

Take Two Aspirin and

Is the new Medicare drug mess a bureaucratic hiccup or the sign of a cost-conscious future?
TIME takes a look

By JYOTI THOTTAM

A MONTH AGO, TRACY PATTERSON WAS simply a woman with more than her fair share of sickness. With multiple birth defects, chronic pain, asthma and bipolar disorder, Patterson, 35, struggled to get by on \$832 a month in disability assistance. But at least one thing in her life was taken care of. California's Medicaid program paid for more than a dozen medications every month. "I always got my meds on time," she says. That changed on Jan. 1, when Medicare's prescription-drug benefit went into effect. Patterson was one of 6.2 million people automatically shifted into the program from Medicaid, and her story has become part of an urgent, nationwide call to fix what both Republicans and Democrats say was a botched transition to the controversial new plan.

Patterson says the abrupt switch has pushed her to the edge. She spent a week without medication, trying to figure out the new plan, called Medicare Part D, and then learned that under the terms of her policy, she would have to pay \$308.68 for a month's supply of morphine, which she takes for her chronic pain. "I flipped out," she says. "First I was shocked, then I started crying. Now I'm just numb. I'm bipolar. I'm kind

of getting depressed." Patterson sobs at the idea of borrowing money she can't pay back. "Whoever voted this into policy was a bunch of jerks, and they never knew what it was like to live on a fixed income and have to have medication."

Any policymakers who once might have glossed over her frustration as a side effect of sudden change are thinking twice. "Katrina showed government's failure to respond, and we can't afford those failures again," says Republican Senator Norm Coleman of Minnesota. A quarter of the 24 million people now enrolled in Medicare Part D are "dual eligibles," people who qualify for both Medicaid and Medicare. In other words, they are among the poorest and frailest people in the country. More than 70% of them make less than \$10,000 a year; 372,000 of them have Alzheimer's. Republicans realize that after Katrina, they

cannot risk another crisis in which the government appears to be abandoning its most vulnerable citizens. Some are already making that connection. Aniela Toscano, 56, a New Yorker living in a shelter, has run up \$885 in credit-card debt thanks to a brand-new bill for drugs and is worried that she can no longer afford her seizure medication. "What happened in New Orleans?" she says. "They let those people die. Why not us?"

Thankfully, no one is waiting for another slow-motion catastrophe to unfold. Governors of more than 20 states have pledged emergency funds to help people, at least temporarily, pay for drugs they are having trouble getting. Insurers say they expect to have any remaining problems fixed in the next two weeks, although patient advocates are skeptical. And in response to the bipartisan outrage, House Republican leaders are considering a proposal, initially suggested by Democrats, to extend the deadline for signing up for the new benefit from May 15 to Dec. 31, a House G.O.P. aide tells TIME. The difficult transition, though, is more than just a product of bureaucratic fumbling. It is a

CHANGE UP César Escobar, 75, right, discovers at a pharmacy in the Bronx borough of New York City that the new drug plan to which he was assigned doesn't cover some of his medications

PRESCRIPTION



WADING IN At the same drugstore, pharmacist Hemant Desai, left, spends hours talking to insurers, trying to help his customers navigate the complexities of their plans

STICKER SHOCK Carmen Gomez, one of Desai's customers, must now pay \$69 for each of eight drugs for, among other things, arthritis and migraines. She used to pay nothing

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RxGrp 788257
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significant step in the march of U.S. health care toward a free-market system governed by choice and risk. President George W. Bush is expected to make that movement a central element in his State of the Union address next week and to emphasize its promise. The patients, families and pharmacists caught up in Part D know its price, at least in the short term.

The fundamental goal of Medicare Part D is hard to argue with. Medicare has no drug benefit; Part D provides one. When Medicare was established in 1965 as a Great Society health-care program for seniors, prescription drugs were a minor planet in the universe of medical treatment. They now account for 11% of every health-care dollar spent. But more than a quarter of the 42 million people on Medicare had no drug coverage at all last year.

