MEDICARE
FACTS AND FACES

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Refused at the Pharmacy Counter:

How to Improve Medicare Part D Appeals

Ann from Tampa, FL.—"I went to the pharmacy to fill my prescription for high blood pressure. But my pharmacist would not give me the medicine, and he could not tell me why my prescription was denied. He told me to call my drug plan to find out. So I left the pharmacy without my prescription and went home to call my plan. The plan told me that I needed to try a different kind of medicine before I could have the one my doctor prescribed.

This is not the first time this has happened to me. A year ago, I took another blood pressure drug and had a severe allergic reaction. I tried to explain this to my plan, but they told me that I had to request an exception and that my doctor had to write me a letter of support. My doctor sent in the letter, but my plan still denied me, stating that there were alternative medicines.

I appealed this decision and after weeks of waiting, my plan let me have my medicine. During this time, my blood pressure went up and I felt exhausted and light-headed. Without my medicine, I was really worried. I am glad the appeal worked out and that I have the medicine my doctor prescribed, but who knows what I will go through next year."

Our Callers—Empty-Handed and Seeking Answers:

Each year, the Medicare Rights Center (Medicare Rights) receives up to 5,000 calls from people with Medicare, family caregivers and service providers seeking help with Medicare appeals and coverage-related issues. Many of these calls are from beneficiaries or caregivers recently refused a prescription at the pharmacy counter. Often, people refused access to a drug are not told the reason their prescriptions are not being filled. Pharmacists tend to have no or, at best, incomplete information and can only direct the person to call their drug plan for the denial reason.

The onus is on the beneficiary to investigate the reason a prescribed drug is being refused at the point-of-sale. Once a drug is denied at the point-of-sale, beneficiaries must embark on a tedious, fact-finding search to learn the reason a drug was refused and then to figure out

whether or not an appeal is the best path forward. This is an experience shared by most callers to the Medicare Rights helpline who seek help with a coverage denial.

Medicare Rights Recommends

Add individually tailored language to the existing standardized notice at the pharmacy. In addition to the plan contact information, including phone and online access, and clear guidance on the next steps in the appeals process, the denial notice should include a clear explanation of the reason the drug is refused.

Initiate the appeal at the pharmacy counter.
The Centers for Medicare & Medicaid Services (CMS) should explicitly require Medicare Part D plans to treat the point-of-sale refusal as the initial coverage determination, at which time the beneficiary has the option to automatically initiate the appeals process.

Refused at the Counter and No Clear Path Forward

Upon passage of the Medicare Modernization Act (MMA) in 2003, millions of older adults and people with disabilities gained access to prescription drug coverage through Medicare Part D starting in 2006. Today, almost 36 million beneficiaries rely on Medicare Part D for basic drug coverage.[1] While most beneficiaries are satisfied with their Part D coverage, barriers to accessing prescribed medications still exist. Beneficiaries are often unclear about the year-to-year changes made to formularies by their drug plan. At the same time, many beneficiaries are unaware of their right to appeal plan decisions.[2]

Private Medicare Part D plans have the discretion to deny coverage of prescribed drugs for several reasons. In some cases the drug is not on the approved formulary. In others, the plan applies utilization management tools to control spending. Plans employ three different types of utilization management restrictions, including prior authorization, step therapy, and quantity limits. Prior authorization requires that a plan approve a medicine before it is filled. Step therapy requires that a cheaper drug be tried first and quantity limits restrain the amount of medication a person receives.

