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Medicare Drug Benefit Implementation Hearing
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Chairman Grassley, Senator Baucus, members of the Committee, I appreciate the privilege and opportunity to speak about Medicare Part D and how it is affecting my patients and pharmacy.

I am the co-owner of a small independent pharmacy in Kalispell, Montana that was established in 1981. There are about 32,000 people in Kalispell and the surrounding areas; we are 200 miles from the state capitol in Helena. Our pharmacy employs two pharmacists, my son and me, and two pharmacy technicians. There are five senior apartment buildings within three blocks of the pharmacy, and we serve primarily geriatric patients. In addition, we provide weekly medication box exchange for three assisted living facilities and the mental health center in our community. About ninety percent of our walk-in patients are elderly.

Medicare Part D has become a major factor in my pharmacy. I contracted with every company offering drug plans in Montana, so I could continue to serve my patients. I would like to address my concerns with this new benefit, in the following four areas: confusion among patients and pharmacists, education and outreach, coverage of dual-eligibles, and burden on pharmacists.

CONFUSION

The implementation of Part D has caused confusion and frustration for my patients. And it has caused confusion and frustration for me. This program doesn't need to be so complicated.

The frustration and confusion for my patients began last summer, when they started receiving information from insurance companies offering Medicare Part D coverage. With over 40 plans to choose from in Montana, my patients said they were scared and intimidated by all of the options. Many of my patients were not fortunate enough to have a family member help them through the process of deciding which plan was best for them. I work with the elderly every day, and this has been overwhelming for them. Bewildered by the complexity, some patients are choosing not to enroll.

Those patients who could make sense of the Medicare mailings faced new obstacles. They were instructed to check the internet to see if the coverage was appropriate for their individual situation. I question this approach, since the vast majority of my elderly patients do not have computers and cannot use the internet. Access to the information through the 1-800 Medicare number was not much better. The phone systems are automated, and many of my elderly patients are unable to navigate through them. Others had the ability to use the phone system but gave up because of long hold times.

EDUCATION AND OUTREACH

Despite this enormous confusion, there were few opportunities for Kalispell patients and pharmacists to get answers. Several meetings were sponsored by the state of Montana, by insurance companies and by senior citizen advocates to help the elderly make their choices and explain Medicare Part D. After attending these sessions, many patients came back to my pharmacy saying they were even more confused. Patients received different answers from different people. They had trouble understanding the literature that they received, and felt a lawyer was necessary to make heads or tails out of it.

On top of this complexity, elderly patients feared they would select the wrong plan. At educational events, patients were instructed to focus on the formularies and pick one that had their medications on the list. But patients found only some of their drugs listed on formularies, requiring patients to choose between medications.

Education for pharmacists wasn't much better. I heard of only one event sponsored by CMS to educate pharmacists, and that was in Billings, nearly 500 miles from my store. I could not attend this meeting, although I did send a pharmacy technician to a local educational event sponsored by an insurance counselor. This seminar did not help us serve our patients enrolling in Part D. But it did help us understand why our patients were so frustrated.

With little information coming from CMS or the insurance plans, I relied on my drug wholesaler to learn how to handle patient in Part D. For instance, in mid-December I called my software vendor to ask how I would determine patients' Part D drug coverage. It was only though this call that I learned about the E-1 transaction, which shows patient plan eligibility. I now use this system many times a day when trying to figure out a patient's coverage, but I had to learn about it on my own.

Over the last few weeks, drug plans have been my only source of information describing the administrative procedures that I must follow to provide drugs and submit claims. But this information is often incomplete. I recently received a notice that patients enrolling in Part D in late January wouldn't be in the system on February 1st. So the problems we heard about at the beginning of January are happening again.

PATIENTS WITH MEDICAID AND MEDICARE

Many of my patients have both Medicaid and Medicare . These "dual-eligibles" were automatically enrolled into the new drug plans as their drug coverage was shifted from Medicaid to Medicare. Unfortunately, these plans did not always meet patients' medical needs. I found many patients' medications were not covered by their plans.

