US: New Medicare plan triggers health crisis for thousands

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The debut of the new Medicare drug plan has been a disaster for tens of thousands of seniors and other eligible participants. Starting from the first week of its implementation on January 1, the program was so riddled by confusion and incompetence that more than two dozen states were forced to take emergency action to pay for prescription drugs that people were not able to obtain by using the plan. Low-income beneficiaries were often overcharged or arrived at pharmacies to discover their old drug benefits had been cancelled, but were not listed as eligible for the new program.

"It's a major public health crisis. People are trying to get their drugs, and they can't get them," Jeanne Finberg of the National Senior Citizen Law Center (NSCLC) told *USA Today*.

The drug plan, Medicare Part D, calls for private insurance companies under contract from Medicare to provide drug benefits for Medicare recipients. A quarter of the 24 million people now enrolled in the plan are "dual eligibles," that is, people who qualify for both Medicare and Medicaid. Medicare is a federal entitlement program that provides health insurance for the elderly and those with certain disabilities, while Medicaid is a state-administered, federal health care program for low-income individuals and families.

These dual participants, who were automatically and randomly enrolled into private drug plans offered under the Medicare program, generally constitute the poorest and the frailest of health. According to *Time* magazine, more than 70 percent of these people earn less than $10,000 a year.

For those eligibles who were not automatically enrolled, the enrollment process was complicated by the multitude of plans tendered by various commercial insurance carriers. These numbered between 27 and 300, depending on where the beneficiary lived, with each plan offering access to a specific list of drugs and pharmacies. For example, Alaska, with only 53,000 eligible recipients, has almost 30 plans.

Further, many seniors who signed up for the drug benefit never received identification cards proving eligibility. Neither seniors nor pharmacists were easily able to reach Medicare offices and help lines or insurance company customer-service departments. In many cases, they were not able to reach them at all. Pharmacists were faced with filling a prescription on faith or sending a low-income customer away empty-handed. So acute are the problems with the plan that House Republican leaders are considering a proposal to extend the deadline for registering from May 15 to December 31. Medicare Part D was created under the 2003 Medicare Prescription Drug, Improvement and Modernization Act (MPDIMA).

"I got a letter a few months ago saying they were going to change my drug coverage from Medicaid to Medicare," Linda told the *WSWS*. "The information was confusing because I thought I had until May to pick a plan, but they just put me in a plan, RxAmerica. I got a letter from them saying I was enrolled, but they didn't send me any literature. I didn't know what drugs they would cover or if there was a copay.... I had to try to get information on the Medicare web site, and it was very confusing. I'm college educated and use the computer. When I tried to call the number on the site, I couldn't get through."

In a press release issued Tuesday, January 24, the NSCLC stated: "Already 20 states have taken emergency action, offering state-funded temporary drug coverage, in response to the grave problems beneficiaries have confronted in obtaining necessary prescriptions.

"Many dual eligibles have been unable to confirm their auto-enrollment or were simply not-enrolled, leaving them without access to prescription drugs when they go to pharmacies. Maine reportedly received 16,000 calls to its pharmacy help desk in the first half of last week."

Until January 1, Medicare never had a drug program, whereas Medicaid has always covered prescription drugs with minimal copayments of just a few dollars.

Over the last year, Medicaid officials, in promoting the new plan, had assured the program's participants that they would receive extra help to avoid paying any deductible and stressed that copayments would not exceed $5 per prescription. (Those not exempted by low-income status are subject to costs that approximate the government's model plan, that is, a $250 deductible, as well as a copayment of 25 percent of expenses up to $2,550. Between $2,550 and $5,100--an infamous "donut hole"--copayments shoot up to 100 percent of drug expenses, and thereafter settle at 5 percent of costs.) But many states are reporting that low-income participants have often been required to pay the full $250 deductible with copays far exceeding $5 or, in some cases, go without life-saving medication.

Further, advocates of the poor are concerned that the government is not reaching millions of additional Medicare recipients who do not receive Medicaid but may qualify for low-income subsidies. "Most of the people haven't been reached," Jim Firman, chairman of the Access to Benefits Coalition, told *USA Today*. The coalition

includes more than 100 non-profit groups seeking to attract low-income citizens into the program.

Severe hardship stories have been reported in the media since the start of the drug plan. Accounts such as the one covered in *Time* magazine are common. Tracy Patterson, 35, one of the 6.2 million people automatically shifted from Medicaid into Medicare Part D, has multiple birth defects, asthma and bipolar disorder. After the transition, she spent a week without medication, trying to figure out the new plan. She then learned that under the terms of the new policy, she would have to pay $308.68 for a month's supply of morphine, which she takes for chronic pain.

