Medicare Rights Center

Medicare Part D Appeals System Breaks Down

Rather than allowing the Medicare program to negotiate lower prices from drug manufacturers, the Part D program tries to hold down costs by giving private insurance companies the ability to deny or restrict coverage in the drug plans they offer.[1]

In some cases, this can steer people with Medicare to a lower cost alternative. But for some people on certain medications, there are no medically acceptable therapeutic substitutes. The Part D program relies on drug plans to put in place procedures to allow coverage for medically necessary drugs that are off-formulary or subject to other restrictions, such as dosage or quantity limits.

Earlier this month, the Centers for Medicare and Medicaid Services outlined how it expects these procedures to work:

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[1] Plans can exclude a drug from coverage by not putting it on the plan's formulary (drug list). They can also require prior authorization or step therapy—the requirement that a lower cost medicine be tried first and shown to be ineffective or cause side effects—techniques known as utilization management. CMS acknowledges that "a formulary drug whose access is restricted via utilization management requirements is essentially equivalent to a non-formulary Part D drug to the extent that the relevant utilization management requirements are not met for a particular enrollee." (Centers for Medicare & Medicaid Services, Draft Transition Process Requirements for Part D Sponsors, February 2006) Plans can also restrict the quantity or dosage dispensed or limit the duration of therapy.

"We have streamlined the grievance, coverage determination, and appeals process requirements[2] in order to ensure that beneficiaries receive quick determinations regarding the medications they need. In all cases, we make it clear that a Part D plan sponsor is required to make coverage determinations and redeterminations as expeditiously as the enrollee's health condition requires."[3]

The experience of Medicare counselors across the country and the stories of people with Medicare and their caregivers paint a very different picture of how this process is working.

Plans are neither "quick" nor "expeditious" in processing coverage requests. Instead, the plans make it difficult for patients and doctors to navigate the appeals process. Here is what patients are encountering when the drugs they need are not covered or restricted by their plan:

- People with Medicare often do not even know they have to appeal for coverage. Customers receive a "transitional" fill of a drug that is normally not covered, but are not told they need to switch to a formulary drug or appeal for coverage. Once their first 30-day transitional fill runs out, consumers are denied coverage at the next pharmacy visit[4] but may not have any medicines to tide them over pending an appeal.
- Calls to customer service lines go unanswered; customers are put on hold for an hour or more; customer service representatives promise to call back but never do.
- Customer service representatives do not have the information necessary, such as the fax numbers for prior authorization requests, and cannot provide the forms required by the plan.
- Customer service representatives provide incorrect information, telling consumers that there is no way to appeal for coverage, or in other cases, wrongly saying that an appeal will be granted automatically upon the request of the enrollee's doctor.
- Each drug plan has its own forms for prior authorization or exceptions, but neither the forms nor contact information are made readily accessible on their web sites.
- Even after the proper forms are obtained, filled out and filed, plans require additional information, including articles from medical journals.

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[2] The terminology and procedures for coverage are complicated, even without the added problems raised by the plans' poor implementation. Generally, if the pharmacy will not fill the prescription, the consumer, their representative or doctor must call the plan to seek a formal coverage decision or to request an "exception" from the plan. If the plan denies coverage, the next step is to seek a redetermination—a second review--from the plan. If coverage is again denied, people with Medicare can then seek reconsideration by an Independent Review Entity (a CMS contractor named Maximus). Further appeals can be taken to an administrative law judge, the Medicare Appeals Council and federal court.

[3] Centers for Medicare & Medicaid Services, Draft Transition Process Requirements for Part D Sponsors, February 2006.

[4] Although plans are required to continue providing additional temporary fills through March 31, many are not doing so, according to reports to the Medicare Rights Centers consumer and professional helplines.

- Plans fail to meet required timeframes to make decisions.[5]
- People with Medicare, especially those who are also on Medicaid, have a difficult time getting their doctors to file the necessary paperwork to obtain coverage. Because of the long hold times and excessive documentation requests, many doctors are unable or unwilling to file paperwork necessary for prior authorization or appeals. Some doctors are charging patients for this work.

Whether these problems are the result of poor service or deliberate obstructionism, the effects are the same. People with Medicare who cannot afford to pay for drugs on their own—the restricted and non-covered drugs are generally the most expensive—go without their medicines to the detriment of their health. .

Here are a few stories from the frontlines:

> In the first week of January, when I went to my drugstore with my monthly prescription for codeine, I was told the insurance company would only cover half the normal prescription: 180 tablets instead of the usual 360.
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> I'm in the process of pushing back. I had them fax my doctor their override form, and he filled it out and faxed it back to them the same day. That was on January 6 or so. I called and asked when I would get an answer. They told me to tell the drugstore it could give me the 180 tablets. So I got that, but it will only last a couple of weeks. I asked when I would get a final answer. The said an override takes two weeks, although on their web site it says I should get an answer within 72 hours.
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> I'm very concerned that I'll get to the end of the supply I have and find myself involuntarily in withdrawal.
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> I have been to two pain specialists and a rheumatologist, as well as my family practice physician who prescribed this drug, and none of them have any problem with my using an opioid for arthritis pain. I know there are those in the War on Drugs who think otherwise, but they don't have my pain." –**Message sent February 10, 2006.**

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> The [prescription drug plan] that I chose will not approve any of my medicines without my doctor calling. My doctor can't get through to them by phone nor can I. **–Message sent February 6, 2006**.