Further complicating matters, information systems did not recognize these patients as dually-eligible. They could not afford the high co-pays that the system said they should be charged. I handled each patient on a case-by-case basis, and it required a huge time

commitment to sort out problems in drug plan data and information systems. Fortunately, we are a small pharmacy and we know all of our patients. So we were able to give them their medications on the spot. I cannot help but think of how many patients across the country must have gone without their medications. Now we are working through billing issues, trying to determine how we will be reimbursed.

FORMULARIES AND MAIL ORDER

I am very concerned for my patients because we are being forced to change their medications to match the formulary for their plan. By changing medication, I expect to see increases in physician visits, labs, and hospitalizations. This will increase costs to the program. Medicare should have a plan to track the costs associated with medication changes.

Some of the plans are offering the mail-order pharmacy, and I do not think that mail-order should even be an option for Medicare Part D. If patients are getting some medications from mail-order and others from local pharmacies there is no continuity of care. This lack of coordination between mail-order and bricks-and-mortar pharmacies increases the likelihood of adverse events and noncompliance. If a patient using mail-order pharmacy is hospitalized, it is very difficult for doctors at the hospital to get drug information when prescriptions are not filled locally. If patients need drug information about a medication and are using mail order, they must attempt to use automated phone systems. In contrast, local pharmacists are readily available to answer questions. The ordering process of mail-order is also difficult for the elderly. These patients have trouble remembering to order a medication before they run out, but if they order too soon the script will not be processed.

As a pharmacist I want to know how certain medications were picked for the formularies. An example is why is one plan using Zocor and another is using Lipitor. I would like to know why some formularies use a branded drug when a generic is available. This appears costly to the program.

PHARMACIES

As the program began on January 1st, it became apparent that the insurance companies were not prepared for the start. Patients had not received their cards or enrollment letters. When this documentation had been received, the information was often incomplete. Missing data included BIN numbers, group numbers, ID numbers and processor control numbers. When I tried to access through the E-1 system, patients would come back as not enrolled. I was not able to bill the appropriate plan

We have spent a tremendous amount of time on the phones with the different companies getting patient billing information or prior authorization to fill. We have been on hold to talk to a representative for as long as four hours before we were able to get through. In other cases, we were simply disconnected after hours on the phone. This is unacceptable.

Drug plans are sending out lists of the pharmacies associated with their plan. While I have contracted with every plan offered in Montana, my pharmacy is not on every company's list. As a result, several of my patients have come in very upset because they think they will have to change pharmacies. I tell my patients that I can fill for them even though I am not on the list. Insurance companies should not send only a partial list of in-network pharmacies. It should be all or nothing. Also, I think that it is totally unacceptable for the drug plans to co-brand patient insurance cards with Wal-Mart, Walgreens, or other chain drug stores. It is confusing to the patient, leading them to think that they can only go to those pharmacies.

The insurance companies have created problems on the business side of my practice. There is no "negotiation" between pharmacists and drug plans on reimbursement rates. If I am going to continue serving my patients, I am forced to accept the low rates offered by insurance companies. Plans are slow to pay claims, and my drug wholesaler requires that I pay for drugs much more quickly than the plans pay me. My pharmacy has over $45,000 in unpaid claims from Medicare Part D.

Pharmacist and pharmacy technician salaries are climbing because of the shortage of available personnel. I am not sure how long independent pharmacies will be able to stay in business with the low reimbursement rates.

CONCLUSION

I wish that before this program started on January 1st that Medicare and the insurance companies would have taken the time to truly consider the elderly. If the people setting up the program had thought about the needs of their own elderly parents, I am sure this plan would be different.

Chairman Grassley, Senator Baucus and Members of the Committee, thank you again for inviting me to appear before you here today. I will now answer any questions you may have.