacies regarding part D plan enrollment. Many of the directors reported that data system errors – missing or erroneous information – resulted in beneficiaries who should have been enrolled in a certain plan, but were not, or were enrolled in the wrong plan, or enrolled in more than one plan, or mistakenly disenrolled from a plan. There was uniform agreement that the information systems of CMS, Social Security Administration (SSA), state Medicaid programs,

Medicare drug plan sponsors, and participating pharmacies must all be able to communicate in an accurate, timely manner.

Looking to the future, many SHIP directors said they were concerned that the 2007 enrollment period could be problematic because it will occur over a relatively short 6-week period and during the holiday season. In addition, some worry that beneficiaries will not revisit plan decisions and instead will keep whatever plan they've already selected, even if their current plan is not ideal for their individual circumstances.

Premium Payments

Medicare beneficiaries can pay Part D plan premiums to plans directly or elect to have them deducted from Social Security checks. Initially, many SHIP directors advised their clients to have premiums deducted from their Social Security checks for ease and convenience. However, the deduction of Part D premiums has resulted in problems that have proved difficult to resolve. Some SHIPs now counsel enrollees against having their premiums deducted from their Social Security checks to avoid these problems.

Several participants described situations where Part D premiums were not being deducted from Social Security checks as they should have been, and worried that beneficiaries would have difficulty making ends meet if Social Security corrected this problem by deducting several months of part D premiums in a given month. Some directors report instances where premiums *were* deducted from the checks but not sent to the plans, remaining *"out there somewhere* "in limbo. Others reported clients having the wrong premium amount deducted from their checks because Social Security had incorrect or outdated information about their Medicare Part D plan enrollment.

Cost-Sharing

Pharmacies need accurate on-line, real-time data systems to determine which Medicare Part D plans their customers are enrolled in, whether plans cover their customers' prescriptions, and how much to charge for each prescription. Pharmacies also need to determine if customers qualify for low-income assistance and confirm the level of assistance in order to charge the correct amount for their medications.

Several SHIP directors reported situations in which their clients have been overcharged for their medications. SHIP directors are particularly concerned that beneficiaries who are eligible for low-income subsidies (LIS), including dual eligibles, are sometimes being asked to pay too much for prescriptions at the pharmacy – primarily because the pharmacist does not have accurate information at hand. In these circumstances, they noted their clients often left the pharmacy without their drugs or paid the incorrect amount and may never be reimbursed appropriately.

Many directors reported that problems related to the "doughnut hole" are just beginning to emerge. Agencies are getting calls from enrollees who are unaware of the benefit structure in their plan, including what costs count towards reaching the limit for the coverage gap and the annual out-of-pocket maximum. And, because plans use

different explanation of benefit forms, it is more difficult for counselors to explain to beneficiaries where they are in their benefit period.

Access to Drugs

Medicare Part D plans have flexibility in designing their own benefit structures and using a variety of cost-management techniques subject to CMS approval. Most plans limit coverage to drugs on the plan formulary. Many require prior authorization before certain prescriptions may be filled and/or impose quantity limits. Plan sponsors are required to have a system for grievances and appeals, although to date, the SHIP directors reported little experience with these procedures.

Most meeting participants said they are dealing with issues related to prior authorization requirements. Some observed that physicians in their states are resisting helping their patients with prior authorization and requiring patients to have a billable office visit before they will assist with prior authorization requirements. Some of the directors report instances of plans requiring enrollees to go through prior authorization on a monthly basis, putting a burden on both beneficiaries and their providers. Several directors are concerned that the various Part D plans use different forms and requirements, posing challenges for beneficiaries, providers and SHIP volunteers.

Medicare Advantage

Medicare beneficiaries have had the option to obtain benefits through managed care plans since the 1970s. In more recent years, lawmakers have sought to expand the role of private plans, giving beneficiaries access to prescription drug coverage through private plans and access to all Medicare benefits through private HMOs, regional PPOs, and private fee-for-service plans, known as Medicare Advantage plans.

Several SHIP directors noted that Medicare beneficiaries often do not understand important distinctions between traditional fee-for-service Medicare and Medicare Advantage plans. Several directors observed that beneficiaries inadvertently signed up for Medicare Advantage plans, thinking they were enrolling in drug plans. Others report that beneficiaries are drawn to Medicare Advantage plans because of the low premiums, without understanding other costs or restrictions in provider networks.

At least half of the participants reported client problems that relate to marketing activities, particularly with several Medicare Advantage plans new to the marketplace. Several directors said that agents for some of the plan sponsors are providing erroneous information, either unintentionally or deliberately, to encourage Medicare Advantage plan enrollment. Several directors indicated that some agents are more aggressively promoting Medicare Advantage plans because they typically receive higher sales commissions for these plans.

