



Medicare Rights Center

People Must Be Allowed to Change Their Drug Plan

May 2006

On May 16, people with Medicare, with certain exceptions,¹ will be locked in to their Part D drug plans until next year. While the May 15 Part D enrollment deadline has garnered much attention because it freezes the unenrolled out of drug coverage for the rest of the year, the fact that most of those who have enrolled will be locked in to their plans for the rest of the year has serious implications for access to prescription drugs.

Lock-in is being imposed on people who have been confused and misinformed about how to select a drug plan. This confusion is only amplified by a troubling pattern of deceptive marketing by private plans. Consumers' ability to select the most appropriate plan has also been undermined by how plans are allowed to limit access to drugs as well as by a series of systems and data exchange problems that have overridden or blocked enrollment.

Access to medicines through both drug plans and Medicare Advantage (HMO, PPO, and PFFS) plans is blocked by a malfunctioning appeals system and plans' failure to meet basic formulary requirements. Furthermore, the Bush administration has failed to provide an appropriate mechanism to override lock-in for the most vulnerable people with Medicare, such as the victims of deceptive marketing.

The only solution is to lift the May 15 deadline and allow people with Medicare the ability to switch their drug plan during the course of the year. The administration, through its broad legal authority to create special enrollment periods (SEPs), should provide an SEP that effectively lifts lock-in for the rest of the year. Congress also bears responsibility for the barrier lock-in creates to the ability to obtain needed medicine. Congress should lift lock-in in conjunction with extending the May 15 Part D enrollment deadline.

Plan Selection Has Been Based on Misinformation and Deception

Consumers have had difficulty getting accurate information about their drug coverage from plans.² Plan customer service representatives and plan marketers have misinformed potential enrollees about what drugs are covered, failed to explain whether there are restrictions on drug coverage, and given false assurances that coverage can be readily obtained under the exceptions process.³

Only a small fraction of people with Medicare have used the CMS plan finder or 1-800-MEDICARE for making plan comparisons.⁴ Both the plan finder and the representatives on the 800 number have provided incorrect information on plan coverage. Similarly, the CMS plan finder and the formulary finder online have provided insufficient information about the utilization management restrictions plans impose.⁵ Nevertheless this remains the most efficient means of comparing plan coverage.⁶

Instead of using the Medicare web site, many people with Medicare have relied on plan representatives and insurance agents to make their plan selection.⁷ The Medicare Rights Centers' counseling experience shows that plan representatives often use deception when marketing their plans, violate marketing guidelines and improperly use providers to steer clients toward particular plans. Specifically, the Medicare Rights Center (MRC) has found:

- Plan representatives tell prospective enrollees their drugs are covered when, in fact, the drugs are off the plans' formularies or subject to utilization management controls that effectively deny coverage.
- Plan representatives give false assurances that a letter from the prospective enrollee's doctor will result in coverage of a drug that is not normally covered.
- HMO representatives falsely claim that prospective enrollees' doctors are in the plan's network or fail to inform prospective enrollees about any network restrictions.
- Drug plan representatives tell prospective enrollees that they must sign up for a plan by May 15, even though the person already has drug coverage through an HMO. Once signed up for the drug plan, people with Medicare are disenrolled from their HMO and billed for their copayments for doctor visits.
- HMO representatives market their plan as drug coverage and do not inform clients that their plan includes cost sharing for medical expenses and network restrictions. People with Medicare and Medicaid, who have their Medicare cost-sharing paid by state Medicaid programs, are particularly subject to such deceptive marketing.
- People with Medicare and Medicaid are enticed into plans with offers of free transportation to medical services already provided by state Medicaid programs or with \$125 gift certificates for non-drug pharmacy purchases. (Plans are prohibited from providing such monetary compensation in exchange for enrollment.)
- People with Medicare and Medicaid are falsely told that they could lose Medicaid coverage if they do not sign up for a particular plan.

- Doctors will steer patients to a particular HMO without regard to drug coverage or whether other providers used by their patients are in-network.

Lock-in prevents victims of such deceptive marketing from taking the most readily available step to remedy their situation. Already the Medicare Rights Center has helped dozens of people who were victims of such practices disenroll from their drug plan or HMO and re-enroll, sometimes retroactively, in the plan that best meets their needs. That has been possible because the open enrollment period allowed such changes and clients had not exhausted the number of plan selections they were allotted.

