Congress of the United States
Washington, DC 20515

January 23, 2006

The Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt:

The Bush Administration's implementation of the new Medicare prescription drug program has been beset with problems that have left some seniors unable to access prescription drugs important to their health. While we were pleased to see that CMS recently reminded plans of their "transition-supply" requirements, this step falls far short of a comprehensive response to address the litany of problems that have come to light since January 1. Indeed, many of the issues currently under discussion were identified in 2004 and 2005, and many were even included in comments on the proposed rules for Part D.

Millions of beneficiaries have faced serious problems during implementation, but consequences of the failures are particularly grave for dual-eligible beneficiaries who are enrolled in both Medicare and Medicaid. Concerns about their transition to a Medicare prescription drug plan were raised prior to the enactment of the law. While the program is voluntary and may provide additional assistance with the cost of medicines for *some,* this is not the case for dual eligibles who are the lowest-income beneficiaries and who are *required to enroll* in the program. Many low-income Medicare beneficiaries face *increased* out-of- pocket costs per prescription under the new Medicare prescription drug plan compared to the coverage they had previously under Medicaid, and they may be automatically enrolled in a plan that does not meet their needs. Many of these beneficiaries are also moving from medically necessary, affordable coverage under Medicaid to a variety of private plan choices with higher cost-sharing, tighter formularies or both. Dual-eligibles are the nation's most vulnerable population, as by definition they have very low incomes, almost no assets, are elderly and/or severely disabled. Not surprisingly, this is the group that appears to be having the most difficulty during the transition. As you know, more than 25 states have already stepped in to pay for essential medications where the private sector is failing. CMS's promise to simply "facilitate" state recoupment of funds from the private plans is painfully inadequate; this is a federal problem, and it demands a federal solution.

The broader population of seniors has also been harmed by the mass confusion and other problems with implementation. For example, some seniors signed up for plans based on information about which medicines the plan covers from the Administration's website, but are now learning that the medicine they need may not be covered at all or they must negotiate additional barriers to receive their prescription medicines. In addition, there have been instances

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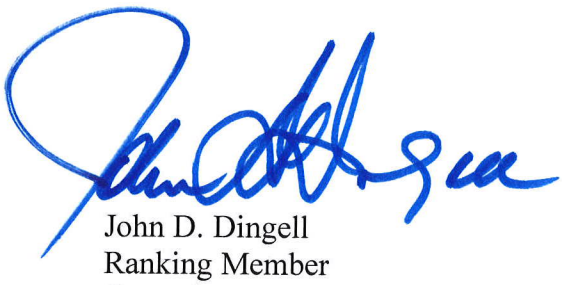
where beneficiaries have not received information to appeal denials of needed medicines, which they are supposed to receive from private plans, and, indeed, there seems to be no standard information on, clear notification of, or a process for appealing a denial that a senior receives at the pharmacy. Thus, seniors are unsure of what to do when they receive a denial and may be going without medicines. Finally, there is a lack of immediate and apparent oversight for even egregious problems, such as door-to-door solicitation, that are not permitted under the law.

Clearly, legislative solutions will be needed to address some of these matters. However, there is much more that can and must be done under your current authority to protect beneficiaries from being harmed and to ensure that the program works as best it can under the limitations of the statute. This includes taking steps to: (1) address data matching concerns with respect to dual-eligibles and other beneficiaries; (2) meet predicted surge capacity for customer and partner service via telephone and computer systems; (3) improve enforcement efforts and plan oversight and impose penalties when appropriate; (4) assure uniform minimum transition policies for all beneficiaries in all plans, (5) permanently assure access to all drugs in protected classes (6) establish and communicate standardized expeditious appeals and exceptions processes (7) require plans to maintain customer service for beneficiaries and pharmacies 24 hours a day/7 days a week/365 days a year, and (8) monitor aggressive sales tactics of the private plan sponsors that offer both drug plans and PPOs or other Medicare Advantage plans.

While there is no doubt that these issues are most acute now, many of these problems will persist as new beneficiaries enter the program, during open enrollment each year, and as Medicare beneficiaries move in and out of eligibility for Medicaid. More than $40 billion will be spent on this program in 2006, and the Administration and the Congress have an obligation to ensure that the money is used appropriately. The House of Representatives re-convenes on January 31, and we expect to hear from you by then with respect to your specific plans and timeline to address these problems and others that have already been identified. We want this program to work for the millions of people who will benefit from it and therefore raise these concerns about the structure of the program and its attendant flaws in good faith. We want to work with you to assure that every beneficiary who is enrolled or wishes to enroll receives the benefits to which he or she is entitled.

Sincerely,



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