Challenges for Special Populations

As of January 1, 2006, individuals dually eligible for Medicare and Medicaid were required to obtain their drug coverage from a Medicare drug plan instead of their state

Medicaid program. To facilitate the transition, CMS randomly assigned *dual eligibles* to Medicare Part D plans.

The transition from Medicaid to Medicare drug plans, according to virtually all participating SHIP directors, was difficult for many dual eligibles. SHIP directors identified numerous problems related to plan enrollment, especially for those dual eligibles who changed plans. Some dual eligibles are overcharged at the pharmacy, and some are incorrectly charged premiums, usually due to data system errors.

A number of different problems surfaced for beneficiaries with retiree plans – particularly among those with spouses. Directors noted that a major problem occurs when a couple has retiree health coverage and one partner becomes eligible for Medicaid, potentially putting the other partner in jeopardy of losing retiree supplemental benefits.

SUGGESTIONS FOR IMPROVEMENT

SHIP directors suggest a number of changes for the program to help address some of the problems or make the program operate better. First and foremost, the SHIP directors recommend simplifying and standardizing Part D in order to help beneficiaries and their caregivers navigate the drug program with greater ease. They also urge improvements in the data systems used to support the administration of the benefit. The SHIP directors also recommend: changing the timeframe for the Part D open enrollment season so it does not coincide with the holiday season (possibly to coincide with Part B enrollment period); implementing more stringent regulation of plan marketing practices; liberalizing the asset requirements for the low-income subsidies; adopting rules for retiree plans so that spouses do not lose coverage when enrollees becomes eligible for Medicaid, and providing more stable funding for the SHIPs.

CONCLUSION

The SHIP directors who participated in this facilitated discussion feel they have weathered the initial storm, but challenges remain, and SHIPs continue to deal with a variety of issues that have emerged in the first year of the new Medicare drug benefit. As they continue to find strategies to resolve problems presented by their clients, SHIPs are also preparing for the 2007 open enrollment period that begins on November 15, 2006. Looking to the future, SHIPs anticipate that Medicare beneficiaries will face a myriad of changes in Part D, including changes in plan benefit structures and premium costs. They are concerned that some beneficiaries may remain in their plan rather than search for one that is potentially better suited to their circumstances. As they reflected on the initial enrollment period and contemplate the one that is coming, SHIP directors are relieved to be beyond the initial implementation stages, but remain mindful of the recurring problems faced by some clients, and expressed the need to simplify the drug program in order to minimize the recurrence of such problems in the future.

INTRODUCTION

In 2003, Congress enacted the most significant changes in the Medicare program since its inception four decades earlier. Most notable was the addition of voluntary outpatient prescription drug coverage under a new Medicare Part D. The addition of prescription drug coverage to Medicare is an expansion of benefits and also a structural change for the program and beneficiaries. Unlike other benefits covered by the traditional Medicare program, the new prescription drug benefit is not administered directly by the government. Instead, it is only available through privately- sponsored health plans, either stand-alone prescription drug plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs) i.e., in a manner similar to Medicare Part C.[1] Additionally, the Medicare drug benefits that are offered by various plans are not uniform nationwide; in fact there is considerable variation in Medicare prescription drug plan premiums, cost-sharing requirements and covered drugs (MedPAC, June 2006).[2]

The structure of the new drug benefit relies on beneficiaries being proactive in making decisions about drug coverage. Consequently, beneficiaries need to understand the implications of enrolling in a Part D plan or not and of choosing one Part D plan over another. Such decisions require consideration of potentially substantial differences across plans that could affect whether they have access to the drugs they need, how much they are likely to pay out-of-pocket for drugs, whether or not they may qualify for low-income subsidies, and if so, how to apply.

The magnitude and complexity of the changes in Medicare, coupled with the relatively short implementation period, has created an enormous need for education and counseling services for Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) initiated the implementation effort along with the Social Security Administration (SSA), state and local agencies, nonprofit organizations and private companies. At the front lines in this effort to provide education and counseling to Medicare beneficiaries were the State Health Insurance Assistance Programs (SHIPs).[3] SHIPs offer free one-on-one counseling and assistance to Medicare beneficiaries via telephone or in-person meetings, public education presentations, and media activities.

The purpose of this research is to gain insights into Medicare beneficiaries' experiences with the new drug benefit and to understand challenges that some beneficiaries are facing, rather than provide an overall assessment of the new program. SHIP directors were invited to participate in a structured, focus group discussion because SHIPs are a key resource for beneficiaries who have questions

[1] All PDP and MA-PD plans must be approved by the Centers for Medicare and Medicaid Services (CMS) as meeting minimum standards for benefit value and plan administration.
[2] Medicare Payment Advisory Commission. *Report to Congress: Increasing the Value of Medicare*. June 2006.
[3] The SHIPs were authorized by federal law in 1990 and are funded through federal grants to the states; they may also receive supplemental funding from their states. SHIPs currently exist in all 50 states as well as the District of Columbia and the territories of Guam, Puerto Rico, and the Virgin Islands.

or issues to resolve related to their Medicare prescription drug coverage. The moderated discussion took place in June 2006 and was attended by individuals, primarily executive directors, from the SHIP agencies in 13 states: California, Colorado, Delaware, Florida, Georgia, Iowa, Louisiana, Maine, Michigan, Minnesota, New Jersey, Pennsylvania, and Tennessee. Participants were asked to be candid and speak off the record about their agencies' experiences working with beneficiaries during Medicare Part D implementation.

