Testimony

Testimony of Robert M. Hayes
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United States House of Representatives Committee on Ways and Means

Implementation of Medicare Part D Prescription Drug Benefit
June 14, 2006

The Medicare Rights Center appreciates the opportunity to submit testimony to the first oversight hearing on the Medicare Part D prescription drug benefit held by the full Committee on Ways and Means. This hearing is long overdue.

Staff and volunteers at the Medicare Rights Center have spent the last six months fighting to get people the medicines they need under the Part D benefit. If you look at the roll out of Part D without a political or ideological agenda, you will see that many people have been hurt by the structure of this benefit and by the implementation of the benefit by the Administration and its insurance company collaborators. You will also see that countless people are paying lower costs for medicines that they need. We, and many others around the country, have worked and continue to work to ensure that the poorest Americans receive the financial help that is their right under Part D. Sometimes we were able to help; too often we were not. We work in the trenches day in and day out helping people with Medicare who face problems with the system. There have been too many problems with the Part D program to list, but we have learned valuable lessons during these first months of the Part D benefit and it is those lessons that we will share with the Committee.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent, relying on a small staff and hundreds of deeply committed volunteers to carry out our mission. We are not supported by the pharmaceutical industry, insurance companies or any other special interest group. Our non-partisan mission is to serve the 43 million men and women with Medicare.

Through national and state telephone hotlines, casework and professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. Each year, the Medicare Rights Center receives over 80,000 calls for assistance from people with Medicare. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1-800-MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). Indeed, for a number of years 1-800-MEDICARE has been the largest source of referrals to our hotline; MRC receives no CMS support for its consumer hotline.

MRC also brings to professional counselors, care givers and consumers across the country *Medicare Interactive*, a web-based counseling tool—developed with major foundation support and with a seed technology grant from the United States Department of Commerce. *Medicare Interactive* assists people with Medicare access benefits, including Part D.

We reach out into low income, minority communities and, in recent months, have concentrated our services on enrolling people with Medicare in low income programs – the Part D Extra Help Program and Medicare Savings Programs, especially QI-1.

We have launched a Part D appeals program, recruiting a battery of volunteer lawyers and physicians to assist people with Medicare to obtain medications denied by their Part D plans. Drug plans place the Medicare Rights Center's toll free phone number on notices informing their enrollees that the Part D plan is denying coverage of a prescribed medication. Since we receive no

federal or state financial support to assist people with these Part D appeals, we can only make a dent in the great need for this assistance. The Committee should know that without competent, independent representation, the Part D appeals and exceptions process is, for most people with Medicare, a sham.

The eight policy recommendations we make are the fruit of lessons learned helping people with Medicare navigate this new drug benefit. We have no political or commercial interest that interferes with our intent to propose sensible, non-ideological public policies that serve the interest of people with Medicare.

Evaluating Part D

I have been using Aciphex since 2000 for acid reflux. It worked fine but was not on the Medco formulary. I filed an exception, with a statement from my doctor that I had tried all medicines on the formulary and none had helped me as much as Aciphex. Medco made it a Tier 3, non-preferred drug. I still have to pay 75 percent of the cost, $284.50 for a three-month supply.

Under my former plan with the State of Virginia, I only paid $32 for a three-month supply. That plan stopped covering drugs once Part D started. I appealed to have it made a preferred drug but it was denied, so I have to pay $1,138 for the medicine I was paying $128 for last year. My breast cancer has since returned in my lungs and I have to take chemo, which is hard on my digestive system. I am going to try to appeal again.

Alice
Mechanicsville, Virginia
Story submitted to Part D Monitoring Project

Some members of this Committee and spokesmen for the Administration claim that the figures released last week—over 38 million people with Medicare now have drug coverage, the administration says—are proof that the Part D program is a success. Enrollment figures, especially enrollment figures designed to inflate the impact of Part D, do not tell the story about this new program.