Mr. A is a disabled veteran calling from Somerville, Texas. In mid-December he researched alternative plans and enrolled in SilverScript. The plan worked in January and early February. However in the third week in February, his pharmacist was unable to process medications. He called SilverScript and was told that his coverage had been cancelled but was not given explanation. A SilverScript customer service representative suggested he re-enroll effective March 1, which he did. However, when Mr. A went to pharmacy in early March, his pharmacy claims again would not go through.

Although Mr. A is enrolled in a Medicare Savings Program (MSP), which entitles him to switch plans on a monthly basis, CMS had rejected his second enrollment in SilverScript, because the previous disenrollment had exhausted the two plan choices allowed during the initial enrollment period to the general Medicare population. After the intervention of Medicare Rights Center counselors, SilverScript agreed to request an exception from Medicare and re-enroll him effective March 1.

On April 25, Mr. A contacted MRC again as he had just received a letter from PacifiCare (dated April 10) saying that he would be enrolled in their plan effective May 1. As an MSP recipient, Mr. A had been automatically enrolled in PacifiCare by CMS, despite his earlier selection of SilverScript. CMS data systems had failed to recognize his earlier plan selection and the agency had failed to notify him of the pending enrollment. Mr. A enrolled again in SilverScript effective May 1.

System Errors Have Undermined and Delayed Plan Selection

The roll out of the Part D program has been plagued with a series of systems problems that have left people with Medicare without coverage by a drug plan, enrolled in the wrong plan or simultaneously enrolled in more than one plan. Any lingering enrollment or disenrollment problems are bound to be exacerbated after lock-in freezes plan selection. Even if CMS provides a special mechanism to resolve these situations on a case-by-case basis, most people with Medicare will believe they have lost any opportunity to enroll or switch plans. A partial list of the enrollment problems caused by systems failures shows that a wide range of people with Medicare could be negatively impacted by lock-in:

- Maine Governor John Baldacci recently wrote President Bush that CMS has failed to process enrollment of 6,000 members of its state pharmaceutical assistance program since February. “If [enrollment] confirmation does not occur by May 15, it will be too late to enroll these residents in Part D for this year, and they will be without Medicare Part D coverage until January 2007.”⁸
- CMS confirmed that up to 20,000 low-income people with Medicare had their own plan selection overridden when the agency automatically enrolled some 1 million people who receive Supplemental Security Income or participate in the Medicare Savings Program.⁹
- Full processing of enrollment can take from six to eight weeks.¹⁰ There continue to be unexplained processing delays when people enroll through Medicare.gov, CMS’ plan finder web site, with the plan chosen still having no enrollment record after coverage was due to begin. Counselors around the country are concerned these delays could freeze clients out of drug coverage if their enrollment is not processed by May 15.
- Since fall of 2005, MRC case workers have experienced delays ranging from weeks to months when attempting to disenroll clients from Medicare Advantage (MA) plans.

One of the most widespread systems failures involves data exchange problems between CMS and drug plans that have resulted in plans’ failure to recognize individuals’ enrollment in the Extra Help (low income subsidy) program. CMS acknowledged in February that hundreds of thousands of low-income individuals, primarily people with Medicare and Medicaid, were impacted. The problem has persisted, and low-income people with Medicare continue to be charged copayments and premiums well above Extra Help limits and well above what they can afford.

Failure by plans to recognize Extra Help status could result in individuals being denied the ability to enroll in Part D or switch plans after May 15 under a special enrollment period (SEP) created by CMS for people with also receiving Medicaid or a Medicare Savings Program. CMS created this SEP in part to preserve plan selection for people who were automatically enrolled in a Part D plan and to address the particular vulnerability of dual eligibles – people with Medicare and Medicaid – to coverage limitations by MA plans under lock-in.¹¹ The persistence of systems problems that prevent recognition of Extra Help status potentially could deny automatic SEP rights to people with Medicare and Medicaid. This is a population with high rates of cognitive and mental impairments that make it particularly difficult for them to appeal for their SEP rights.

Mr. L is a disabled New Yorker with Porphyria, a rare genetic condition. Medicaid had always covered Mr. L's medications, including Anzemet and Protonix. Due to his condition, Mr. L is unable to tolerate alternative doses or medications. Since early March, Mr. L has been unable to obtain medically-necessary quantities of his medications from his plan, First Health Premier.

MRC referred Mr. L's case to the CMS regional office then to the CMS Central office. To date, MRC has not received a response.

With MRC's help, Mr. L filed a quantity limit exception request to First Health Premier on April 17. Although all relevant time limits have expired, Mr. L has not yet heard about whether or not this request has been granted.