The moderated discussion covered a range of issues and challenges facing beneficiaries, including: plan enrollment, premium payments, cost-sharing, access to medications, Medicare Advantage plans, marketing, and issues facing special populations, such as dual eligibles and retirees in employer plans. Participants were also asked to offer their suggestions and perspectives on potential improvements to the program's operations. The views expressed by the participants were their own and do not represent the position of their agency or other officials in their states.

It is important to note that because SHIPs are a resource for people who need help and seek out assistance, people who do *not* experience problems are unlikely to contact their SHIP to share that positive experience. Therefore, the problems described in this report are examples of problems encountered by a number of beneficiaries but should not be construed to apply generally to the Medicare population as a whole.

KEY FINDINGS

Beneficiaries contact SHIPs for a variety of reasons. They call because they are unsure if they need to sign up for a drug plan, and by when. They call because they are not sure if they are already enrolled in a plan, or whether it is a PDP or MA-PD. The fact that a large number of plans exist in their respective states, and that plans vary in numerous ways contributed to the volume of calls and sources of confusion among beneficiaries in the first six months of the year. Beneficiaries also contact their SHIP when they are concerned that they have been charged too much by their pharmacist, or do not understand if or how their premiums are getting paid, or how to get prior authorization from a plan, or if they reached the so-called "doughnut hole," and why. Some of the issues raised were transitional, but others were not and continue to persist. In general, SHIP directors said they encountered a great deal of confusion among the beneficiaries they helped, and to some extent, among the volunteers providing counseling services.

Enrollment

Beneficiaries must be enrolled in a Medicare drug plan in order to receive the Medicare drug benefit. Therefore, the enrollment process is critical. Medicare beneficiaries were given six months, November 15, 2005 through May 15, 2006, to decide whether to participate in Part D and which plan to join. Enrollment could have been accomplished in several ways. Beneficiaries, or people acting on their

behalf, were able to enroll in a Part D plan by calling 1-800 Medicare, by visiting Medicare.gov, or by contacting the plan directly. However, no single, centralized enrollment process existed for Part D (unlike Part B which is administered directly by the Social Security Administration). To enable beneficiaries to compare plan options and choose the best one given their individual circumstances, CMS established an online Medicare Prescription Drug Plan Finder tool. This resource and others, were used by the SHIPs to assist beneficiaries in making their enrollment decisions.

Inadequate data systems – missing, erroneous or outdated information - create enrollment problems for beneficiaries. The SHIP meeting participants were unanimous in expressing their concerns about the adequacy of the data systems necessary for the Medicare Part D benefit to operate as intended. The information systems of CMS, SSA, individual state Medicaid programs, Medicare PDP and MA-PD sponsors, and participating pharmacies must all be able to communicate information in a timely manner in order to identify the plan a beneficiary is enrolled in; determine the premium and cost-sharing required by the plan; and establish whether the enrollee qualifies for additional low-income subsidies (LIS).

"The systems are not talking to each other fast enough."

All of the meeting participants reported that they had experienced significant case work related to problems resulting from data system errors or inadequacies. Many of the directors reported that data system errors – missing or erroneous information – resulted in beneficiaries who should have been, but were not enrolled in a Medicare drug plan, or enrolled in the wrong plan, or enrolled in more than one plan, or mistakenly disenrolled from a plan.

An added complication is that the various players in the system update their enrollment data on differing schedules. This often results in problems with having current, accurate enrollment information, in order to provide benefits, especially for individuals who change plans. Errors were especially common for individuals who elected to disenroll from one plan and enroll in another under circumstances allowed by law. *"The fact it's a month cycle instead of a more tighter cycle is adding to the problem. Because by the time you find out what the problem is they've already gone weeks and weeks without their coverage."*

"People are trying to enroll late; they didn't understand."

Enrollment problems are emerging for those first becoming eligible for Medicare. Another enrollment problem identified in the meeting involves the disconnect between Medicare and Social Security eligibility.[4] Evidently some individuals are not being notified of their Medicare eligibility or are not paying attention to it until their Social Security eligibility is effective. Therefore, they may miss their initial Medicare open enrollment period and be subject to late enrollment penalties.

[4] Medicare eligibility generally begins at age 65 whereas Social Security eligibility is now being phased up to age 67, so that it begins in months after age 65 depending on the year.