First, a breakdown of the numbers:

According to the Administration, 9.3 million men and women have drug coverage because they are retired federal employees or military veterans or they get coverage from a current or former employer with no Medicare subsidy. Their drug coverage has nothing to do with the Part D benefit.

Another 6.8 million people have coverage through a former employer that is now subsidized by Medicare, not through a Part D plan.

Roughly 6.3 million people lost Medicaid coverage on December 31 and were automatically enrolled into a Part D plan. Overwhelmingly, the coverage they receive under Part D is worse than they had under Medicaid. There are more restrictions and higher out-of-pocket costs. The fact that New York and California, both states with Republican governors, have maintained Medicaid drug coverage as a safety net for these dual eligibles –people with Medicare and Medicaid—into June speaks volumes about the deficiencies of Part D.

Another 5.3 million people have drug coverage under a Medicare Advantage plan, usually an HMO. They had drug coverage in 2005. Now with more taxpayer money being committed to private plans that are already overpaid, according to the non-partisan Medicare Payment Advisory

Commission (MedPAC), they have somewhat better coverage.

About 11.5 million people with Medicare have drug coverage through a stand alone drug plan. Of these, over 1 million were autoenrolled either by Medicare because they were low income, or by their state pharmaceutical assistance program. That leaves roughly 10 million people who voluntarily signed up for the Part D benefit. Does that mean Part D is a well designed program that provides the same health security that people have come to expect from Original Medicare? We think the American people deserve better.

Prescription drug coverage is a crucial component of modern health care coverage. With manufacturers threatening to cut off charitable assistance programs and the Food and Drug Administration ramping up seizures of Canadian medicines, of course people signed up. Part D is just about the only game in town. Congress made sure of that when it decided to give people a bewildering array of plan choices but deny them the one choice they really want --- the option of receiving drug coverage directly through Medicare with low prices negotiated by Medicare.

What have people with Medicare experienced under the Part D benefit? Here is a small sampling of the problems our hotline counselors have faced since May 15, when enrollment was closed and much of the press attention shifted away.

- Formulary restrictions imposed by plans like prior authorization, step therapy and quantity limits continue to impair access to vital drugs.
- Complicated and varied appeals procedures make it nearly impossible for consumers to navigate the process alone.
- Consumer confusion continues to plague critical aspects of the program like eligibility for special enrollment periods, calculation of the doughnut hole and coverage of drugs by Part D versus Part B.
- People continue to learn of limitations in their coverage that were not disclosed by the plans or the agents that enrolled them.
- Problems with coordination of Medicare Part D drug coverage with other benefits like State assistance programs, Medicaid or retiree insurance result in higher than appropriate out-of-pocket costs.
- Many dual eligibles report that Extra Help co-pays are an excessive financial burden.
- Extra Help program is vastly under-enrolled.
- Lack of Medicare coverage of benzodiazepines continues to risk stability of people with certain mental illnesses.
- Financial burden of the doughnut hole results in people having their treatment interrupted and losing access to critical medicines.
- People who have switched drug plans are not having their accrued drug costs forwarded to their new plan.
- Plans are unaware that individuals who are determined eligible for Extra Help may continue to enroll in drug program.
- Individuals who have switched drug plans are charged premiums for both their old and new plan.
- Mail order pharmacy programs are sending participants the wrong prescriptions.
- People with Extra Help continue to be charged inappropriate co-pays.
- Data mismatches between Social Security, the Centers for Medicare & Medicaid Services (CMS), state Medicaid programs and drug plans are still obstructing access to drug coverage.

The negative publicity that surrounded the implementation of Part D reflected the reality of millions of people with Medicare struggling to afford the medicines they need under a program that was not designed with them in mind. Some, including the Chairman of this Committee, have criticized

those who shared the truth about the hundreds of thousands of impoverished Americans whose health and very lives were put at risk by the reckless implementation of Part D earlier this year. Only an honest appraisal of this program can lead to necessary reforms.

