

Oversight of Medicare Part D Prescription Drug Plans

With the advent of Medicare Part D on January 1, 2006, Congress and the Bush Administration created a new structure to administer outpatient drug benefits for those on Medicare who decide to enroll. As a result of prohibiting the government from negotiating for the best drug prices on behalf of the 43 million eligible people on Medicare, the Medicare Part D program was placed in the hands of private health insurers.

This short policy brief describes the oversight of these newly-created private prescription drug plans, which are charged with covering needed medications for seniors and people with disabilities. Among the findings:

- The federal government has placed few resources in overseeing these new drug plans.
- The federal government is not providing data to the public on complaints about these drug plans
- Five of these plans are operating but not licensed in California; two are not licensed anywhere.

California has the opportunity to lead the way in filling one of the major gaps in the Medicare Part D program, most notably the lack of oversight over these prescription drug plans.

The New Private Prescription Drug Plans in Part D: Insurers, not the Medicare program, negotiate with drug companies, and each plan establishes its own lists of approved drugs, individual premiums, co-insurance, deductibles, coverage, customer service, and appeals processes. Also, some prescription drug plans operate as part of an established managed care business in California and some, called “stand-alone” plans, are offering an entirely separate prescription drug package.

The Problems Raised With These Private Plans: This has led to a bewildering array of plans from which beneficiaries had to choose by prescribed deadlines, with penalties for late enrollment. In addition, the clumsy conversion of each state’s Medicaid population (Medi-Cal in California) to Medicare Part D resulted in delays in getting drugs, higher beneficiary costs, and worse health outcomes for this very vulnerable population. The problems in the last year arose due to the confusion created by the complexity of the new program; computer problems that affected beneficiary eligibility and out-of-pocket costs; and the fact private prescription drug plans were ill-equipped to handle calls and questions and resolve problems. In addition, beneficiaries are now falling into the so-called Donut Hole—the gap in coverage where plans pay nothing but beneficiaries must continue to pay their prescription drug plan premium. This occurs after drug costs reach \$2250 and continues until they reach \$5100 when the private plan again begins to pay a percentage.

Minimal Federal Oversight: CMS will shortly announce the benefit packages for the plans that will remain in the program; reveal which plans will leave the program; and disclose the specifics of any new plans that will be offering benefit packages for the first time. Consumer and health advocates have been left to fill the information gap, assisting beneficiaries and caregivers in making informed decisions about choosing a Part D Plan.

CMS acknowledges there are great differences among plans, but has provided little information about those differences. In addition, CMS has undertaken minimal visible oversight of the plans at a time when the differences in plan performance could strongly influence plan selection.

Spotty State Oversight: States are authorized to license these new prescription drug plans. In 2005, California enacted AB1359(Chan), which attempted to make clear California's ability to license these plans, as the state licenses other health insurers. However, the Medicare Part D law attempts to limit state oversight, and gives the federal government broad authority to pre-empt it.

Findings: In reviewing the oversight of these private prescription drug plans, Health Access has learned:

THERE IS LITTLE FEDERAL ATTENTION OR OVERSIGHT ON DRUG PLANS

- **CMS has insufficient resources devoted to plans being regulated at the federal level. There are only two employees at CMS responsible for overseeing PDPs.** In addition, they must review quarterly financial submissions by all PDPs under contract to CMS as well as presumably undertake a more thorough review of plans not licensed in any state.
- CMS says that their data shows **complaints about PDPs run at the rate of two complaints per 1000 enrollees**, but there are considerable variations among plans.
- **CMS is not making public at this time any data regarding beneficiary complaints about individual plans, nor is it undertaking administrative sanctions or penalties.** Even though CMS has data to suggest that consumers are experiencing greater troubles with some plans more than others, that is not being shared with the public—which soon has to make decisions about which plan to join in the next few months.

SOME DRUG PLANS ARE LEFT WITHOUT ANY STATE OVERSIGHT

- There are five Prescription Drug Plans (PDPs) who are doing business in California who have applied for federal waiver of state oversight under the Medicare Part D program. **This means there are five plans operating without a state license in California.** Their consumer and business practices are not being overseen by either The California Department of Managed Health Care (DMHC) or The California Department of Insurance (DOI).
- **Two of the PDPs are not licensed in California and are not licensed in any state.** CMS stated that some plans have “no domestic license,” but implied some do business outside of the U.S.
- The five plans who have applied for the federal waiver of California licensing requirements **are only loosely overseen by CMS in the interim.** Those plans have until January 1, 2008 to submit proof to CMS of things such as financial solvency. During this time when CMS is monitoring the PDPs, it is possible for a plan to withdraw its state application for licensure, and then resubmit its application when circumstances are more favorable for its approval.
- **Significant numbers of Californians are enrolled in stand-alone drug plans that are not being overseen by state regulatory agencies:**

MEDICARE STAND-ALONE DRUG PLANS IN CA			
Drug Plans Doing Business But Not Licensed in CA	Licensed in Other Jurisdictions	CA Enrollment as of 4/27/06*	National Enrollment as of 4/27/06*
RX America	No Domestic License	14,100 (est.) ¹	214,400
Member Health	No Domestic License	25,300	924,100
SilverScript	TN	6,600 (est.) ¹	413,200
Wellcare	AZ, DE, DC, FL, HI, ME, MA, MS, NV, NY, ND, OK, PA, SC, SD, TX, UT, VT	136,100	849,700
Medco Health Solutions	FL, NJ	143,400 (est.) ¹	410,400
<p><i>*Latest enrollment figures available</i> <i>¹No California figures available on CMS website. Estimated figures obtained by subtracting other states' enrollment from national enrollment data</i> <i>Source: www.CMS.HHS.gov, confirmed by telephone with CMS, Baltimore</i></p>			

Recommendations: Given the minimal oversight of these new private Part D prescription drug plans at the federal level, it is crucial for California draw on its knowledge and experience with plans and insurers and to exercise its regulatory authority where appropriate.

*** As a Regulator:** The Department of Managed Health Care has clear regulatory authority over managed health care plans in California. The beneficiary concerns under Medicare Part D coincide with typical concerns for health plans in general. Even where federal vs. state regulatory responsibility is not entirely clear, DMHC has the established relationships with health plans and the expert knowledge to intervene on behalf of consumers on these same issues. California should not relinquish our role in California to help safeguard consumer rights, particularly in light of lack of aggressive oversight at the federal level.

Two significant measures have been passed by the California legislature to assist consumers. At the time of release of this policy brief, both bills are awaiting Governor Schwarzenegger's signature. In both bills, California policymakers have shown interest in creatively using the state's authority to provide some oversight to protect beneficiaries.

*** As a Purchaser & Provider: AB2667(Baca)** would allow California to use its ability as a purchaser of services in other lines of business (such as CALPERS, Medi-Cal, etc.) to penalize those companies with bad records.

*** As a Public Evaluator: AB2170(Chan)** would add prescription drug plans to the state's HMO report card, collecting information and publishing helpful data about the plans' quality, services, and access to care.

*This brief is done in coordination with **Health Access Foundation**, the statewide health care consumer advocacy coalition, and the **California Alliance for Retired Americans, the Congress of California Seniors, the Gray Panthers, and the Older Women's League of California**.. It was prepared by Elizabeth Abbott, Project Director, Health Access Foundation, who previously served as Regional Administrator for the Centers for Medicare and Medicaid Services, in the San Francisco regional office.*

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