Many directors expressed concern about the forthcoming enrollment period for 2007. Several SHIP directors said it was impractical to conduct an open enrollment period over the holidays, and in a 6-week period. One director thought it would be helpful to coordinate the enrollment period with the Part B enrollment period.

> ***"It's cruel to make it November 15-December 31st. It's cruel for clients and counselors. It's not enough time with the holidays."***

Some directors worry that beneficiaries will not revisit plan decisions as the new enrollment period approaches and instead will take the path of least resistance – even if the plan they selected for 2006 is not ideal for their individual circumstances. Enrollment decisions are not one-time only. Beneficiaries are generally locked into their plan choice for a year, with an open enrollment opportunity occurring each fall during which time they may switch plans.[5] Meeting participants worry that many beneficiaries assume they only have to make a decision once (in their lifetime) about their Part D participation. Several directors expressed some concern that beneficiaries may not understand the importance of making plan comparisons again if they want to make sure they are enrolled in the plan that best suits their needs in terms of cost, benefits, and service.

Premium Payments

Medicare beneficiaries have two options for paying Part D plan premiums: they may elect to have their premiums deducted from Social Security checks or they can choose to pay the plan directly. Initially, many SHIP directors advised their clients to have premiums deducted from their Social Security checks both because it conforms to the way in which Medicare Part B premiums are paid, and because it was thought to be more convenient for beneficiaries. However, the deduction of Medicare Part D premiums is more complicated than it is for Part B premiums because Part D premium amounts vary according to the plan chosen and the subsidies available, whereas the Part B premium is uniform for virtually all beneficiaries.[6]

Beneficiaries who elected to have their Part D plan premiums deducted from their Social Security check are encountering problems that are difficult to resolve. Several participants described situations where enrollee premiums were either not correctly deducted from Social Security checks and paid to the plans, or were deducted from the checks but not sent to the plans, remaining *"out there somewhere* " in limbo. One director reported that some of their clients were concerned that Social Security would deduct from a future check several months of unpaid Part D premiums in a large lump sum – making it difficult for those living on modest incomes to manage.

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[5] Enrollees are allowed to switch plans outside the annual open enrollment period under certain circumstances.
[6] There are a few instances where the part B premium for an individual beneficiary will differ from the standard amount.

Other participants reported clients having the wrong premium amount deducted from their checks because Social Security had erroneous information about the plan in which they were enrolled. In some cases this was due to the fact that the individual had changed plans and updates to SSA data files reportedly lag up to 90 days. Such problems with premium payments may have serious implications for beneficiaries.

> ***"Even though Social Security is withholding the premium from the person's check, the plan is not getting the premium, so the plan is billing the person for the premium that they had withheld from the check or sending them to a collection agency."***

Several SHIP directors indicated that problems related to premium payments were relatively difficult to resolve because they often involved several parties, including SSA, CMS, and the plans.

Some SHIP directors say they now counsel enrollees against having their premiums deducted from their Social Security checks because of all of the problems they have encountered this year. Directors noted that while people generally prefer to have premiums deducted from their Social Security checks for convenience, they have encountered so many problems that some SHIPs are now changing course and suggesting enrollees pay the plans directly. Even CMS, they say, is suggesting the SHIPs tell clients to wait a year before they encourage people to have their premiums deducted.

> ***"The whole premium payment system is a problem."***

Cost Sharing for Drugs

In practice, pharmacies need to know, in real time, which Part D plan their customers are enrolled in, whether the plans cover their customers' prescriptions, and the appropriate amount to charge customers for each of their prescriptions. This is not quite so straight-forward in that plans vary considerably in terms of the amount they charge for covered drugs, and whether drugs are covered at all. In addition, pharmacies need to know, again in real time, whether individuals qualify for low-income assistance, and which level of assistance, in order to be sure they do not overcharge customers the cost-sharing for their prescriptions. For example, dual eligibles in Medicare drug plans have copayments of no more than $5 for a covered brand-name drug, rather than higher copayments that other enrollees would be required to pay.

As a result, pharmacies are dependent on the availability and accuracy of on-line data systems to determine how much to charge an enrollee at the time of purchase.

Some enrollees continue to be overcharged for copayments. Meeting participants reported client problems with being overcharged, especially in the case

> ***"A lot of times people don't know they are being charged too much… a lot of them don't know they should be charged less."***

of those eligible for the low-income cost-sharing subsidies. In many of these cases, patients either left the pharmacy without their prescription because they could not afford it, or somehow found a way to pay the erroneous amount charged by the pharmacist. In some cases, beneficiaries were overcharged because the data systems did not have current enrollment data listed. In these instances, beneficiaries went to the pharmacy thinking they were covered by the plan, but were charged the full retail price as though they were not enrolled in a plan.

Some directors wondered if they would ever be able to figure out if their clients were reimbursed by their plan once the data systems used by the pharmacist were corrected.