Criticism based in reality is not propaganda. Hiding the truth is. Older Americans and people with disabilities can tell the difference. Even the many individuals who experienced no problems with their Part D plan understand: Health insurance—drug coverage—needs to work every time you need it, every time you fall ill. Coverage that works some of the time is not insurance, it is Russian Roulette.

To downplay the very real confusion people with Medicare felt when forced to choose from a dizzying array of plans, each covering different drugs, charging different copayments and subject to change at any time, is about spin, not truth. But these Part D boosters – including some members of this Committee-- demand that older Americans be sheltered from news accounts that describe Part D accurately. Disguising the truth is not the path to getting public policy right.

Some of the initial problems with Part D implementation have now abated, but our hotline is fielding a new round of frantic calls as more and more people reach the doughnut hole, the gap in coverage that is built into Part D. We have yet to find a drug plan that candidly explained this gap in coverage in their advertising. People with Medicare continue to pay premiums but they must also pay full price at the drug store. Estimates suggest that some 7 to 10 million people with Medicare are at risk for reaching the coverage gap. Recent research confirms what many knew intuitively: when people reach a limit on their drug coverage and cannot afford to fill their prescriptions, they stop taking their medicines. As a result, they get sick, and Medicare pays the price when they seek emergency care in a hospital. We have no doubt that many people with Medicare will make that fateful choice when they hit the doughnut hole.

That brings us to our first policy recommendation:

FILL THE DONUT HOLE; MAKE MEDICARE NEGOTIATE LOWER PRICES

I had excellent prescription coverage in a supplemental plan that I received from the railroad industry. I paid $125 a month for it but my prescriptions only cost $20 for generics and $40 for the brand name drug, and that was for a 4-month supply. The plan stopped covering prescription drugs when Part D started. Sixty days after enrolling, I was in the "doughnut hole." This is going to cost me more than my previous plan! It is a farce. Congress no longer does any work for the American people who elected them to office. With Part D (for disaster) they turned the job over to the insurance and pharmaceutical companies. I am appalled at my government for shoving this down our throats.

Lawrence
Lady Lake, Florida
Story submitted to Part D monitoring project

We understand that the doughnut hole resulted from the financial constraints imposed on Congress by the White House when it was debating the Medicare Modernization Act (MMA) in 2003. But the decision to hand the drug benefit over to private insurers rather than have Medicare secure lower prices precluded savings that could have been used to fill the coverage gap. Studies show that if Medicare secured the same prices that the Veterans Administration or other industrialized countries pay, there would be enough money to fill the doughnut hole. We appreciate that there is much debate, some of it informed, about this assertion. Circumstantial proof of Medicare's effectiveness as a negotiator is found in the pharmaceutical industry's virulent opposition to allowing Medicare to negotiate drug prices. If private plans were so successful at

driving down drug prices, don't you think your former colleague, now lobbying for PhRMA, would be here fighting to require that Medicare, and not the plans, negotiate drug prices? Is this Congress prepared to stand up to the pharmaceutical industry for older Americans and people with disabilities? Existing evidence is not encouraging.

We realize that these are far reaching demands and that many in Congress are invested in the privatized structure they created in Part D. However, there are other steps that Congress can and should take to improve and extend drug coverage to people with Medicare.

ELIMINATE THE ASSET TEST FOR THE LOW INCOME SUBSIDY

Violet, a retired resident of Montgomery County, New York, receives $1006.50 each month from Social Security. Although her monthly income falls below the Extra Help income limit of $1225 per month, she is not eligible because she has $13,000 in assets, $1,500 over the income limit. Because she lives in New York, she can qualify for a Medicare Savings Program (MSP), which will pay her Part B premium and automatically enroll her in the Extra Help program. This is possible because New York has eliminated the asset test for the QI-1 program, the MSP program for people with Medicare earning less than 135 percent of the poverty line. Only five other states have eliminated the asset test for any of their MSP programs.