The law that was passed in 2003 is not really an expansion of Medicare, which is an entitlement with standardized care. Part D, although funded by Medicare, is actually private insurance, similar in design to high-deductible health policies that

shift more of the costs to members in an effort to make them more conscious of what they're spending. "People are used to it being an entitlement, but [Part D] wasn't the same sort of generous benefit that Medicare is," says David Scrase, president of Presbyterian Health Plan, a Part D provider in Albuquerque, N.M.

The array of selections available under Part D—

even Alaska, with only 53,000 eligible recipients, has almost 30 plans, all with different premiums, deductibles, co-pays and covered drugs—has bewildered seniors trying to choose. But that confusion is only part of what has gone wrong. The main reason for the problems of the past three weeks is that the vast majority of enrollees—20.4 million of 24 million—already had some kind of drug benefit, in many cases Medicaid, and were automatically switched to Part D. Their information had to make its way through several layers of private and public bureaucracy for the new system to work. Medicare allowed people to sign up for Part D until Dec. 31 for coverage on Jan. 1, but insurers couldn't process their enrollment cards fast enough to be ready by then. People eligible for both Medicaid and Medicare were assigned to plans randomly, in many cases to plans that did not cover the drugs they took. Insurers are supposed to cover 30-day emergency supplies of medicines that are not included in their plan, but many companies are stonewalling on fulfilling that guarantee. So many seniors have had to pay out of pocket for their drugs or go without. Medicare promised subsidies to poor people for their co-payments and deductibles, but insurers still do not have complete information on who is eligible for the extra help.

Some insurers blame pharmacists for

lacking the right software or failing to carry out stated policies, while pharmacists say Part D has been a disaster for them too. Many of them have been handing out prescriptions but don't expect reimbursements from Medicare until early February. That cash-flow crunch is putting some pharmacies in danger. Art Whitney of Rockland, Calif., borrowed \$500,000 to cover what he owes his wholesaler. "I've been in business since '87, and I've never borrowed a nickel," he says.

Why shift so many people, particularly those least equipped to handle a chaotic change, all at once into a system with so many moving parts? Health-care advocates have been asking that question for at least two years. In January 2004, the Kaiser Family Foundation, a nonpartisan health-care research group, published a report predicting that dual eligibles would be "overwhelmed" by a sudden change to Part D. The report of a Kaiser gathering of Medicaid directors from 11 states held last November to discuss concerns about the Part D transition reads like a screenplay for the horror stories that followed. "It wasn't that they didn't know," says Drew Altman, president of the foundation.

In an interview with *TIME* last week, Mark McClellan, administrator of the Centers for Medicare and Medicaid Services, said most people entered the new system without encountering trouble. He attributed much of the difficulty of those who did to the huge number of people who enrolled or switched plans at the end of December. Although assigned to plans, dual eligibles had the right to change by Dec. 31 to one that best suited their needs. The Medicare bureaucracy is still catching up with all that data, McClellan says. "Those are the

WAITING At another Bronx pharmacy, Rose Skrapitz, 78, near right, explains that weeks after enrolling she still has no insurance card



Prescription Drug Plan
re Plan
Copays
Generic: \$0
Preferred Brand: \$69
Non-Preferred Brand: \$69
CMS-55967037

issues that we're working through right now."

McClellan, along with the insurers, is closely watching whether the bad publicity from the start of Part D will affect enrollment. The pace of voluntary enrollment so far is picking up, with 2.6 million people signing up since Dec. 13. High enrollment is crucial to the program's success. Any insurance program relies on pooling the risk of a large group of people, and insurers that can't capture enough members will eventually have to shut down.

Any talk of turning Medicare into market share, of course, is catnip to Democrats, who are ready to use the Medicare mess against Republicans in the November midterm elections. Seniors tend to turn out for midterms in higher numbers than younger

people, "so there's a real opportunity here," says Democratic pollster Mark Mellman. The Democratic Congressional Campaign Committee is advising candidates to visit senior centers and press the argument that the drug benefit was written by and for the health-care lobby. Those candidates hope to point out, for example, that drug manufacturers lobbied to avoid negotiating drug prices directly with Medicare. Instead, Medicare provides funds to insurers, which use intermediaries called pharmacy benefit managers, who then negotiate with the drugmakers. That system breaks Medicare into smaller purchasing pools, and drugmakers get higher prices. Insurers, meanwhile, successfully lobbied for a provision that limits potential losses in the first two years.