Access to Medicines

Lock-in does more than limit consumer choice. Because of the ability of plans to limit drug coverage through formularies, lock-in can also act as a barrier to needed medicines by locking people into plans with restrictive coverage. The formularies submitted by Part D plans were reviewed by CMS to ensure access to "all medically necessary drugs." However, there is evidence that the standards set by CMS have not been met by all Part D plans.¹² A review of coverage of antipsychotics and antidepressants by 15 prescription drug plans in New York State found that some plans did not cover all the drugs in these two classes that they were mandated to cover.¹³ Formulary surveys in Maine yielded similar results.¹⁴

Even if formulary restrictions were truly medically justified, formulary restrictions must also be imposed in a manner that promotes access to medically necessary drugs. If plans simply deny claims to certain drugs without providing a transition to a covered drug, then the continuity of drug regimens is threatened. The experience of the three-month transition at the outset of the drug benefit showed that many plans failed to provide the transitional supplies required by CMS and to take the necessary action to move people to covered drugs. Nearly half of those affected by formulary restrictions remained on non-covered drugs at the end of the transition period.¹⁵

Drug plans also failed to differentiate between new prescriptions and maintenance prescriptions, imposing prior authorization and other restrictions on patients stabilized on mental health drugs in violation of CMS guidance.¹⁶ For people who enroll in a drug plan in the weeks before the deadline, especially those transitioning from other drug coverage under Medigap, state pharmaceutical assistance programs and other private plans, the impact of formulary restrictions will hit after they have lost the ability to switch plans.

Finally, efficient and fair appeals procedures are crucial to implementing formulary restrictions in a manner that maintains access to drugs that are medically necessary for an individual patient. However, the exceptions process has broken down on a number of levels, largely due to obstacles placed by Part D plans but in part because of the difficulty in securing cooperation from prescribing physicians.¹⁷ MRC advocates recently found

that Part D plans are delaying resolution of appeals beyond the mandatory timelines set by CMS. For example, plans do not start the clock until they acknowledge receipt of the appeals request, sometimes days after it was sent.

During the first four months of the Part D drug program, the ability to switch to a more appropriate plan has proven to be a crucial safety valve for people facing formulary restrictions. The failure of plans to provide an effective transition or a working appeals mechanism has left switching plans as the only viable option for ensuring access to needed medicines. That option disappeared for many people with Medicare starting May 16.

Submitted by Mrs. C in Nashville, Tennessee:

“I work in disability advocacy which means I am fairly familiar with Medicare and Part D and have attended the “roll outs,” the trainings, and the help sessions. I have also assisted a number of folks through the plan selection process. Fortunately, I am fairly “web savvy.”

“My father, who is 80 years old, asked for help in identifying a plan. He has a Medigap policy but does not have any prescription drug coverage. He had by-pass surgery in 2004; he has high blood pressure, diabetes and neuropathy. In November, he printed out a list of his medications, dosages, and costs (he uses a computer and is a meticulous record-keeper). I used the drug list to search for a plan and sent him my recommendation. He was hesitant to sign up without my presence (I live two hours away) and not sure how it would all roll out, so he waited until he and I could sit down together to do it. The holidays and an emergency hospitalization slowed us down.

“Last week, with the deadline looming, we knew it was time to act. Father printed out his new list of medications—a variety of changes had taken place because his hospitalization. When I ran the search this time, the plans that were on the top of the November list did not appear at all on the plan options list this time. Imagine if he had signed on to the “best” plan in November. By March he would have been in trouble.”

Special Enrollment Periods

CMS has the legal authority to create special enrollment periods (SEP) to allow people to switch Part D plans.¹⁸ CMS has created SEPs that cover some, but not all, circumstances that necessitate an override of lock-in, and has not established standards or a working mechanism for granting SEPs.¹⁹

In particular, CMS has said it will allow an SEP if an individual is able to demonstrate that her drug plan “substantially violated a material provision of its contract.” Contract violations include failure to provide benefits under the plan on a timely basis or in accordance with applicable quality standards. In theory, this could encompass a failure to

provide a transitional supply of a non-covered drug, delays in handling appeals for coverage, or failure to cover a drug that is required under CMS formulary guidance.

Material representation of the drug plan, for instance if plan marketing agents present an HMO as a drug plan, could also trigger an SEP, according to CMS' guidance, although it remains unclear how individuals would be able to demonstrate such deception. It remains uncertain whether CMS would consider more widespread misrepresentations, such as the near universal failure of plans to alert potential enrollees about the coverage gap or "doughnut hole" in coverage, or the failure to adequately explain formulary restrictions, as warranting an SEP.