MRC Client

Since the beginning of the debate of the MMA, there has been widespread, bipartisan agreement that the number one priority of a Medicare drug benefit is to assist the poorest Americans in securing the medication their doctors prescribe. The low income subsidy, popularly called the Extra Help Program, offers the promise of a comprehensive and affordable drug benefit – so long as the patient selects a drug plan that works for her.

One of MRC's key priorities over the past six months has been to enroll as many people in that benefit as humanly possible. With funding from the Starr Foundation and Robin Hood Foundation, among others, we have enlisted hundreds of volunteers to reach out to likely candidates for Extra Help, explain the program to them and whenever possible enroll people online. We are probably as sophisticated as anyone in conducting this work. We advertise a toll free phone number through AARP, chain drug stores, senior centers and elsewhere. We have public service announcements and look to work cooperatively with drug plans, which gain enhanced payments when we sign up their enrollees in Extra Help. We work with pharmaceutical companies that supply us with contact information for people with low incomes who have been disqualified from their patient assistance programs because of Part D: they are good prospects for Extra Help eligibility. Still, the results are dismal: it routinely takes 33 calls by MRC volunteers and staff to identify a likely candidate for the Extra Help Program.

The administration now says that there are 3.2 million people who qualify for the Extra Help program but are not enrolled and have failed to sign up for Part D. That number is surely low. But without quibbling over numbers, we should all agree that leaving 3.2 million impoverished older Americans and people with disabilities without drug coverage, in the context of a trillion dollar benefit program, is not a success story. Congress should take immediate steps to remedy this situation. Pinning our hopes only on renewed outreach efforts will not find and enroll this hard-to-reach population.

The first step is to eliminate the asset test for the Part D program. The asset test disqualifies over half of the low income people with Medicare who apply for Extra Help. It penalizes working class Americans who have diligently saved for their retirement.

The asset test also discourages eligible individuals from applying. It makes the application needlessly complicated, for instance, by requiring individuals to calculate the face value of their life insurance policies. The asset test also creates a barrier to automatically enrolling people based on income data already in the possession of the federal government. When Congress decided to means test the Part B premium for higher income people with Medicare, it found a way to do it automatically, based on IRS data. Similar efforts should be made to automatically enroll low-income individuals in the Extra Help program.

REQUIRE MEANINGFUL PART D PLAN COMPARISONS

Reasonable public policy would not require people with Medicare to shoot in the dark to pick a drug plan that would work for them. We have worked hard to help people with Medicare select a drug plan that has a good chance of working for them. Secretary Leavitt, according to published reports, made a similar if less successful effort to assist his parents in selecting a drug plan. Las Vegas-style gambling on one's health care is not what we should be purchasing for our parents, our grandparents and ourselves. But that is what Part D provides.

Many callers to MRC's hotlines are among the more sophisticated of consumers. They did what the President and others told them to do. They found help with the internet, they found a plan that said it covered the drugs they now are taking, they found a plan with premiums and deductibles that seemed affordable, and they signed up.

Now they call us in a panic. They never understood that a "covered drug" could come with a $100 per prescription co-payment. They never thought that a "covered drug" would come with trapdoors – requirements that they try other medications first, or that their doctor would have to agree to become a witness in a legal appeal so they could get the "covered drug." Almost no one now hitting the gap in coverage, the infamous doughnut hole, was told about this by the plans. How many brokers, people earning commissions for each person they enroll, do you think told their customers about the doughnut hole?

If a majority of the members of Congress continues to support this marketplace experiment, two steps could help: one, Congress should authorize a drug benefit integrated into Medicare to serve as a reliable safe harbor, a genuine choice, for people dissatisfied with the private plans; and two, Congress should force a more finite number of plans into meaningful comparisons that will allow, however imperfectly, some consumers to make a less risky selection.

END MARKETING ABUSES

I am a 47-year old woman who has been disabled for 9 years. I had originally been enrolled in HIRSP, Wisconsin's state insurance plan for high risk members, in which I paid $333 a month to cover my health care costs. This plan covered all of my medications, but the payments were starting to put some strain on my limited resources, making me more receptive when a sales representative from a private insurance Part D plan visited my home.

