Patients, Physicians Struggle With Part D Rollout

BY MARY ELLEN SCHNEIDER
Senior Writer

As Medicare beneficiaries grapple with the new prescription drug benefit that went into effect on Jan. 1, physicians report that they are spending valuable clinical time explaining the benefit, rewriting prescriptions, and navigating drug company Web sites.

"It's taking up a disproportionate amount of our time," said Dr. Maurice Wright, medical director and staff internist of the So Others Might Eat Medical Clinic in Washington, a group that provides primary care services to needy patients, including Medicare beneficiaries.

Physicians weren't armed with the necessary information to properly advise patients about the new Medicare Part D benefit, Dr. Wright said.

And even after exploring the Medicare and drug plan Web sites, Dr. Wright said he still has unanswered questions about how to help his low-income Medicare patients apply for the "extra help" subsidy.

That low-income subsidy is especially important for his Medicare patients who do not qualify for Medicaid, he said. And without information about how to enroll, they can't choose a drug plan because they don't know how much it will cost, he said.

Dr. Wright has also noted problems among his patients who are dually eligible for Medicare and Medicaid. These patients were automatically enrolled in a Part D drug plan before the beginning of the year.

But some technical glitches in transmitting that enrollment information from Medicare to the drug plans means that for some patients there is either no record of their enrollment when they show up at the pharmacy or they are asked to pay higher prices.

Dual-eligible beneficiaries are also facing other problems as a result of automatic enrollment, Dr. Wright said.

For example, these patients may be signed up for plans that don't cover their medications. Alhough they can switch plans, figuring out the formulary list for the various plans can be difficult for patients, Dr. Wright said.

As of Jan. 13, the Department of Health and Human Services reported that 14.3 million Medicare beneficiaries have been enrolled in a Part D drug plan. The bulk of those enrolled—6.2 million—are beneficiaries who are dually eligible for Medicare and Medicaid and were assigned to Part D plans.

In addition, 4.5 million have enrolled in Medicare Advantage plans, which include drug coverage, and 3.6 million have signed up for stand-alone drug plans under Medicare.

AARP—which sponsors a prescription drug plan for AARP members—reports that overall the benefit implementation is going well. George Keleman, campaign manager for the AARP Medicare Rx Outreach Campaign, said the problems reported relate to communication systems between Medicare, the drug plans, and the pharmacies that have mainly affected dual-eligible beneficiaries.

Dr. Donna E. Sweet, an internist in Wichita, Kan., and chair of the board of regents for the American College of Physicians, has seen those problems firsthand in her practice. The biggest problem has been among her dual-eligible patients with AIDS who are on a three- or four-drug regimen that must be taken to keep from developing resistance. "They are leaving the pharmacy without medications," she said.

The problem isn't that the drugs aren't covered by the participating drug plans but that the patient is either not in the system or is listed incorrectly and thus asked to pay a high copay or deductible.

Among her other patients, she's noticed that the very elderly—those aged 90 years and older—are opting out of the process entirely. For those patients who have selected a Medicare drug plan, Dr. Sweet has spent a lot of time reviewing medications and figuring out which ones can be switched to better correspond with the patient's formulary list. "It's a tremendous amount of staff and physician time," she said.

But Dr. Sweet said that in the long run, the program will likely be an asset for most seniors.

Physicians can also expect to see a spike in the number of requests they receive for prior authorizations as a result of the Part D benefit, said Dr. Yul D. Ejnes, an internist in Cranston, R.I., and chair elect of the ACP board of governors.

Although most of the drugs requiring prior authorization are approved, Dr. Ejnes noted that prior authorization is being required by many plans for standard medications such as statin drugs or proton pump inhibitors.

He advised physicians to have patience and to make their patients aware that the plan they have selected requires this level of administrative hassle.

Many of his Medicare patients have also been receiving letters from their drug plan saying that the medication they have been prescribed is limited to a certain number of doses per month.

In most cases the quantity limits have no impact, he said, but it has caused confusion among patients and he has spent a lot of time explaining it. ■

States to Recoup Emergency Drug $

The federal government and private drug plan sponsors will reimburse states that have provided drug coverage to Medicare beneficiaries since the Medicare Part D prescription drug benefit went into effect on Jan. 1.

Twenty-five states and the District of Columbia have been paying for prescription drugs on an emergency basis for beneficiaries who are dually eligible for Medicare and Medicaid but have had difficulty getting their medications.

Starting on Jan. 1, people who were eligible for both Medicare and Medicaid had their drug coverage transferred from the states to a Medicare prescription drug plan.

At the end of January, officials at the Centers for Medicare and Medicaid Services announced that they would begin a demonstration project that will allow them to ensure that states are fully reimbursed for their costs from the first date that the state paid claims until Feb. 15.

The states will be reimbursed by the prescription drug plan sponsors for contracted costs, and Medicare will pay any remaining drug costs. CMS will reimburse states for their administrative costs.

The move came just days after a group of senators introduced legislation—the Medicare State Reimbursement Act (S. 2181)—that would require the federal government to reimburse states for all of their costs plus interest.

Sen. Frank R. Lautenberg (D-N.J.), the chief sponsor of the legislation, said the CMS plan does not change the need for legislation.

"This is no solution," he said in a statement. "It is simply more red tape from the Bush Administration."

Sen. Lautenberg said the CMS plan will put a greater burden on the states by forcing them to act as bill collectors.

Wisconsin Physicians Fight to Restore Damage Cap

Wisconsin physicians are continuing to push for the reinstatement of a medical liability damage cap despite recent legal and legislative setbacks.

"I think our legislature clearly understands that something has to be done," said Dr. Susan Turney, executive vice president and CEO of the Wisconsin Medical Society.

Last summer, the Wisconsin Supreme Court struck down the state's $445,775 cap on noneconomic damages as unconstitutional because it was set "unreasonably low."

The state legislature acted quickly to pass legislation that enacted a $450,000 cap for adults age 18 and older and a $550,000 cap for those under 18.

But Gov. Jim Doyle (D) vetoed the bill last December, saying that legislators had passed virtually the same cap and ignored the concerns of the court.

"Legal experts agree that a court which found a $445,775 cap unconstitutional would most certainly strike down a cap not even $5,000 higher," Gov. Doyle said in his veto message. "Approving a law that would be quickly overturned doesn't do anyone any good. Instead, I encourage all the interested parties on all sides of this issue to get together and figure out a responsible and lasting solution that has a real chance of being upheld by the Wisconsin Supreme Court."

The Wisconsin Supreme Court struck down the state's $445,775 cap on noneconomic damages as unconstitutional because it was set 'unreasonably low.'

An attempt to override the governor's veto failed in January.

Dr. Turney said she and her colleagues at the Wisconsin Medical Society are "concerned that the absence of caps" will hurt the state's "historically stable medical liability environment" and drive physicians out of state.

The Wisconsin Hospital Association reported that since the state Supreme Court struck down the cap last July, hospitals have had "greater difficulty recruiting physicians" and that damage awards and lawsuits have begun to rise.

In addition, officials at the state's Injured Patients and Families Compensation Fund, which is funded through mandatory premiums from hospitals and physicians, have proposed a 25% increase in annual fees. The proposal is under consideration, and if it is approved, would go into effect on July 1.

But Dr. Turney said she is optimistic that the state legislature will pass new legislation addressing the cap issue this spring. "Both Democrats and Republicans clearly want to see this issue resolved," she said.

—Mary Ellen Schneider

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