Drug Benefit Draws Fire at Conference on Aging

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WASHINGTON — Delegates to the 2005 White House Conference on Aging made it clear that they weren't happy with Medicare's new prescription drug benefit.

Challenging administration claims that the benefit's tools were accessible and easy to use, delegates recommended that Part D be simplified to create one prescription drug program for beneficiaries.

The Medicare drug benefit was one of 50 resolutions chosen as the "top" issues on aging by the 1,200 delegates at the meeting. Delegates were then charged with drafting implementation strategies suggesting how these resolutions might be put into action.

Nearly half of the resolutions addressed health care issues, including Medicare and Medicaid, long-term care, and training health care personnel.

The new drug benefit is "clearly in line" with the principles of the White House Conference on Aging to promote the dignity, health, and economic security for current and future generations, Mike Leavitt, secretary of the Department of Health and Human Services, said in his address to the delegates.

"The benefit will be of immediate help to older Americans now," plus the next group of rapidly expanding aging Americans, the baby boomers, said Mr. Leavitt, who said he helped his own parents enroll in the drug benefit.

"By having the medicines they need, seniors will have the ability to live longer lives. They will save money, they will stay healthy, and they will have peace of mind that their savings will never be eroded because of prescription drugs," he said.

His remarks were a hard sell for the delegates, which included governors, members of Congress, and representatives from the National Congress of American Indians, national organizations, academia, business, and industry.

The main source of frustration has been the complexity of the plan, said Ellen Camerieri, a delegate from the Bronx, N.Y., and executive director of Riverdale Senior Services Inc. "Secretary Leavitt talked about how easy it is to sign up … and to get your family together to do it. But what if [you're an aging patient] and you don't have a family?"

In her own community, she said, there's a sense of "confusion and paralysis" over the drug benefit.

Opting into a new drug program under the benefit can be daunting, especially if a beneficiary has a Medigap policy that's not a union or government pension, "but a policy to help them bridge the gap between what Medicare covers and what the actual costs are. You have a vast number of seniors who have had a relationship with a policy, and now must decide whether to continue in the new version of that policy under Part D, or go to the [numerous] other odd policies [offered] within their state."

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Ellen Camerieri, a delegate from the Bronx, N.Y., said there's a sense of "confusion and paralysis" over the drug benefit.

Dr. Mark McClellan, CMS administrator, assured delegates that the agency is taking steps to ensure that there is not any lapse in drug coverage.

"For example, we have worked closely with states over the past year to obtain very high match rates between their enrollment information and Part D enrollment—match rates well over 99%," Dr. McClellan said.

The agency also has developed a process for a "point of sale" solution, if the beneficiary somehow has not been automatically enrolled in Part D. In addition, multiple efforts are taking place to provide counseling and assistance to beneficiaries, he said.

Seniors can ask, before they sign up for the plan, whether all of the drugs they are taking now are covered, and the agency has tools so that patients can find the lowest cost for a particular drug, Dr. McClellan said. Yet his praise of the new 800-MEDICARE customer service line evoked jeers from some delegates.

"He claims that every call was answered right away," said Steve Kofahl, a delegate from Seattle. But when one of Mr. Kofahl's employees tried to call the number to get information, that person "could not get through."

The problem is a patient has to be able to predict the future to know which plan he or she should sign up for, Ms. Camerieri said. Certain plans under the new benefit cover certain drugs and not others "and you might not be on a medication you'll be needing in 6 months" when you sign up, she said. There's a limited ability to change your plan without some penalty, she said.

Many in the health care field would like to think that Part D is for the people, Ms. Camerieri said. "But the underlying suspicion is that it was drafted to benefit the pharmaceutical and insurance companies who are the people putting together these plans," she said.

"We want Medicare—not the private insurance companies—to negotiate drug prices," agreed Marilyn Askin, a delegate from West Orange, N.J.