Problems related to the "doughnut hole"[7] are beginning to emerge. Some of the SHIP directors reported that their agencies are now beginning to get calls from beneficiaries seeking assistance with cost sharing because they had reached the doughnut hole, or gap in coverage, and now face paying the full cost for their prescriptions until they reach their annual out-of-pocket limit. They reported that some Part D enrollees are unaware of the benefit structure in their plan, including what costs count toward reaching the limit for the doughnut hole, and then for the annual out-of-pocket maximum.

> ***"I'm beginning to hear people grumble because they're hitting the doughnut hole."***

Variations in the explanation of benefit forms issued by Part D plans contribute to confusion about the doughnut hole. Understanding claims information is important for beneficiaries so that they know what they have spent on medications and where they are in terms of reaching their annual benefit limits (e.g., deductible, initial benefit limit, annual catastrophic limit). Some of the directors expressed frustration with CMS' decision to waive the requirement that beneficiaries receive a monthly explanation of benefits. The fact that plans use different explanation of benefit forms makes it more difficult for counselors to explain to beneficiaries where they are in their benefit period.

Access to Drugs

Medicare Part D plans, including PDPs and MA-PDs, may not only define their own benefit structure, but may also incorporate various cost-management techniques that affect access to drugs. Such techniques include establishing pharmacy networks, limiting coverage to drugs on the plan formulary, and imposing additional requirements, such as prior authorization, before prescriptions may be filled. The law

[7] The standard drug benefit defined in the law provides up front coverage as well as catastrophic coverage for individuals, but leaves a gap in coverage, called the "doughnut hole." Although plans are allowed to offer coverage that is different, many plans' benefit structures have such a gap.

requires that plans employ cost management techniques and that they be approved by CMS. The law also requires plan sponsors to have a system for hearing grievances and appeals from enrollees who have difficulty obtaining the drugs that have been prescribed for them.

SHIPs have not had to deal with issues related to grievances and appeals. Meeting participants had limited experience counseling individuals who had difficulty obtaining their prescriptions due to plan formularies and drug management policies. None reported any experience with formal grievance and appeals procedures, possibly because beneficiaries have not been enrolled in Part D plans for very long. *"I'm remarkably surprised at the lack of problems that have been reported to the SHIP in [my state].*

"It's much quieter than I thought. I really thought the exceptions and appeals and complaints would just be …more intense right after June 1 and it really hasn't been."

Most states represented at the meeting said they are dealing with issues related to prior authorization requirements. The directors seemed somewhat surprised that the plans were imposing prior authorization not just for the drugs themselves, but also for dose levels and quantity limits. There was some concern that plans are using different forms and requirements. And, several directors have encountered problems with physicians who seem to be resisting helping their patients with prior authorization.

"They'll give prior authorization; it's only good for a month, and the plan says, 'now we want another prior authorization for the next fill, and the doctor says, 'uh-uh, I'm not doing any more. I've done enough'. Doctors say, 'I don't have time for this' and they're not doing it. 'I'm not going to fill out any more of this'."

Some physicians, according to the directors, are even requiring patients to make another appointment for a billable visit before they will submit the prior authorization paperwork required by a patient's plan for certain prescriptions to be filled.

Some directors also say that they have encountered a few plans that require beneficiaries to get prior authorization each month before refilling certain prescriptions – imposing what they viewed as an excessive burden on beneficiaries and their doctors.

Since each plan has its own prior authorization requirements, procedures, and forms, it is difficult for SHIP personnel to assist individuals without investing significant time trying to resolve each individual circumstance. One SHIP director expressed a concern that some plans were imposing complicated prior authorization requirements as a means to encourage sicker enrollees to move to other plans. *"My sense is that they're doing this for the patients who are the most frequent users of medications. It's their way of saying to these people, 'we don't want you in this program' and those people are going to change in November."*

"Meanwhile, they're not getting the prior [authorization] to get the meds they need. It's beginning to become in my state, a trend."

Medicare Advantage

Medicare beneficiaries have had the option to obtain benefits through managed care plans since the 1970s. In more recent years, lawmakers have sought to expand the role of private plans, giving beneficiaries access to prescription drug coverage through private plans and access to all Medicare benefits through private HMOs, regional PPOs, and private fee-for-service plans, known as Medicare Advantage plans.

When beneficiaries enroll in MA plans, they agree to obtain their Medicare benefits according to plan rules. Thus, they may be subject to different cost-sharing requirements than in original Medicare, or may be required to use only network providers to qualify for coverage. In addition, MA plans may provide extra benefits not covered by Medicare and may or may not require payment of an additional premium on top of the Part B premium.