That's when the trouble started. Though I was concerned about whether or not I could switch back to HIRSP, the salesman convinced me that I would have no problem switching back if I didn't like the plan. I asked him if he was sure, and the salesman told me that a client had recently gone back to HIRSP insurance after four months because he wasn't happy with the plan. I had no reason not to believe him – after all, he seemed very knowledgeable about HIRSP and its policies.

After about two months with this new plan, my health was worsening so I decided to return to HIRSP. However, I was told that because I voluntarily left the insurance plan, I had to wait a year before I could sign up again.

My new plan is costing me much more than I had ever paid with my old insurance, even though it doesn't cover all of my prescriptions, and I have had to skip treatments. A HIRSP representative told me that other people had also been told by this insurance plan that they could switch back when they wanted. I feel that I was duped by this plan, and I worry about others who are also in my situation. Now all I can do is endure the wait until next year.

Sue
West Bend, Wisconsin
Story Submitted to Part D Monitoring Project

MRC's experience with frantic callers to our hotline is leading us to the unhappy conclusion that nearly all marketing of Part D plans is misleading, nearly all of it exploitative of the neediest and frailest older Americans. Worst off are people who were contacted by telemarketers, a practice sanctioned by CMS. Caller after caller tell us that they did not know much about the plan they had enrolled in, and that they had been told things that were just not true. Other callers tell us that they did not know that they had signed up for an HMO, not a drug plan, until their doctor presented them with a bill and told them he is out of the HMO's "network." Increasingly, as people fall into the gap in coverage, the infamous "doughnut hole," they are shocked. Why?

The design of this privatized drug program creates a single commercial incentive for the drug plans, the brokers they employ, and the marketing firms they retain. The incentive: market share. Even putting aside purposeful fraud by the unscrupulous, deception is an inevitable by-product of this market created by the MMA and CMS.

Have you reviewed marketing material from the drug plans? Have you heard sales pitches at free breakfast meetings? At senior centers? A plan with a low deductible or a low premium will highlight that feature. People will be sold low deductible plans without understanding the other side: restricted formulary, rigid medication utilization tools, and excessive costs per prescription. How many members of Congress have seen plan marketing materials – TV ads, brochures radio spots – talk about the gap in coverage? Even CMS is part of the problem. Late last year CMS spent untold public dollars running an insert about Part D in *Parade Magazine*. CMS, supposedly explaining the standard drug benefit, neglected to even mention the doughnut hole. Shareholders are protected by the Securities Exchange Commission and securities laws. Aren't older Americans entitled to similar protections from the predatory practices of the insurance industry? Deception comes in many forms: omitting material information from drug plan advertising is one that is epidemic in Part D.

Telemarketing of drug plans must be banned, and all marketing materials must be limited to accurate and comprehensive comparisons of standardized plans.

IMPROVE ACCESS TO MENTAL HEALTH DRUGS

Karen has Medicare and Medicaid and was autoenrolled in the AARP plan offered by United Healthcare. In January, she attempted to fill prescriptions for three antidepressants, Mirtazapine, Wellbutrin and Cymbalta, but United Healthcare would not pay for the prescribed doses. United Healthcare set a quantity limit for each drug at 30 pills per month.

Karen has Severe Refractory Depression and has been prescribed numerous combinations of various drugs over the past eight years. Lower doses of all three drugs had been tried and failed to provide relief. According to both her treating physician and a consulting psychiatrist, this is the only combination that gives her any relief.

Despite this evidence of medical necessity, United Healthcare twice denied coverage of these medicines at the prescribed dosages. Maximus, the independent review entity contracted by CMS, also rejected Karen's appeal. The case is now before an administrative law judge.