But Mary Watts, a delegate from Washington, questioned whether it is useful to even debate the issue. The delegates "are trying to fix something that was done 2 years ago," she said, referring to the Medicare Modernization Act of 2003.

Frustration toward the drug benefit was fairly reflective of the meeting's general tone. At one point, several delegates disrupted meeting proceedings to issue a petition to reinstate the "10% rule," which allows for discussion of resolutions not approved by the conference if 10% of the delegates agree on the merits of a proposed resolution.

Dorcas Hardy, chair of the conference's policy committee, said the delegates had ample time to review the resolutions before the meeting. As for the 10% rule, applicable to previous White House Conference on Aging meetings, "this is a different meeting," she said, adding that the conference organizers had the right to choose a new format.

Some delegates thought that the time taken up by speeches from administration officials and industry representatives could have been used toward the implementation sessions.

In particular, the delegates didn't get a chance to engage in dialogue with Secretary Leavitt or Dr. McClellan, Ms. Camerieri said. "The conference didn't offer much involvement except voting on a preselected list of items. This seems to be the opposite of what the White House Conference is supposed to be about—respect for your elders."

Others felt slighted that President Bush didn't make an appearance at this White House–sponsored event. Pedro Rodriguez, a delegate from Philadelphia, said, "We wanted to create a momentum, a platform for policy, but people were prevented from coming up with alternative strategies. We were not allowed to go outside of the box."

To perhaps put some muscle behind these implementation plans, delegates drew up language insisting that the White House recognize the work that comes out of the conference.

In the meantime, the delegates agreed to follow through on their own grassroots efforts and convene meetings to disseminate the recommendations. ■

Medicare Part D Could Affect Patient Assistance Programs

BY MARY ELLEN SCHNEIDER
Senior Writer

Some Medicare beneficiaries may still qualify for extra help in purchasing drugs through patient assistance programs, despite the new Medicare Part D drug benefit that started Jan. 1.

But pharmaceutical manufacturers that offer assistance will have to tread carefully to avoid running afoul of the federal antikickback statute, according to a special advisory bulletin from the Department of Health and Human Services' Office of Inspector General.

In the bulletin, Inspector General Daniel R. Levinson said that it would raise serious concerns if the manufacturer of a drug covered under the Part D program were to subsidize cost-sharing amounts for its product.

In the meantime, drug manufacturers that operate patient assistance programs do not need to rush to disenroll all their Medicare Part D beneficiaries. During the first year of the Medicare drug benefit, OIG officials will take into consideration whether the assistance program is taking "prompt, reasonable, verifiable, and meaningful steps to transition patients who enroll in Part D to alternative assistance models, such as independent charities."

OIG said the practice of pharmaceutical company–sponsored programs offering assistance to Part D beneficiaries could steer patients to particular drugs, increase costs to Medicare, provide a financial advantage over competing drugs, and reduce beneficiaries' incentives to use less expensive alternatives.

The OIG bulletin also raised questions about the practice of bulk replacement, in which drug makers donate their products to pharmacies, health centers, clinics, and other facilities.

Such programs would need to be evaluated on a case-by-case basis, according to OIG, but these arrangements could potentially violate the antikickback statute if the recipient of the free drugs is in a position to generate federal health care program business for the drug maker.

Alternative program designs could allow Medicare beneficiaries to continue to receive assistance. For example, a pharmaceutical manufacturer could donate its products to an independent, bona fide charity that provides cost-sharing subsidies for Part D drugs. This action would raise few, if any, concerns under the antikickback statute as long as the patient assistance program was not functioning as a conduit for payments by the drug maker and did not unduly influence beneficiaries' drug choices.

Patient assistance programs are also less likely to run into legal trouble if the patients are not receiving Medicare Part D benefits at the same time, OIG said. To prevent the potential for fraud and abuse in this case, the patient assistance program would need to notify the Part D plan that the drug is being provided so that no payment is made and the cost of the subsidized drug is not counted toward the beneficiary's true out-of-pocket costs. ■

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