"The whole thing with Medicare Advantage plans…People aren't familiar with them. People would be thinking they were getting a stand alone drug plan and partly, I think, sometimes it's just what they want to hear…it's not that the agent didn't necessarily tell them but…zero premium gives you drug coverage and that's what they hear…So these folks were signing up thinking they were getting a stand alone plan and now we're getting all kinds of cases where people are saying "I went to my doctor and they say I don't have Medicare." And they don't realize they were switching to Medicare Advantage, they thought they were getting a stand alone."

Medicare beneficiaries do not understand what it means to be in a Medicare Advantage plan. SHIP directors from several states reported problems with individuals enrolling in MA plans and not understanding the implications. Some Medicare beneficiaries do not understand that plan sponsors may offer several different plans, some PDPs and some MA-PDs. Some enroll in an MA plan without understanding the difference between using network vs. non-network providers. As one SHIP director said, *"A lot of beneficiaries don't know what they have."*

Some of the directors expressed concern that Medicare Advantage plans were aggressively trying to enroll dual eligibles who did not understand the implications of choosing an MA plan instead of fee-for-service Medicare.

Another SHIP director expressed concern with a plan that was encouraging residents of senior citizen homes to sign up for a certain plan en masse.

Plan Marketing

The law requires that CMS approve and monitor Part D plan marketing activities. In addition, some marketing regulation, such as the regulation of insurance agent activities, is within the purview of the states.

Marketing problems exist, especially with some Medicare Advantage plans. At least half of the meeting participants reported client problems due to plan marketing, especially with regards to Medicare Advantage (MA) plans. They described cases where beneficiaries found themselves enrolled in a MA plan when they thought they had enrolled in a PDP to obtain drug coverage only. These problems tended to be associated with certain specific plan sponsors within the state rather than an issue with MA plans in general. The problematic plans tended to be new to the Medicare marketplace and were being marketed aggressively.

Agents for these plans reportedly are providing beneficiaries with erroneous information, either unintentionally because the agents are poorly trained and unfamiliar with Medicare rules, or deliberately. In addition, evidently some plan sponsors offer much greater sales commissions to agents for enrolling beneficiaries in certain plans, such as enrolling beneficiaries in one of their MA plans, instead of one of their PDPs, thus encouraging agents to pressure beneficiaries to enroll in certain plans that may not be in their best interests.

As one SHIP director said, *"The private fee-for-service and the PPO are brand new plans…There's been a lot of misinformation going out, whether people are listening wrong or agents are lying or misrepresenting their product, it's been a pretty big issue…I think it's because in most of our rural areas there's only been one provider…and so people haven't had these products."*

> ***"They're brand new and they're aggressively marketing them and doctors don't understand and the people don't understand them."***

The marketing of Medicare drug plans is providing an opportunity for other insurance products to be marketed at the same time. In at least some states, sales agents have been marketing other insurance products, such as annuities and long-term care insurance, along with MA and PDP plans. A potential for abuse exists because some beneficiaries believe all of these products are somehow government sanctioned due to the association with Medicare and thus have purchased products they may not have otherwise purchased.

Challenges for Special Populations

Individuals Dually Eligible for Medicare and Medicaid ("Dual Eligibles")

As of January 1, 2006, individuals dually eligible for Medicare and Medicaid (known as "dual eligibles") were required to obtain their drug coverage from a Medicare drug plan instead of their state Medicaid program. To facilitate the transition, CMS randomly assigned each dual eligible individual to a Part D plan. The law allows dual eligible individuals to change their plan enrollment at any time during the year. Dual eligible individuals pay no premium if they enroll in a plan with a premium that is at or below the area average, and pay nominal copayments of up to $5/month for covered drugs.

The transition from Medicaid to Medicare drug coverage was rocky for many dual eligible individuals. SHIP directors identified a number of issues related to the dual eligible population. As discussed above, there were numerous problems related to plan enrollment, especially for those dual eligibles who opted to change plans. Some dual eligible individuals were being overcharged at the pharmacy, usually because of data system errors. In other cases, dual eligibles were incorrectly being charged premiums.

Medicaid beneficiaries who are newly eligible for Medicare pose a challenge. Medicaid beneficiaries who become eligible for Medicare after the initial implementation of Part D will not be automatically assigned to a drug plan by CMS. The meeting participants expressed concern that individuals in these circumstances may not understand that their drug coverage is switching to Medicare and that they need to enroll in a Medicare drug plan. In the meantime, their Medicaid drug coverage may be terminated and they may find themselves with a gap in coverage.

Individuals Eligible for Low-Income Subsidies (LIS)

As indicated above, certain low-income Medicare beneficiaries who do not qualify for Medicaid may qualify for additional Part D subsidies to reduce their out-of-pocket costs for premiums and cost-sharing. To qualify, individuals must submit an application to SSA or their state Medicaid office and meet certain income and asset requirements.

"It goes to the distrust issue…that when they're encouraged to apply and then it doesn't work out, well it's just another ... blow."

