



## Citing Health Emergency, Senator Feinstein Urges Bush Administration to Solve Medicare Drug Foul-ups

January 13, 2006

**Washington, DC** – U.S. Senator Dianne Feinstein (D-Calif.) today charged that a series of bureaucratic foul-ups by the Bush Administration in setting up the new Medicare prescription drug program is creating a major health emergency in California and other states.

In a letter to Health and Human Services Secretary Michael Leavitt, Senator Feinstein noted that California officials have been forced to cover drug costs for 1 million elderly citizens, many of whom have been denied life-saving medications or charged exorbitant amounts because of glitches in the new federal prescription drug program.

**“It appears that the Centers for Medicare and Medicaid Services (CMS) and the ten prescription drug plans serving more than one million individuals dually eligible for Medicare and Medicaid in California are incapable of identifying these and other low-income individuals and communicating their enrollment status to pharmacies,”** Senator Feinstein said. **The result is a major health emergency in California, particularly for people with chronic and debilitating diseases who rely on multiple medications daily to keep them alive.”**

**“In my view, the State of California is absorbing a federal cost caused by incompetence,”** Senator Feinstein said. **“California is not alone. Fourteen states (Maine, New Hampshire, North Dakota, Vermont, New Jersey, Massachusetts, Connecticut, Arkansas, South Dakota, Illinois, California, Pennsylvania, Hawaii, and Rhode Island) have announced they will provide emergency funding to ensure residents in their states do not lose access to prescription drugs. Unless these significant implementation errors are fixed immediately, the new drug benefit amounts to a massive unfunded mandate. The Bush Administration must reimburse states, in full, for the costs they have absorbed due to faulty implementation which has resulted in hundreds of thousands of poor, vulnerable Medicare recipients being denied access to lifesaving and life sustaining drugs.”**

**The following is the text of the letter to Secretary Leavitt:**

January 13, 2006

The Honorable Michael Leavitt  
U.S. Secretary  
Department of Health and Human Services  
200 Independence Ave., SW  
Washington, D.C. 20201

Dear Secretary Leavitt:

I am writing you with serious concerns about problems that have arisen in California as a result of the implementation of the new Medicare prescription drug benefit. It appears that the Centers for Medicare and Medicaid Services (CMS) and the ten prescription drug plans serving more than one million individuals dually eligible for Medicare and Medicaid in California are incapable of identifying these and other low-income individuals and communicating their enrollment status to pharmacies. The result is a major health emergency in California, particularly for people with chronic and debilitating diseases who rely on multiple medications daily to keep them alive.

It is incomprehensible to me that problems such as identifying who is eligible for a low-income subsidy and what plan an individual is enrolled in and not having enough phone operators to staff 1-800-MEDICARE have not been worked out in advance of the start of the new prescription drug benefit. The problems with this program have so escalated in California that the Governor has just announced that he will provide emergency prescription drug coverage for five days to more than one million Californians who are dually eligible for Medicare and Medicaid. The California state legislature is expected to pass legislation next week extending this emergency relief for another ten days at a cost of \$70 million.

In my view, the State of California is absorbing a federal cost caused by incompetence. California is not alone. Fourteen states (Maine, New Hampshire, North Dakota, Vermont, New Jersey, Massachusetts, Connecticut, Arkansas, South Dakota, Illinois, California, Pennsylvania, Hawaii, and Rhode Island) have announced they will provide emergency funding to ensure residents in their states do not lose access to prescription drugs. Unless these significant implementation errors are fixed immediately, the new drug benefit amounts to a massive unfunded mandate. The Bush Administration must reimburse states, in full, for the costs they have absorbed due to faulty implementation which has resulted in hundreds of thousands of poor, vulnerable Medicare recipients being denied access to lifesaving and life sustaining drugs.