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[5] Plans must respond to initial exceptions requests within 72 hours. A doctor can ask for an expedited request if the patient's health is in jeopardy, and plans must respond within 24 hours or sooner. Plans must decide rederminations within seven calendar days, or 72 hours in the case of an expedited appeal. If plans miss these deadlines, they must forward the appeal to the Independent Review Entity.

My doctor gave me samples of a medication to try. I thought he might prescribe it. It was covered in my plan's formulary, but was designated "Step Therapy." In the formulary, Step Therapy is defined as "You are required to try certain drugs before the plan will cover another drug."

I called my plan to ask what drugs I needed to try first. The representative was as helpful as he could be, but had no information about what drugs needed to be tried first. It seems to me if Step Therapy is required, information on the drugs that must be tried first should be readily available. Alas, that is not the case. **–Message sent February 17, 2006**.

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My plan told me they covered Benicar, Zithromax, and my pain medication, Naproxen, but not my Minocycline. I asked if there was an appeal process and was told there was not and that they just don't cover it at all.

I have a very serious autoimmune disease (that almost killed me three years ago) that I need to take several specific antibiotics in specified doses for, and Monycycline is one of the most important ones. Since it is not used as much as the newer antibiotics one is less likely to build up a resistance to it, and that's the very reason why it is so crucial.

I went to the pharmacy and hat to pay full price ($40.70) for one month's supply of Minocycline. This is a lot for somebody on Social Security Disability.

I don't have a social worker, so I couldn't call one. I had called the private Medicare Part D plan provider and they basically (as I said in the above section) told me I was out of luck. Nobody offered me any solution.**—Message sent February 20, 2006.**

Because many people with Medicare had problems obtaining their medicines during the first months of the drug benefit, most states offered stop-gap coverage to people with both Medicare and Medicaid and CMS extended the transitional period during which drug plans were supposed to provide temporary supplies of medications not on the plan's list of covered drugs. Both those safety nets end in March, and there will be widespread denials of needed drugs in April – a situation exacerbated by a non-functioning appeals process.

There are a number of steps that drug plans and CMS can take to avoid a repeat in April of the public health crisis created in January by the multitude of transition problems with the new benefit.

Plans need to evaluate the staffing levels and streamlined procedures necessary to deal expeditiously with the appeals and prior authorization requests they face. If they do not, plans should lift prior authorization requirements, quantity limits and formulary exclusions, consistent with patient safety requirements, in order to triage the appeals they receive.

CMS should mandate these steps, order plans to meet required appeal standards, and issue stiff financial penalties—including debarment from the Medicare program—for non-compliance.

At least one prescription drug plan, the AARP branded plan offered by United HealthCare, has already taken such steps. In early February, the plan reduced from 39 to four the number of drugs subject to prior authorization. The plan has also lifted or raised the upper thresholds on quantity limits imposed on some drugs. No mental health drugs are now subject to prior authorization, step therapy or quantity limits.[6]

For drugs in the six protected classes—immunosuppressants taken by transplant patients, antidepressants, antiretrovirals used to treat HIV/AIDS, antipsychotics and antineoplastics that treat cancer, and anticonvulsants used to treat epilepsy and other disorders—CMS should require that drug plans lift all quantity limits, prior authorization and step therapy requirements. The overwhelming majority of plan enrollees are already stabilized on these medicines and should not be subject to these restrictions, according to CMS. Since plans have demonstrated an inability to distinguish between new and maintenance prescriptions, patient safety requires that these restrictions be lifted for all plan members.

CMS should immediately implement strengthened transition protections proposed for 2007. These added protections will help create a safety net for people with Medicare who are now stuck in a non-functioning appeals process.

CMS should immediately provide contact information for the contract manager for each drug plan, so that consumer advocates and people with Medicare can efficiently report appeals problems they encounter. CMS should enforce, with meaningful sanctions, existing regulations governing appeals procedures. CMS should also post on a single, well publicized web site the appeals and prior authorization forms used by all plans.

Congress, in particular the House Ways and Means Committee whose chairman has refused to schedule hearings on Part D, should conduct thorough oversight of plan performance, with a particular focus on problems with prior authorization, exceptions and appeals procedures.

Evidence developed through CMS and Congressional oversight should prompt an honest evaluation of whether the cost containment strategies employed by the Part D plans are impairing access to needed medicines. If they are, as the stories of people with Medicare demonstrate, **Congress should enact a Medicare drug benefit that provides comprehensive coverage while using the market power of 43 million Medicare beneficiaries to lower drug prices.**

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[6] Meeting between consumer advocates and Thomas Paul, Chief Pharmacy Officer for Ovations, a business unit of United Health Group, on March 3. The changes are not reflected on the formulary posted on the AARP plan's web site and the Medicare Rights Center has received complaints in February of quantity limits imposed on mental health drugs, so it is not clear how consistently the new policy is enforced.