Many beneficiaries with low incomes do not qualify for LIS assistance because they have assets just above the threshold set in law. While the SHIPs do not themselves qualify individuals for low-income subsidies, they do screen individuals and refer them to the SSA or their state Medicaid office if it appears they might qualify. Concern was expressed by the directors, however, regarding the low number of referred beneficiaries who ended up qualifying for the subsidies.

One director reported that only 25% to 30% of individuals they referred ultimately qualified for the subsidies. The primary reason for the low rate of qualifications among the referrals is due to the failure to meet the asset test. According to another participant, rejected beneficiaries feel as if the government has reneged on a promise.

Retirees

The law allows retirees with employer-sponsored benefits to retain drug coverage under their employer plan without incurring a penalty for late enrollment – as long as the employer's plan is at least equivalent to the standard Part D benefit (known as "creditable coverage"). Employers providing this benefit are eligible to receive a subsidy from the federal government to offset the cost of providing prescription drug coverage to Medicare-eligible individuals. The arrangement is voluntary for both employer plan sponsors and for enrollees. Employers are required to inform their enrollees of the value of the coverage they offer and whether it meets Medicare creditable coverage requirements.

A number of problems surfaced for beneficiaries with retiree plans – particularly those with spouses. A major problem occurs when a couple has retiree coverage, and one individual becomes eligible for Medicaid.

"The husband is in the nursing home on Medicaid. The wife is still living in the community, and they have employer coverage from when he was working, and because he is in nursing home with Medicaid he is auto-enrolled in a Part D plan, and the employer plan finds out that he's in a Part D plan, and they notify Mom and she loses her [retiree] supplemental plan."

Directors noted that CMS and employers have tried to address this issue for spouses of nursing home residents. However, the problem persists.

Many directors observed that employers who offer retiree health benefits seem to have maintained drug coverage for 2006, while cutting back on benefits and positioning themselves for changes down the road. While many employer plans are providing the equivalent of Part D coverage, some are neither accepting Part D subsidies for their retirees nor having them enroll in a Part D plan. Presumably, they are providing creditable coverage and are simply taking more time to understand the implications of Part D before changing their plans and affecting their retirees. In other cases, participants indicated it was evident some employer sponsors were offering less attractive coverage in order to encourage their retirees to leave the retiree plan and enroll instead in a Part D plan.

Nursing Home Residents

The Medicare law requires that all PDPs and MA-PDs have the capability of serving the nursing home resident population, and must include long-term care pharmacies in

their networks. Nursing home residents with physical and cognitive limitations are especially challenged by the complexity of Medicare Part D.

SHIPs generally do not counsel nursing home residents. Many nursing home residents are physically and cognitively disabled and not able to seek counseling on their own behalf. For the most part the participants noted that their SHIPs did not have much interaction with beneficiaries residing in nursing homes. They noted that nursing home patients have a separate pharmacy system and a network of patient advocates that focus solely on the nursing home population.

SHIP EXPERIENCES

Experiences differ. All of the SHIPs involved in this meeting engaged in extensive beneficiary education efforts during the last year. They reported different experiences as the end of the open enrollment period on May 15, 2006, approached. Some experienced tremendous volume and had queues of individuals who called in and were unable to get assistance before the enrollment deadline. For these individuals, CMS allowed an additional three days for them to enroll in a plan without penalty. At least one SHIP director attributed the last minute influx of calls to the fact that they had encouraged people who did not need drug coverage to wait until the end of the initial enrollment period to make their enrollment decisions. On the other hand, other SHIPs reported that they were expecting a lot of volume as the deadline approached but that, in fact, it did not materialize.

Community partnerships are important. SHIP education, outreach, and enrollment efforts were typically conducted with other community partners, which came from all levels of government (federal, state, and local) as well as non-profit organizations and for-profit stakeholders such as pharmacies and pharmaceutical companies. One participant described a statewide effort involving 700 community partners that met twice a month to coordinate education activities. The group continues to meet once a month in an effort to remain coordinated and prepare for the upcoming 2007 open season.

Relationships with CMS regional offices are strong. The meeting participants all indicated that they had very good working relationships with the CMS regional offices. They did express some concern about decisions and directives from the CMS national office, but felt the regional office staffs were committed to doing all they could to facilitate Part D implementation.

SHIPs used a variety of strategies to handle their caseloads more efficiently. One SHIP was able to relieve pressure on individual phone or face-to-face counseling by sponsoring a series of education and enrollment events throughout the state during the open enrollment period and referring call-in clients to an event in their community in lieu of trying to serve all clients one-on-one.

Another SHIP reported that call volumes would spike whenever the new Medicare Part D benefit was in the media. The SHIP had no advance knowledge that the story was being run and therefore was not prepared for the increased volume. The SHIP director suggested that SHIPs try to establish relationships with the media in their communities so that they know when stories are going to run and thus can staff appropriately to meet the increased demand for counseling.

