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STATE AND CONSUMERS AFFAIRS AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

Meeting Summary

Subcommittee on Medicare Drug Benefit Plans
April 4, 2006
1-3:30 p.m.

Department of Consumer Affairs
First Floor Public Hearing Room
1626 N. Market Boulevard
Sacramento, California

Present: Stanley Goldenberg, Board President
Bill Powers, Board Vice President
Andrea Zinder, Board Member
John Jones, Board Member

Patricia Harris, Executive Officer
Virginia Herold, Assistant Executive Officer

Vice President Powers called the meeting to order at 1:05 p.m.

He explained that the purpose of the meeting was to discuss the implementation of the Medication Prescription Drug Act, and specifically the Part D Benefit. These changes, began 1, 2006, and represent an enormous change in the Medicare benefit program.

Bonnie Burns of California Health Advocates began the presentations. Ms. Burns stated that initiating the program by placing the dual eligibles into the system first swamped the system. She expressed concern that other individuals who will enter the program over the coming months may experience similar difficulties. She said that 10,000 MediCal enrollees become eligible for Medicare each month. Some may end up without coverage or delays in coverage.

She noted that the 90-day transition period that provided drugs without respect to a plan's coverage expired on April 1, and problems that will occur from this have not yet manifested themselves.

Other problems noted by Ms. Burns are:

- Plans are required to send benefit summary notices to patients – regarding how much money has been paid through their drug benefit, but the notices cannot be read.
- Dual eligibles are being charged costs for medications higher than they should be.
- Generally dual eligibles lost under the Part D, they are now paying more for their drugs than before.
- Some firms are selling Advantage Plans without prescription drug benefits, and then selling a second policy for prescription drugs at higher premiums than a consolidated policy would be.

Ms. Burns stated that there are 19 sponsors of prescription drugs plans, three of which are PBMs and are not licensed anywhere (they have been issued a waiver by CMS). She expressed concern about how these entities would be regulated.

She suggested that CMS should be encouraged to use its regulatory authority to protect beneficiaries, and enforce plan provisions.

Margaret Riley, HICAP, stated that pharmacists are caught in the middle between getting patients their drugs and the health benefit companies who provide the drug benefits. In the next few weeks, many patients will need new prescriptions because the transition period is over and the drugs they have been taking may not be covered. She stated that patient advocates are attempting to aid large numbers of confused patients in selecting plans and resolving medication copay problems or eligibility problems, but cannot obtain resolution fast enough for patients because they are dealing with medication issues.

Patient Tracy Patterson described the problems she is experiencing as a dual eligible. She stated she is taking 20 drugs and her copayments are significant in relation to her monthly income. She is uncertain how she will be able to continue to obtain her medication.

There where three representatives from CMS who provided information about the implementation of the program -- Lucy Saldana, PharmD, Beverly Binkier and MaryAnn Grandlich.

Dr. Saldana stated that as of March 23, 27million Medicare beneficiaries are now enrolled in the program nationwide. There are 3 million Californians enrolled in Part D. She stated that initially, there were data problems that greatly hampered the system, and very long waits on the telephone for those who attempted to resolve problems. CMS is now continuing to monitor the wait times for those who are calling the health plans, and there is a manager in charge of monitoring each health plan.

CMS expects prescription drug plans to provide a 30 day supply of medication to patients during a transition to a new plan, and to inform the enrollee that this is a temporary supply, while the physician and plan verify coverage.

She provided an overview of the exceptions process: a coverage determination is made that determines whether an individual gets prescription drugs or not. If a negative determination is made because the medication is not on the formulary or tier, the patient will not get the drug under the program. The enrollee's physician can request an exception. The exception form is available on the prescription drug plan's Web site. There is an expedited exception request (where the answer would be provided within 24 hours) or a standard exception request (where the answer would be provided within 72 hours).

If the exception is denied, the plan must advise the patient in writing. The enrollee has 60 days to request a redetermination.

If the redetermination is denied, an appeal can be made to Maximus. Maximus uses an administrative law judge process in federal courts. CMS asks plans to provide drug coverage during an appeal. CMS is monitoring the appeals process.

Patients who have overpaid should request refunds from the plans first. If there is no resolution, contact CMS.

Sue Olson with the federal Social Security Administration, provided information about a special low income program that is available to Medicare individuals to aid them in obtaining medications. She stated that people with incomes and assets generally too high to qualify for many programs may qualify for this program. As of 3/31/06, SSA has received 262,776 applications, of which 205,889 have been processed and 79,932 individuals (39 percent) have qualified for the program

Ms. Olson suggested that pharmacists whose patients state that they cannot afford their drugs or copayments to refer these patients to their local Social Security Administration office to see if these patients could qualify for the special federal program. This program is for all patients, not just those over 65 years of age.

Pharmacists Gary Thomassen and Ed Solomon stated concerns of pharmacies serving long-care nursing homes regarding medications prescribed for patients that may or may not be covered. These pharmacies have to absorb a copayment for these patients, yet there should be no copayment at all. There are also eligibility problems for these patients. A major problem is that the health plans do not aggressively work to resolve patient problems timely, nor to pay pharmacies for the medication they dispense quickly. Additionally physicians must initiate the exception process, and it is difficult for pharmacies attempting to get drugs to nursing home patients to secure the intervention of physicians fast enough. They expressed an interest in seeking the ability of pharmacists to become involved in pursuing exceptions on behalf of patients.

Board members Goldenberg and Powers expressed their concern for patients that are being denied medication, and resolutions are not coming fast enough.

President Goldenberg and Vice President Powers thanked those who attended the meeting, and indicated their gratitude to all individuals who are working very hard to make this program successful for patients.

The meeting was adjourned at 3:30 p.m.