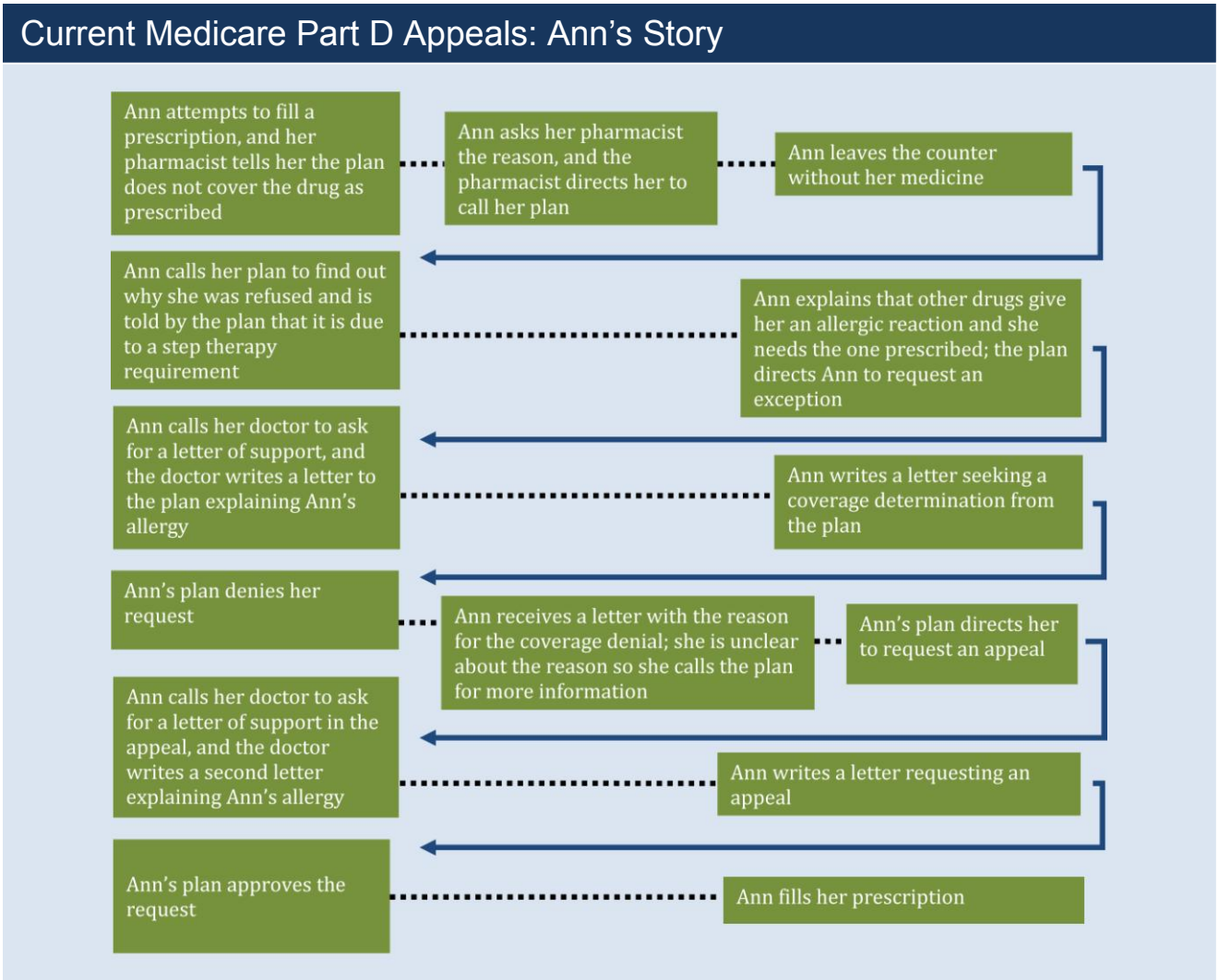
In 2012, 36 percent of medications, such as Ann's blood pressure prescription, were subject to utilization management restrictions—a significant increase from 18 percent in 2007.[3] Based on our experiences serving people with Medicare, beneficiaries and caregivers often find these utilization management tools difficult to follow. And, as noted above, increased confusion results for beneficiaries as plan formularies change from year-to-year.

Cracking an Elusive Code—the Path to an Appeal

In most cases, a beneficiary first learns that she will have difficulty obtaining her medication when she attempts to fill a prescription and is refused at the pharmacy counter. This refusal does not equate to a formal denial by the drug plan. After being refused, she must make an exception request to her plan, essentially asking the plan to make an exception to its coverage rules. The plan must follow up with a written denial, termed a coverage determination.[4]

Using Ann's story as a backdrop, the figure[5] below outlines the steps triggered at the pharmacy counter that make up the Medicare Part D appeals process and contribute to confusion and ambiguity for beneficiaries.