Most meeting participants indicated that they had good working relationships with the plan sponsors and that the sponsors were committed to assisting in problem resolution. One SHIP director described a very successful system where the SHIP established a liaison with someone in each plan sponsor's government relations department. Government relations people (i.e., lobbyists) were responsive to addressing issues in a timely manner and as a result, the system resulted in a very high problem resolution rate.

SUGGESTIONS FOR IMPROVEMENT

The SHIP directors were asked to suggest changes for the program that might address some of the problems or make the program operate better. Most of the suggestions they offered had to do with simplifying the program so that beneficiaries, as well as others involved, were less confused and better able to compare plans to make enrollment decisions. Specifically the suggestions included:

- **Simplify and standardize Part D in order to help beneficiaries (and those who assist them) navigate the drug program with greater ease.** There was widespread agreement that the system was excessively complicated for their clients, with too many plans, and unnecessary variation across the plans in terms of premiums, benefits, covered drugs, rules, forms, and procedures. Many had the view that the complexity was not in the best interest of their clients.

> ***"Simplify, simplify, simplify, standardize, limit the choices, standardize the plans and the benefits so people can compare apples to apples and not apples to beefsteak."***

One director expressed some concern that the Medicare private insurance marketplace would become excessively complex as it was before Congress created standards to simplify the Medicare supplemental insurance market, known as Medigap. *"It is to the marketplace's advantage to have complexity. Medigap is a primary example. In the beginning of Medigap, it was chaos. If you get the chaos out, all of a sudden the picture gets clearer. "*

> ***"Try to power through from the beneficiary perspective, not from the perspective from the drug companies or other entities that are benefiting from this financially."***

- **Change the open enrollment season to another time during the year – potentially so that it coincides with the Part B enrollment season.** The current enrollment period of November 15 through December 31 for coverage effective the following year is too short and conflicts with other distractions of the holiday season for beneficiaries and the SHIP counselors who work with them.

- **Improve the data systems of all of the major participants in the system (SSA, CMS, state agencies, plans, pharmacies) so that they operate on a more real-time basis, and are more accurate.**

- **Implement more stringent regulation of plan marketing practices.** Beneficiaries need to know and understand the plans in which they enroll but should not be pressed into purchasing other insurance products under the auspices of "Medicare" that may be of limited value for them.

- **Liberalize the asset requirements to qualify for the low-income subsidies.**

- **Adopt rules for employer-sponsored retiree plans so that spouses do not lose coverage when the covered worker is institutionalized and eligible for more comprehensive Medicaid benefits.**

- **Provide more stable funding for the SHIPs.** Because of the critical role the SHIPs play in educating and counseling Medicare beneficiaries regarding the complexities of the program, SHIP agencies require more secure and predictable funding. SHIPs must go through an annual grant application process and cannot rely on a stable base funding amount. Additional funding that is provided is often done on a targeted basis, directing the funds towards a specific activity. This system makes it difficult for the SHIPs to plan and maintain staffing levels from one year to the next. In at least one state, the SHIP receives additional funds from a per enrollee assessment on insurers.

CONCLUSION

The SHIP directors that participated in this facilitated discussion feel as though they have weathered the storm. Some worry about future issues that will undoubtedly emerge, but there is a general sense of relief now that May 15 has passed. Most of their current work is related to resolving problems that have emerged in the first year of the new Medicare drug benefit. However, directors report that they are again receiving casework about Medicare issues not related to Part D.

Given the limited number of meeting participants and the time allowed for discussion, this report presents only a subset of the issues that SHIPs may have had to deal with during the implementation of the Part D program. Some of the issues are not

surprising given the complexity of the new program. For example, no directors were surprised that beneficiaries were confused and sought counseling to help them understand their options and find a plan best suited for their needs. Other problems discussed here, however, were not anticipated, such as the extent to which beneficiaries have had problems with their premium payments being deducted from their Social Security checks, or some of the issues that stem from the interaction of retiree plan drug coverage with Medicare Part D. On the other hand, some problems that were anticipated have yet to materialize, such as the challenges involved in assisting individuals with grievance and appeals procedures.

Although the initial open enrollment period is over, challenges remain and the SHIPs are likely to remain very busy. They are now preparing for the open enrollment period that begins November 15 of this year. Medicare beneficiaries will face a myriad of changes in Part D: plans may change their benefit structures and premium costs, new plans may enter the market, and some plans may elect to leave. Beneficiaries who did not enroll before May 15th will have another opportunity to pick a plan that meets their needs, albeit they will now face a premium penalty.

The SHIP directors who participated in this discussion were relieved to be beyond the initial implementation stages. However, they remain mindful of the recurring problems faced by some of their clients, and expressed the need to simplify the Medicare drug program in order to minimize the recurrence of such problems in the future.

> ***"The finish line hasn't been crossed yet – we're only six months in."***

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