MRC Client

Clients continue to flock to MRC seeking help with barriers drug plans are putting in the way of access to antidepressants and antipsychotics, drugs commonly needed by people with mental illnesses. As you know, CMS required plans to cover "all or substantially all" of these medicines, along with drugs in four other critical therapeutic classes. But that requirement is being undermined by other restrictions imposed by plans -- prior authorization, step therapy and quantity limits. Quantity limits, in particular, are billed as "safety edits," but drug plans (seeking, of course, to maximize profits) generally impose them only on the most expensive drugs. Cost, not safety, is motivating the plans.

One important, and relatively inexpensive, class of drugs – benzodiazepines – is excluded by law from Part D coverage. This exclusion threatens the stability of the drug regimens of many people with mental illness. Most state Medicaid programs continue to provide coverage but many people with low incomes do not qualify for Medicaid, and states are under financial pressure to cut back coverage. In Florida, people who qualify for Medicaid through spend down are finding it difficult to maintain access to these medicines.

Congress should end the exclusion of benzodiazepines from the Part D benefit. It should ensure adequate coverage of mental health drugs and should enjoin plans from doing an end run around formulary requirements with utilization management dodges.

STANDARDIZE, STREAMLINE PART D EXCEPTIONS AND APPEALS

Parts A and B of Medicare have worked well because they are based on the concept that individuals will have access to care deemed medically necessary by their treating physician. In theory, drugs under Part D are supposed to follow a comparable concept: while Part D consists of a patchwork of plans with various options and limitations on prescriptions, the MMA also includes exceptions and appeals provisions intended to allow individuals to access medically necessary drugs.

We now know from our first hand experience that the current system fails to deliver on this bedrock concept – access to medications that are medically necessary. Over the last several months MRC has helped hundreds of men and women take on the Part D appeals system. Most of our appellate clients had been denied access to medically necessary medications, and almost all were stymied by the Part D appeals process. Here are ways to improve this flawed, consumer hostile system:

- standardize the appeals process and forms;
- streamline the appeals process; and
- provide resources for independent consumer organizations to provide representation to people denied medically necessary medicine.

The Part D appeals process is impossible for the average consumer to navigate. Following near universal criticism, the recent move to standardize the coverage determination request form is a welcome, but very small start. Use of these forms by plans is voluntary, and they are only the first step in a multi-step appeals process. Steps must be taken to standardize the rest of the appeals process. There should be one form and one set of rules for obtaining an exception. That form and those rules should be posted on the CMS website and mailed to all people with Medicare.

Obtaining life-saving medications should not be akin to navigating a mine-field.

I have been denied coverage for Byetta, a medication I have been on for my diabetes for nearly a year. When I was first denied, I was told by my Part D plan, Wellcare, that my doctor only needed to fill out a form and the Byetta would be added to the allowed list, which it has not. I have been denied coverage for this medication. I have also had to get prior authorization for my asthma meds, Singulair and Spriva. It took over a month to get the authorization, during which time I became ill. I am constantly charged copays on syringes, insulin and albuterol, which I did not have to pay before Part D. I get charged copays for generic meds, which are supposed to have a $0 copay. I have called the insurance company and have been told that my many prescriptions cost too much, and I will have to pay copays on everything. I have tried to work with the pharmacy to get all of my prescriptions. They now look at me like I am a problem when I go to pick up a prescription.

Andrea
East Wareham, Massachusetts
Submitted to Part D Monitoring Project

A standardized appeals process must also be a streamlined one. Individuals should receive a formal denial before they leave their pharmacy, complete with straightforward instructions on how to appeal that denial. After an initial appeal to a Part D plan, individuals would then appeal directly to the Independent Review Entity.

This would cut out an unnecessary and generally futile step. Currently, after being denied a claim at the pharmacy, people with Medicare must ask the plan twice to cover their drug before receiving an independent review. Drugs subject to prior authorization require three requests for coverage at the plan level before an independent review is allowed. Each of these preliminary steps causes delays in violation of mandatory timelines and at considerable risk to the well being of the patient.

