



APPROPRIATIONS COMMITTEE

Public Hearing – House Bill No. 6365
An Act Concerning the State Budget

February 18, 2009

INTRODUCTION

The Center for Medicare Advocacy, Inc. (The Center) is a private, non-profit organization headquartered in Mansfield, Connecticut with offices in Washington, D.C. and throughout the nation. The Center provides education and legal assistance to advance fair access to Medicare and health care. We represent Medicare beneficiaries throughout the state, respond to approximately 7,000 calls and e-mails annually, and host two websites. The Center also provides written and electronic materials, education, and expert support for Connecticut's CHOICES health insurance, counseling, and assistance program, and provides a vast array of other services for Medicare beneficiaries throughout Connecticut and the United States.

PROPOSED CUTS TO PRESCRIPTION DRUG COVERAGE FOR LOWER INCOME OLDER PEOPLE AND PEOPLE LIVING WITH DISABILITIES

The Center for Medicare Advocacy has extensive experience working directly and through CHOICES with Connecticut's low-income Medicare Part D enrollees. The cuts to prescription drug coverage contained in the Governor's budget would be devastating to our clients. My colleagues at the Center and on Connecticut's Part D Coalition have testified about many of the proposed cuts already. I would like to focus on one proposed cut – the proposed elimination of state coverage of drugs not on a dually eligible's or ConnPACE recipient's Part D plan's formulary.

It is only by covering non-formulary drugs that the State can be assured that ConnPACE and dually-eligible individuals will continue to be able to access all medically necessary drugs that are currently covered by Medicaid and ConnPACE. The Department of Social Services has stated in defense of this proposed cut that it will not create an access problem because Part D plans are required to pay for medically necessary non-formulary drugs. This defense is extremely misleading. In order for beneficiaries to obtain coverage for non-formulary drugs, they must go through an Exceptions process. This process places a number of obstacles in the beneficiary's way to obtaining coverage for medically necessary prescription drugs.

First, it is unclear how Part D enrollees even learn of their appeal rights when coverage is denied at the pharmacy. Medicare regulations place the burden on the Part D plan to provide notice of appeal rights, not on the pharmacy. In fact, the pharmacy is not even required to provide the reason for the denial. Instead, each drug plan must arrange with its network pharmacies to either post at the pharmacy or distribute a generic notice that tells enrollees to contact the plan if they disagree with the information provided by the pharmacist.

In order for a beneficiary who has requested an Exception to prevail, s/he must obtain and submit a supporting statement from the treating physician. The law states that the treating physician must state that no other drug on the formulary is as effective as the prescribed drug and/or that there are adverse effects associated with the drugs on the formulary. The beneficiary will likely not know what the treating physician's statement should say and s/he will likely run into resistance trying to obtain such a statement from his or her physician because there is no reimbursement provided to physicians for preparing such statements. Also consider that a beneficiary may need to request an exception for coverage of several non-formulary drugs, each of which may have been prescribed by a different doctor, and you see what a beneficiary is up against.

If a beneficiary is unable to obtain a supporting statement from the prescribing doctor, the Exception request is automatically denied. If s/he is able to obtain such a statement, it is not determinative of the Exceptions request – it is only one thing that the drug plan considers.

It is important to note that under the current wrap-around procedures, if DSS pays for a non-formulary drug on a beneficiary's behalf one of DSS's pharmacy technicians is supposed to contact the prescribing physician and advise him of alternative drugs on the plan's formulary. If none of the formulary drugs are appropriate, the doctor is supposed to file for an exception. By DSS's accounts, this process is going well. If it is going well, why would DSS now want the burden for filing exceptions to be on ill-equipped older beneficiaries or those living with disabilities? If it's not going as well as reported, how could DSS expect older beneficiaries and those living with disabilities to fare any better than it has in pursuing these exceptions?

The fact is that the Exceptions process is burdensome even for those of us with many years of experience doing Medicare appeals. To place the burden of pursuing Exceptions on beneficiaries themselves is unconscionable. We urge you to reject the cuts to the State's wrap around of Medicare's prescription drug benefit.

I thank you for the opportunity to provide testimony on this matter and I am happy to provide further information and/or to answer any questions you may have.

Respectfully submitted,



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