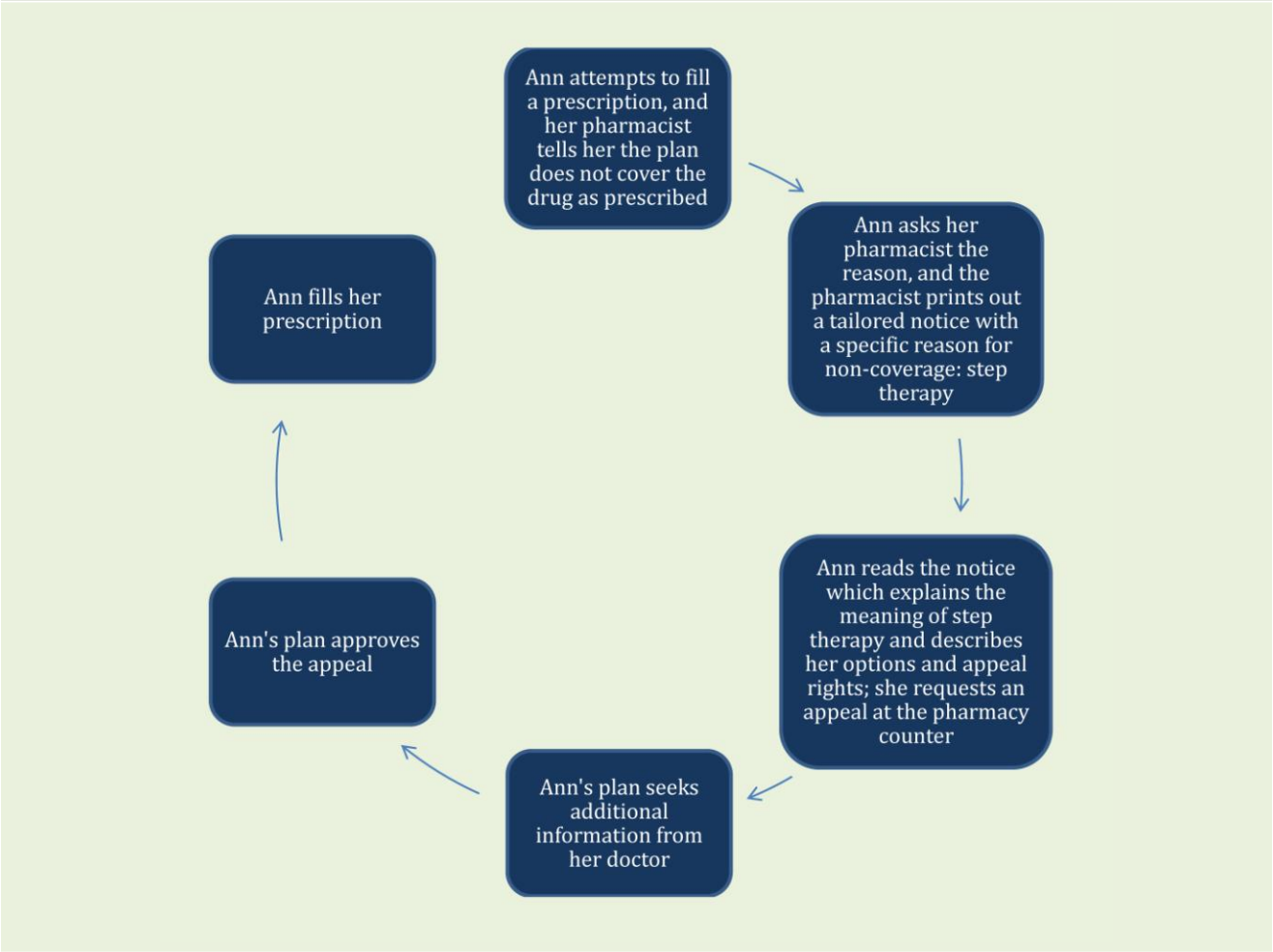
As it currently exists, the appeals process causes many beneficiaries to experience delays in accessing needed medications.[6] Many beneficiaries bypass the formal appeals process entirely.[7] Our experience on the helpline confirms that a lack of real-time, consistent information causes some beneficiaries to leave the pharmacy empty-handed, pay for the full cost of the prescribed medication, or purchase one or two pills at a time to get by.



Easing the Beneficiary Burden—An Appeals Process that Works:

The needs of a growing aging population, coupled with the increased use of utilization management tools by private drug plans, demand that the Medicare Part D appeals process be improved. The current appeals process should be streamlined and clarified to promote the health and well-being of people reliant on Medicare Part D.

Recommended Medicare Part D Appeals Process: Easing the Burden



Medicare Rights Center recommends:

Provide a standardized notice at the pharmacy that adds individually tailored language on the reason behind the coverage denial.