Further, for the current process to be meaningful, people with Medicare require assistance in prosecuting appeals. The current system assumes a helpful and willing physician. Do members of this Committee know many doctors who are routinely willing to take on arduous, uncompensated paperwork for the sake of their patients? And who is to help patients pursue appeals?

As noted, MRC is listed on plan denial forms as a go-to patient advocate for people denied coverage of medicines prescribed by their doctors.

How much does CMS contribute to this representation?

Nothing.

How much do the drug plans contribute?

Less.

If Congress wants people with Medicare to have access to medically necessary drugs, it must standardize and streamline the Part D appeals process, and provide assistance to individuals with bona fide appeals of a plan's denial of medically necessary medications.

DELAY ENROLLMENT PENALTY AND END LOCK-IN

Now that the May 15th enrollment deadline has passed, many people find themselves locked in to their prescription drug plan or locked out of drug coverage all together until the next open enrollment period. Starting July 1, people will be locked in to their Medicare Advantage plan.

The prospect of a late enrollment penalty, which accrues during the months people with Medicare are locked out of drug coverage after May 15 and will rise each year as the average drug plan premium rises, created needless anxiety among people with Medicare already frustrated by a confusing choice of plans. As a result, many people enrolled in plans without knowing what the coverage restrictions are, or that they will only be able to use doctors and hospitals that are in-network. Many have been deceived by plan marketing agents on these very issues.

MRC has spent the last 15 years helping people disenroll from their Medicare HMO so that they could continue to receive care from their treating physician. Others need to disenroll when they discover that the plan provides no help with cost sharing for chemotherapy or other serious illnesses. Among drug plan enrollees, plans' failure to cover their medicines is the primary reason people seek to disenroll. The administration should lift lock-in under its broad authority to create special enrollment periods. If it fails to act, Congress should step in.

The prospect of a late enrollment penalty creates needless anxiety among people with Medicare already frustrated by a confusing choice of plans. The late enrollment penalty accrues during the months people with Medicare are locked out of drug coverage after May 15 and will rise each year as the average drug plan premium rises. With all the problems and confusion associated with the roll-out of the Part D benefit, it is inevitable that some people with Medicare will miss the enrollment deadline. Congress should step in and waive the late penalty for 2006.

ENACT A MEDICARE DRUG BENEFIT

These reforms would be helpful, because we believe in the principle that anything that helps a single person is a worthy reform. But, even with these reforms the drug benefit will continue to waste billions of dollars that could better be used to deliver a reliable and comprehensive drug benefit to people with Medicare *through the Medicare program.*

Americans need affordable prescription drug coverage that meets our changing health care needs, a program that cover the drugs we need today – and the drugs we will need tomorrow. Medicare provides a cost effective and largely affordable safety net, reliably allowing older and disabled Americans the peace of mind and the security of knowing that medically necessary and reasonable health care services will be covered. There is a human cost to abandoning that Medicare design for the coverage of prescription drugs.

To provide a benefit as good as we can afford with finite dollars, we think the lessons of Part D – objectively evaluated – teach that Congress should enact:

- A drug benefit administered directly by Medicare, without the waste and restrictions that come with private health insurers as commercial, profit seeking middleman;
- Negotiated drug prices that keep costs down; and
- One comprehensible, reliable and secure drug benefit that adapts to the needs of the American people now and in the future.

Health security, not a health care lottery, is what people with Medicare require. People may in good faith still believe, even after the evidence of 2006, that the new cottage industry of for-profit middlemen hawking incomprehensible drug benefit packages is the way to go. We do not think so. But we are content to allow those plans to continue, so long as these middlemen face a real market. Let the for-profit insurers compete with a Medicare drug benefit, one that fights for lower prices, and keeps administrative costs low and profiteering non-existent.

Honest supporters of a market approach cannot fear competition, not even from Medicare. There is nothing to fear but a better deal for people with Medicare and a fairer deal for the American taxpayer.

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Last Modified:07/26/2006 12:04:37