CMS will also allow, on a "case-by-case basis," an SEP for individuals who disenroll in connection with plan performance that gave rise to a CMS sanction. Despite widespread reports of plans failing to performance standards, such as minimum responsiveness standards for call centers, there has not been any published CMS sanction to date.

An SEP can also be granted, on a case-by-case basis, to individuals whose enrollment or non-enrollment in a Part D plan is due to an error by a federal employee. Theoretically, this could apply to individuals who were misinformed about plan coverage due to errors on the CMS web based plan finder, Medicare.gov, or by answers provided by operators on 1-800-MEDICARE. There is ample evidence of errors from both sources of information, which are critical to plan selection.²⁰ However, there is no way of identifying which individuals were impacted by these errors. Even the affected individuals may not know they received erroneous information from these government sources.

These protections, however, remain purely theoretical since CMS has not established a mechanism for granting SEPs nor has it established standards of evidence for granting an SEP.

Agency guidance indicates that CMS regional offices will be used to process at least some requests for SEPs, but it appears to be the plans themselves will have the discretion to obtain SEPs for prospective members.²¹ Once the May 15 deadline takes effect, the vast majority of people with Medicare will likely assume they have no rights to an SEP, and will stick with a plan that does not meet their needs. The SEP protections are, in effect, phantoms; they will not be accessed to any meaningful extent by people with Medicare who need them and have a right to them.

Individuals who make the mistake of disenrolling from their original plan rather than simply enrolling in another plan (and thereby automatically disenrolling) are considered to have used their second allotted plan selection and are blocked from enrolling through 1-800-MEDICARE or through Medicare.gov. CMS has instructed plans to use an SEP to process the enrollment of these individuals.²² This process is problematic, however, since the determination of an SEP is made by the plan, not the individual or by CMS. Plans may have a disincentive to use an SEP for individuals with high drug or medical costs.

Again because the process is not transparent, individuals who are denied enrollment would have no knowledge that an SEP is even an option.

There are also a variety of circumstances that could require an override of lock-in that are not covered by SEPs.

For example, there is no SEP for enrollees in plans that change their formularies during lock-in. CMS recently required plans that reduce formulary coverage to allow people who had already received coverage under the plan of the affected drug to continue receiving coverage for the remainder of the year under the same cost-sharing terms. It remains to be seen how plans will implement this requirement, in particular, whether they will be able to distinguish at the pharmacy counter, between new prescriptions and prescriptions for those with grandfathered coverage or cost-sharing terms. It is also unclear whether prospective enrollees comparing plan formularies will be alerted to imminent formulary changes before they sign up for a plan. Grandfathering existing prescriptions also does nothing to help consumers that select a plan based on how its overall formulary coverage compares to other plans.

Most people do not have the specialized knowledge necessary to make broad comparisons of plans' formulary coverage. At best, they can compare coverage of the drugs they now take. They have no ability to predict what drugs they will need in the event of a new illness or diagnosis. These unforeseen medical events can radically change the parameters of plan selection, but there is no SEP for individuals whose medical needs change. While individuals can appeal for coverage of medically necessary prescriptions if the plan denies their exception request, appeals take a long time and there is no provision for emergency coverage of a drug while the appeals process is taking place.

The failure of CMS to provide public notice of consumers' right to an SEP after May 15 or to provide a viable mechanism to obtain an SEP means CMS must establish an alternative method to secure these rights. An SEP that effectively lifts lock-in for **all people with Medicare** would protect individuals in circumstances identified by CMS and others whose access to medicines can now only be secured by an override of lock-in.

Conclusion and Recommendations

The lock-in for Part D plan selection that takes effect May 16 and for MA plans on July 1, threatens to exacerbate problems with the Part D program that are already impeding access to medicines.

The wide disparity in plans' formulary coverage in combination with a malfunctioning appeals system means lock-in acts as barrier to access of medically necessary drugs.

Lock-in will prevent corrections of systems problems that have undermined or blocked plan selection.

People who based their decisions on deceptive marketing or misinformation will be locked in to plans that misled them into enrolling.

The special enrollment periods CMS has established as a safety valve are not an effective remedy because of the agency's failure to establish a working mechanism for granting an SEP. In particular, systems problems threaten to undermine the SEP granted for people with Medicare and Medicaid, a particularly vulnerable population.

Recommendations:

CMS has to take responsibility for ensuring that people with Medicare get the medically necessary drugs to which they are entitled by allowing continued enrollment in and disenrollment from Part D plans after May 15. The exceptional circumstances surrounding the first year of the Part D program provide the legal justification for CMS to create a special enrollment period that applies to everyone with Medicare and Medicaid.