In 2011, the Centers for Medicare & Medicaid Services (CMS) announced that it would require pharmacists to give beneficiaries a printed, general explanation of their appeal rights after a pharmacy counter refusal.[8] In December 2012, CMS issued detailed guidance on notice distribution requirements for Part D plans and will enforce this guidance starting March 2013.[9]

Once implemented, this action by CMS will help to better educate beneficiaries about their appeal rights.

Nonetheless, the current notice lacks specificity on the reason behind a prescription refusal and only directs Medicare beneficiaries to call 1-800-MEDICARE or their plan for additional information. An individually tailored notice would empower beneficiaries and those who help them, including their doctors, to pursue the appropriate next step, which may or may not involve an appeal. This notice would alleviate the fact-finding burden placed squarely on the shoulders of beneficiaries in the current appeals process.

Initiate the appeal at the pharmacy counter.

While not all pharmacy counter refusals warrant an appeal, the reason for denial should be clear at the point-of-sale to allow beneficiaries to exercise their appeal rights should they need to take that next step. Combining the plan's point-of-sale refusal at the pharmacy counter with the formal request for a coverage determination serves the dual purpose of removing a burdensome step for beneficiaries and their doctors while also expediting the appeals process in the interest of health promotion.

CMS' current guidance states: "A plan sponsor is not required to treat the presentation of a prescription at the pharmacy counter as a request for a coverage determination. Accordingly, the plan sponsor is not required to provide the enrollee with a written denial notice at the pharmacy as a result of the transaction."[10]

We recommend that CMS require that the presentation of the prescription serve as the request for a coverage determination in order to eliminate an inefficient step in the appeals process. As noted above, we also suggest that plans provide an individually tailored notice of denial alongside information on appeal rights, so that a beneficiary can initiate a formal appeal at the point-of-sale. Further, we believe the onus should fall to the plan to contact the doctor for supporting documentation to process the appeal.

Unlike the current appeals system, under our scheme, beneficiaries would be empowered to exercise their right to appeal at the moment a drug is refused at the pharmacy counter. Access to the right information at the point-of-sale allows the beneficiary to determine the right course of action for his or her individual situation, to appeal or not to appeal. From that point forward, the plan—not the beneficiary—should determine whether or not the prescribed medication is appropriate. In the absence of these improvements, the health and well-being of Medicare beneficiaries will remain at risk.

[1] The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, (April 2012). 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

[2] E. Hargrave, B. Piya, J. Hoadley, L. Summer, and J. Thompson, (MedPAC: May 2008). Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists

[3] J. Hoadley, L. Summer, E. Hargrave, J. Cubanski, and T. Neuman, (Kaiser Family Foundation: September 2012). Analysis of Medicare Prescription Drug Plans in 2012 and Key Trends Since 2006

[4] Medicare Rights Center, (May 2012). How do I ask my Medicare drug plan to cover a drug that was denied at the pharmacy? (How to ask for an exception)

[5] There are many steps in the appeals process beyond the plan for those beneficiaries who need to seek independent review. For more information, visit Medicare Interactive: Timeline for Part D Appeals (2011) or review the Medicare Rights helpline packet on the topic of Medicare Part D appeals.

[6] Both beneficiaries and plans are held to specific timelines for particular steps within the Medicare Part D appeals process. For instance, for standard requests plans must respond to an exception request within 72 hours. If this exceptions request is denied and a beneficiary appeals, then plans must respond to a standard request within 7 days. For more on these timelines, visit Medicare Interactive: Timeline for Part D Appeals (2011).

[7] E. Hargrave, B. Piya, J. Hoadley, L. Summer, and J. Thompson, (MedPAC: May 2008). Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists; L. Summer, P. Nemore, and J. Finberg, (The Commonwealth Fund: May 2008). Medicare Part D: How Do Vulnerable Beneficiaries Fare?

[8] Centers for Medicare and Medicaid Services, Revised Standardized Pharmacy Notice (CMS-10147) (October 2011); 42 C.F.R. §§423.128 and 423.562.

[9] Centers for Medicare and Medicaid Services, (December 2012). Revised Guidance for Distribution of Standardized Pharmacy Notice (CMS-10147)

[10] Centers for Medicare and Medicaid Services, (August 2010). Prescription Drug Benefit Manual: Chapter 18: Part D Enrollee Grievances, Coverage Determinations, and Appeals, Section 30