



CMA Weekly Alert – February 9, 2006

PART D FORMULARIES FAIL TO COVER MANY PRESCRIPTION DRUGS TAKEN BY DUAL-ELIGIBLE BENEFICIARIES

Dually-eligible beneficiaries (people eligible for both Medicare and Medicaid) were each randomly assigned to one of 409 Medicare Part D prescription drug plans with 37 unique formularies. Further, approximately 10% of dually-eligible beneficiaries who were already enrolled in Medicare Advantage (MA) plans were enrolled in their MAs' drug plan. The Department of Health and Human Services' Office of Inspector General (OIG) recently evaluated whether these plans covered the 200 prescription drugs that were most frequently used by the dual eligible population in the first two quarters of 2005. These 200 drugs accounted for approximately 78% of prescription drugs taken by dually-eligible beneficiaries during this period.

OIG found that 22 of the 200 most commonly-used drugs are excluded from coverage by the Medicare Modernization Act and that many of the 178 drugs that are eligible for coverage by Part D plans are not covered by beneficiaries' plans. Nearly one-third of dually-eligible beneficiaries who were randomly assigned to prescription drugs plans were assigned to plans that include less than 85% of the 178 commonly-used drugs. Only 18% of dually-eligible beneficiaries were randomly assigned to plans covering all 178 drugs. On average, plans covered 92% of the 178 Part D-eligible drugs.

Half of the 178 drugs are included in all 37 formularies and an additional 27 drugs (15%) are included in all but one or two formularies. However, 21 drugs (12%) – all brand name drugs without a generic equivalent – are excluded from at least 25% of the formularies. These excluded drugs are prescribed for high blood pressure (six drugs), high cholesterol (three drugs), and pain relief (three drugs).

OIG reported that, as of December 2005, 45 of 47 states had decided continue to cover all 22 drugs excluded from Part D coverage by the MMA. (At present, 49 states will cover some of these drugs.) Tennessee planned to end coverage of benzodiazepines and barbiturates (6 of the 22 drugs) for all Medicaid beneficiaries; North Dakota planned to discontinue Medicaid coverage of drugs used for symptomatic relief of cough and colds (1 of the 22 drugs). Both states will cover the remaining Part D-excluded drugs.

OIG reported that four states are offering wraparound coverage for at least some drugs that are omitted from plan formularies. Connecticut and New York will cover any noncovered drug that the state provides to Medicaid beneficiaries; New Jersey and Vermont will cover some nonformulary drugs.

More than six million beneficiaries are dually-eligible. OIG reports that:

- Nearly ¾ of them have an annual income of \$10,000 or less;
- 38% have a cognitive or mental impairment;
- More than one-third are disabled;
- Less than one-half are high school graduates;
- On average, they take “at least 10 more prescription drugs than nondual eligible beneficiaries.”

Unless they live in an institution such as a nursing home, dual eligible beneficiaries must pay co-payments of \$1 or \$3 for their prescription drugs.

Dual-eligible beneficiaries who take a drug that is not included in their plans’ formulary can:

- Apply for an exception; or
- Get a prescription from their physician for a different drug that is included in their plan’s formulary; or
- Change to a plan that covers their drug. OIG reports that at least one plan in every PDP region uses a formulary that includes all 178 drugs. Any change in plan becomes effective on the first day of the next month.

The above processes may well be impossible for a large percentage of dual eligibles to navigate on their own.

During the transition process, when a beneficiary moves into a Part D plan for the first time, the Centers for Medicare & Medicaid Services recommended, but did not require, that plan sponsors provide a temporary one-time transition supply of non-formulary drugs. CMS has now asked all plans to extend the initial transition period for 60 additional days, so that *all* prescription drugs should be provided through March 31, 2006. During this period, dual-eligible beneficiaries can take one or more of the actions described above.

The Center for Medicare Advocacy believes that coverage of prescription drugs by PDPs may be even more limited than OIG suggests. First, plans can further control use of drugs that are included in their formulary by requiring prior authorization or step therapy (requiring a beneficiary to try a less expensive drug first) or by using tiers for copayments. A drug’s appearance on a plan formulary does not necessarily mean that a beneficiary can get the drug without further action or additional payment. Second, since the OIG did not review the specific drugs needed by any particular beneficiary, a dually-eligible beneficiary may take drugs that were not reviewed by the OIG and that may not be included in the plan’s formulary.

While CMS was critical of OIG’s methodology, OIG points out that CMS’ methodology, which analyzed formulary coverage at the individual beneficiary level, also found that PDP formularies cover 92.8% of beneficiaries’ drugs. CMS was also critical of the scope of OIG’s study.

See OIG, *Dual Eligibles’ Transition: Part D Formularies’ Inclusion of Commonly Used Drugs*, OEI-05-06-00090 (Jan. 2006), <http://www.oig.hhs.gov/oei/reports/oei-05-06-00090.pdf>.

Recent Guidance on Niacin Products

Recent guidance from CMS requires plans that included Niaspan® in their formularies to continue covering Niacin products until they have given 60 days' advance notice of removal of the drug. CMS has determined that Niacin products are prescription vitamins that are excluded from Part D, effective June 1, 2006. See "*Prescription Niacin products,*" Memorandum from Abby Block, Director, Center for Beneficiary Choices, to Medicare Part D Plans (Feb. 3, 2006).

The Block memorandum is not available on CMS' website, but appears on the Center for Medicare Advocacy's website at http://www.medicareadvocacy.org/PartD_BlockMemo.pdf.

Reimbursing Beneficiaries for Improper Prescription Drug Payments

Many Medicare beneficiaries who are enrolled in a Part D drug plan have paid more than they are required to pay for their prescriptions. Improper payments include payment of the \$250 deductible by people who are dually eligible for Medicare and Medicaid or who are eligible for the low-income subsidy (extra help); payment of co-payments in excess of the low-income subsidy amounts, and, in some states with Part D wrap-around coverage, of any co-payment; and payment of the full cost of drugs that should have been provided during the transition period.

CMS had advised advocates informally that beneficiaries who paid incorrectly can submit a request for reimbursement, along with copies of their receipts, to their drug plan. In a letter sent to drug plan sponsors on February 7, 2006, CMS requests plan sponsors not to implement a 30-day billing limit on pharmacists and beneficiaries who seek reimbursement. CMS says that "... beneficiaries should have 90 days in which to provide documentation to the plan for any incorrect payments they have made."

CMS also has advised advocates that beneficiaries who do not have receipts may be able to obtain copies of the transaction from their pharmacies. In addition, beneficiaries should contact their regional CMS office if plans do not act on their reimbursement request promptly.

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