"I just flipped out," said Ms. Patterson. "First I was shocked, then I started crying. Now I'm just numb. I'm bipolar. I'm kind of getting depressed," she related. Upset over the thought of having to borrow money she can't pay back, Ms. Patterson angrily states: "Whoever voted this into policy was a bunch of jerks, and they never knew what it was like to live on a fixed income and have to have medication."

"You cannot speak to anybody at any help desk anywhere," Ed Derderian, who runs a small pharmacy in Dinuba, California, told *USA Today*. "Every insurance plan has set this up differently. We're just having nightmares trying to figure out how to bill them."

The NSCLC points out that while the Part D legislation requires that eligibles be given a "first fill," a temporary 30-day supply of medicine for the first month of the transition, in most cases the transition plans are not in place. "Many beneficiaries are being told by their drug plans that their drugs are not covered. They are not told about any transition plans or exceptions and appeals. Some are given a two, three or five-day supply, or nothing at all. Others are being told they must pay full price," revealed the advocacy group.

A little-reported feature of Medicare Part D relates to how the states pay back the federal government for the drug benefit. Under the new law, Medicare rather than Medicaid pays for the drug coverage of the dual eligibles. The amount of each state's reimbursement to the federal government is determined by a formula established by MPDIMA. Starting in 2006, these payments will make up the largest single source of state revenue going to the federal government. In deep financial crisis, some states have already begun trying to reduce the number of those who qualify for dual enrollment by tightening the restrictions for Medicaid reenrollment.

Problems with the drug plan are being blamed on pharmacists by some insurance companies that claim that pharmacies lack proper software or fail to carry out proper policies. Pharmacists say they have been hurt by the program, as many of them have been filling prescriptions for which they don't expect to be reimbursed by Medicare until early February. Art Whitney of Rockland, California, told *Time* magazine that he borrowed $500,000 to cover what he owes to his wholesaler. Complains Whitney: "I've been in business since 1987 and I've never borrowed a nickel."

The chaos and trauma surrounding the new drug plan's introduction represent far more than a few bureaucratic glitches that will in time be ironed out. That the ultimate aim of Part D is full-blown privatization of Medicare and Medicaid is demonstrated by the career paths of the two men most responsible for drawing up the legislation. Before Bush appointed him to oversee Medicare, Thomas Scully was a hospital industry lobbyist who infamously threatened to fire his chief actuary if he told Congress the truth about the massive cost for the drug program. As soon as the bill was passed, Scully, who had received an ethics waiver allowing him to negotiate prospective jobs with lobbying and investment firms, is now a lobbyist for the pharmaceuticals.

Representative Billy Tauzin, the bill's promoter on Capital Hill, left Congress with the passage of the bill to become president of Pharmaceutical Research and Manufacturers of America—the drug industry lobby.

According to Wednesday's *Wall Street Journal*, the new drug program with some 42 million eligible beneficiaries represents a golden opportunity for private insurance companies "at a time when the industry's traditional business—administering employer health benefits—is stagnant or shrinking."

Steve Brueckner, a vice president of the insurance carrier Humana Inc., gloated: "Basically 42 million people have been put in the marketplace and that won't happen again. If you don't get your fair share, you're going to be in trouble later on."

Not only does the Medicare drug benefit open up new markets for insurance companies, but the Bush administration is shouldering much of the risk. Under the program, each year, insurers submit bids based on their estimated costs to the federal government, which then calculates a national average and pays the insurer some 74.5 percent of that average. The government mandates that the carriers charge customers the balance between the government subsidy and the company's initial cost. If insurers spend more than the estimate, the government helps pay the excess. "The extra government payments mean there's little downside risk," states the *Journal*.

With all the onus on the federal government, there may be little risk for the private insurers, but plan recipients will be hard hit by rising drug costs. In a further tilt to big business, MPDIMA prohibits Medicare from negotiating lower drug prices from the pharmaceuticals or re-importing drugs from Canada, where prescription drugs are on average 50 percent less expensive.

The administration's privatization agenda continues with six major metropolitan areas set to introduce health insurance vouchers in 2010. In these regions, eligible participants will be given a dollar amount and have the choice of paying for Medicare or purchasing private plans. Meanwhile, Medicaid is also threatened. As the federal government moves to cut billions from the program, Florida under Governor Jeb Bush has gained federal approval for a Medicaid plan that substitutes government-guaranteed services with subsidized private insurance schemes.

President George W. Bush is expected to make the drive for privatizing Medicare and Medicaid a central element of his January 31 State of the Union address.