Republicans insist that January's

Many on Medicaid were assigned to plans that don't cover the medicines they take

rough transition will be all but forgotten by November. And they will remind voters that Democrats were unable to get any drug benefit, however flawed, passed while they were in power. "Seniors would have nothing if it weren't for Republicans passing this plan," says Amy Call, spokeswoman for Senate majority leader Bill Frist. C.O.P. leaders have so far rejected the major changes proposed by Democrats, including allowing direct negotiation with drugmakers and easing the rules on reimportation of drugs from Canada.

They are taking seriously the bipartisan calls from states to be reimbursed for the tens of millions of dollars in emergency funds states have set aside to cover the gaps in Part D coverage. Health and Human Services Secretary Michael Leavitt spent last week on damage-control patrol, trying to placate anxious seniors and state lawmakers angry about footing the bill for Medicare's mistakes. Maine Republican Senator Olympia Snowe said Leavitt reassured her on Friday that the Federal Government would use its authority to compel insurance plans to reimburse the states directly. Maine has spent \$5 million.

Ultimately, the future of Medicare Part D will depend not just on Republicans or Democrats, insurers or drugmakers, pharmacists or health-care experts. It will hinge on the willingness of the millions of people eligible for Medicare to submit to this experiment in free-market health care. Americans could decide that the health of the old, the sick and the needy deserves a system separate from the one that rules whether Internet companies and T shirt makers live or die. But if enough people agree to endure the smaller upheavals that are sure to come, Part D gives them a drug benefit based on the American ideal of unlimited choice. Some plans will change their rules or increase their prices; others won't survive, and their members will again have to navigate a new plan. For those without any drug coverage at all, that may be a risk worth taking. —With reporting by Matthew Cooper, Eric Roston and Douglas Waller/Washington and Sean Scully/Philadelphia

5 Tips to Survive Medicare Part D

1. Get some help

The president of one Part D insurer, a physician, admitted that

he had trouble understanding the details of the new drug benefit, so don't be surprised if you feel baffled the first time you look at it. Ask social workers, your local pharmacist, senior centers or family members to help you understand the particulars.

2. Sign up early

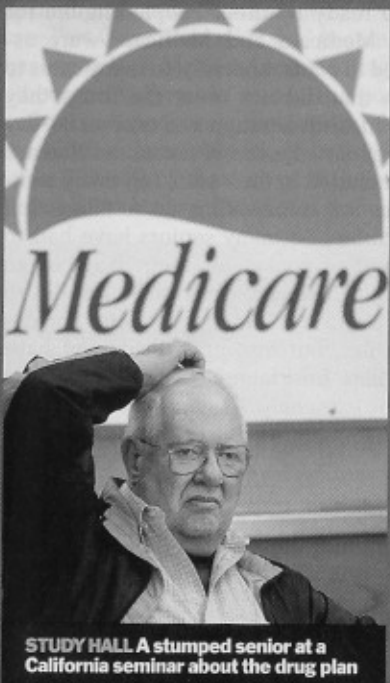
When you submit or change your enrollment in a plan, it can take two weeks to receive your card. Federal agencies and insurers are working through the start-up bugs and are still processing 2.6 million people who signed up after Dec. 13.

3. Know what you have

If you are enrolled in a Medicare Advantage plan that already has drug benefits, Medicare Part D automatically replaces your existing drug benefit. Don't sign up for Part D separately; you could risk losing your Medicare Advantage coverage.

4. Understand the doughnut

In most plans, once you hit \$2,250 in expenses, you will bear 100% of the cost of your drugs. That limit includes spending by you and the insurer, so you could fall into the so-called doughnut hole sooner than you think. Usually you get back onto the doughnut if expenses reach \$5,100, at which point insurance coverage resumes at 95% of drug costs.



STUDY HALL A stumped senior at a California seminar about the drug plan

5. Bring your paperwork

Low-income Medicare recipients whose incomes are nonetheless too high for Medicaid may gain the most from Part D. Subsidies are available for premiums and co-payments once Medicare determines, according to a complex formula, whether you are eligible for this help. Even if you are approved, your pharmacist may not have access to proof. So take your approval documents with you to the drugstore.