I have several questions I would like CMS to respond to:

- **What is CMS doing to speed up the issuance of prescription drug enrollment cards? What is CMS doing to ensure Medicare beneficiaries are reimbursed for premiums and co-payments they should not have had to pay? What is CMS**

**doing to prevent pharmacies from charging premiums and co-payments when individuals present proof of enrollment in Medicare and Medicaid?**

In California, it can take up to five weeks for a prescription drug plan to issue an enrollment card. This time lag is significant because dual eligible individuals can switch prescription drug plans without penalty within a given month. Those dual eligible individuals who have been automatically enrolled in a prescription drug plan and have not yet received an enrollment card or have recently switched plans and do not yet have an enrollment card are reporting that they are being charged premiums and co-payments even if they can show proof of being enrolled in both Medicare and Medicaid. This is also in light of federal law which states that these individuals should pay no deductible. Inappropriate cost sharing requirements is particularly worrisome for individuals living with HIV/AIDS given the high cost of antiretroviral medications.

- **What is CMS doing to correct problems with the electronic system used by pharmacists to communicate with CMS?**

Reports from California are that the electronic system by which pharmacists inquire with CMS about the enrollment status of dual eligible individuals has not functioned properly since it began on January 1, 2006. Pharmacists have had to rely on 1-800-MEDICARE and thus hours of wait times in order to obtain enrollment information such as the name of the individual's prescription drug plan and plan member identification number. In cases where CMS cannot provide the plan member identification number, the pharmacists must then call the respective drug plan's 1-800 number, waiting additional hours, to obtain that information so that the pharmacy can bill Medicare. The state of California reports that pharmacies lack sufficient staff or time to make these calls.

- **What is CMS doing to ensure plans comply with the 30-day one-time refill requirement and will CMS prohibit plans from requiring pharmacies to call them prior to the one-time refill of a beneficiaries' drug?**

All prescription drug plans must provide new enrollees with at least a one-time refill of drugs not on their plan's formulary. It appears that plans in California are not adhering to this one-time refill requirement. Instead, the plans are requiring that the pharmacy call the drug plan in each instance to request that the plan override its automatic denial of the drug since it is not on the plan's formulary. I am told that even when pharmacies have taken this cumbersome step, refill claims are still being denied by plans. I am extremely dismayed to hear reports of denied claims only thirteen days into this program's operation, especially given the time and resources drug plans have been given leading up to the start of the drug benefit.

- **When will CMS fix the lag time that occurs between when a low-income individual switches drug plans and when their enrollment information appears**

**in CMS's electronic database? What is CMS doing to ensure prescription drug plans know when a low-income individual has enrolled in their plan?**

I am told that CMS has reported a system error when a dual eligible (or other low-income) individual switches prescription drug plans which has resulted in drug plans erroneously telling pharmacies to charge them deductibles and co-payments. In some cases that is because the prescription drug plan does not know that the individual qualifies for a low-income subsidy. These are individuals who either have no income or have limited incomes. The result has been that sick and poor individuals have left pharmacies without necessary drugs because they can't afford them.

Lastly, I have heard allegations that prescription drug plans are not adhering to requirements that they make appeals forms available to both individuals living with HIV/AIDS and their physicians. Apparently, some plans are requiring a physician to request the appeals forms rather than providing them to individuals upon their request. Here again, if these allegations are true, I am disheartened that plans would not take every step to adhere to the law, especially given this program's infancy. I would ask that you look into these allegations and take every step necessary to ensure HIV/AIDS patients receive every protection guaranteed to them by law.

As a Senator who voted for the 2003 Medicare Modernization Act which created the new prescription drug benefit, I stand committed to ensuring this new benefit works and seniors, especially those with low incomes, take advantage of it. However, I am baffled by the problems that have occurred and believe that unless CMS takes immediate action to correct these implementation errors, this program will cause undue harm to millions of Americans.

Thank you.

Sincerely,

Dianne Feinstein  
United States Senator

cc: The Honorable Mark B. McClellan, Administrator,  
Centers for Medicare and Medicaid Services