Congress should enact legislation that would extend open enrollment beyond May 15 and provide people with Medicare additional opportunities to switch in and out of drug plans.

¹ People with Medicare and Medicaid (dual eligibles) and people enrolled in Medicare Savings Programs or receiving Supplement Social Security Income receive a special enrollment period (SEP) that allows them to change plans on a monthly basis. People with Medicare entering or leaving a long term care facility also receive an SEP that allows a change of drug plan. On July 1, lock-in starts for Medicare Advantage plans—the HMOs and other private plans offering medical and prescription drug benefits.

² Sokolovsky, J: "Many [beneficiaries] reported difficulty getting services lines to tell them whether their specific medications were covered. They were often told by the customer service line that they only gave that information to people who were enrolled in the plans," Transcript of MedPAC meeting, April 2006.

³ California Health Advocates and the Medicare Rights Center, "The Knowledge Gap: Drug Plans Fail to Provide Critical Information to People with Medicare," February 2, 2006 (<http://www.cahealthadvocates.org/advocacy/2006/02.html> last accessed on May 11, 2006).

⁴ Sokolovsky, J: Transcript of MedPAC meeting, April 2006 (http://www.medpac.gov/public_meetings/transcripts/0406_allcombined_transc.pdf last accessed on May 16, 2006).

⁵ "Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved," Government Accountability Office, May 2006 (http://www.house.gov/stark/news/109th/pressreleases/20060503_GAOReport/GAO-06-654.pdf last accessed on May 11, 2006).

⁶ "The Knowledge Gap: Drug Plans Fail to Provide Critical Information to People with Medicare," California Health Advocates and the Medicare Rights Center, February 2, 2006 (<http://www.medicarerights.org/CHABrief2.2.2006.pdf> last accessed on May 16, 2006).

⁷ Sokolovsky, J: Transcript of MedPAC meeting, April 2006.

⁸ Letter from Maine Governor John Baldacci to President George Bush, May 2006 (hereafter Baldacci).

⁹ Lueck, S. and Fuhrmans, V: *Large Insurers are Big Winners in Medicare Drug Benefit*, Wall Street Journal, April 2006.

¹⁰ Baldacci.

¹¹ Laschober, M, "Estimating Medicare Advantage Lock-In Provisions Impact on Vulnerable Medicare Beneficiaries," Health Care Financing Review, Spring 2005 (hereafter Laschober).

¹² “Deadline Near, Jams Are Seen for Drug Plan,” *The New York Times*, April 24, 2006.

¹³ Forthcoming research by the Medicare Rights Center.

¹⁴ Maine Association of Psychiatric Physicians, Medicare Part D Prescription Drug Plans” (http://www.mainepsych.org/mapp_0406.pdf last accessed on May 16, 2006).

¹⁵ “Well under half” of beneficiaries who used transitional coverage have not transitioned fully to drugs covered by their health plans, McClellan said. “Democrats Urge Bush to Extend Medicare Transitional Drug Coverage Period,” *Congressional Quarterly*, March 31, 2006.

¹⁶ Medicare Rights Center, “Medicare Drug Plans Should Lift Restrictions On Mental Health Drugs,” February 2006 (http://www.medicarerights.org/Restrictions_on_Mental_Health_Drugs.pdf last accessed on May 16, 2006).

¹⁷ Ibid.

¹⁸ Medicare Rights Center, The Part D Enrollment Deadline Can and Should Be Lifted, April 2006 (http://www.medicarerights.org/ExtendMay15_4122006.pdf last accessed on May 16, 2006).

¹⁹ Centers for Medicare & Medicaid Services, “Final Part D Enrollment and Disenrollment Guidance,” 2005. Additional SEPs exist for MA enrollees, such as for those who have transitioned from Medigap supplemental coverage to coverage under an MA plan.

²⁰ Government Accountability Office, May 2006; Forthcoming research by the Medicare Rights Center.

²¹ Centers for Medicare & Medicaid Services, Final Part D Enrollment and Disenrollment Guidance, 2005

²² Conversation with Tom Paul, Chief Pharmacy Officer for Ovations, United Health Group, March 2006; Communication from CMS, May 2006: “In recent weeks, we have received reports that some beneficiaries have chosen to disenroll from a plan--which constitutes an enrollment choice--without enrolling in another plan at the same time. To address situations where this occurred, we have instructed plans to accept enrollments from these individuals, even if they had otherwise used up their enrollment opportunities under the mistaken impression that they could later select a different Part D plan.”