Testimony on

Implementation of the Medicare Part D Prescription Drug Program

By

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Mr. Chairman, Senator Baucus, and other members of the Committee, thank you for permitting me to testify about one of the most important benefits Medicare beneficiaries now receive – an outpatient prescription drug benefit. I am William Fleming, a pharmacist and Vice President of Pharmacy and Clinical Integration for Humana Inc. Humana is headquartered in Louisville, Kentucky. For more than twenty years, Humana has been serving Medicare beneficiaries through health plans that offer affordable, comprehensive health care coverage. We also offer private health plan options through the TRICARE program to military families, both active and retired; we offer plans to government employees through the Federal Employee Health Benefits Program, and, we offer plans to Medicaid recipients in Florida and in Puerto Rico. In total, today, we provide medical insurance to approximately 9 million members. We offer coordinated health insurance coverage and related services – through traditional and Internet-based plans to employer groups, government-sponsored plans and individuals.

I am pleased to talk about our participation in the new Medicare Part D prescription drug program. Humana has launched three, new stand-alone Medicare prescription drug plans in every state except Maine, New Hampshire, Alaska and Hawaii, and we are also offering coverage to beneficiaries in Puerto Rico. (Please see Attachment #1 for a description of these plans.) Each of these plans has the same formulary. This formulary contains all of the top 100 prescriptions prescribed for beneficiaries that are covered by Medicare. We have an open formulary, in that all FDA-approved medications covered under Part D are on our drug list.

Today, I look forward to talking to you about the great opportunity this new benefit is for Medicare beneficiaries, especially those who are low-income. This is an extraordinarily important benefit – 24 million Medicare beneficiaries have Medicare-supported prescription drug coverage either through plans or their employers. Tens of thousands of Medicare beneficiaries are enrolling every day, and many people with Medicare are experiencing lower drug costs. While this program is important for Medicare beneficiaries, today I will discuss our experience, including the challenges in program implementation, and, I will discuss some opportunities to improve the program.

OPPORTUNITY FOR MEDICARE BENEFICIARIES

As of January 13, there are more than 13.7 million Medicare beneficiaries who are receiving prescription drug coverage through either stand-alone Part D prescription drug plans or Medicare Advantage health plans. Today, over 2 million Medicare beneficiaries belong to a Humana prescription drug plan or a Medicare Advantage prescription drug plan, including over 600,000 dually-eligible beneficiaries. Over 600,000 of our members have enrolled through the CMS website or our Humana website.

Humana has contracted with more than 53,000 pharmacies, including all major chains, thousands of independent pharmacies, and long-term care pharmacies. We have a co-branded relationship with Wal-Mart to ensure maximum accessibility to beneficiaries, especially those who reside in rural areas. We have preferred arrangements with CVS, Rite Aid, Brooks/Eckerds and Albertsons. Our plans offer mail order, along with low premiums, broad formulary, and comprehensive health education programs. Other plans

have similar goals, and we are hopeful that more Medicare beneficiaries will sign up for this new benefit.

Since January 1, we have processed claims for nearly 8 million prescriptions. I wanted to share some specific success stories describing the true benefits of this new program:

William, from the State of Washington, wrote to our CEO: ". . .I read everything there was to read about the Medicare Rx plan, everything AARP wrote about it and spent hours at the Medicare website. The entire thing was a mystery to me. . .In desperation, I picked a plan that cost about what my drugs cost for a year and enrolled. . .online in late December. I promptly received an acknowledgement letter from Humana and a day or so later, my Humana card. I have used it twice already without any trouble. . .Yesterday I received the Summary of Benefits, Formulary, etc. Your summary of benefits does, in a single page column, what our great government has been unable to do for the last year, explain the plan. Your explanatory materials are complete, to the point, and easy to understand. . ." (For this beneficiary, we note that all our materials are reviewed by a nationally-recognized expert in beneficiary health literacy prior to submission to CMS for approval to ensure simplicity and ease of understanding by beneficiaries.)

The Idaho Statesman newspaper on January 9 carried a story that included the fact that Elizabeth Trudeau of Mountain Home, a low-income senior, got a prescription filled by showing the pharmacist her letter from Humana (she had not received her card yet) and was satisfied with her experience.

And from the Bloomington, IN, Herald Times, a retiree, Jack Tosti, is "ecstatic about his new prescription drug benefit. . . .Tosti said he used to pay $300 to $500 a month for several prescription medications and now—after having signed up for a Humana plan. . .he pays less than $50 a month for the same drugs. . ." 'I am as dumb as a box of rocks, but I went to Sam's Club and a guy explained it to me in 20 minutes. . .I wish people would stop whining and complaining. If they keep it up, the government might mess with the program and that would hurt me. . . .'"

For most beneficiaries and their families or caregivers, including low-income seniors, those with chronic diseases and those who are nursing home residents, this new prescription drug benefit provides savings and coverage relief. We hope that Congress works through the challenges presented these first 39 days of the program.

IMPLEMENTATION CHALLENGES

Humana and other Part D plans began preparing for implementation since enactment of the Medicare Modernization Act. In our case, planning and staffing were based on historical data we have acquired during more than 20 years of government program contracting. We increased the data drawn from our experience to reflect both increased membership and the unknown variables resulting from sweeping changes to the Medicare program. Our plans included: 1) Creating a consolidated Medicare operation with a dedicated Medicare focus (enrollment, calls and claims); 2) identifying and enhancing our systems, processes and procedures to support increased membership and new products; 3) increasing customer service staff from 210 in August to 975 employees

today—a 450% increase (customer service calls flow through two Humana call centers in Louisville, KY and Tampa, FL as well as through two U.S. call center contractors;

4) using outside contractors to help us respond to variations in staffing needs; and

5) developing detailed contingency plans for potential problems.

The Centers for Medicare & Medicaid Services (CMS) converted to a new information management system in November shortly before the launch of the annual enrollment period. CMS required PDP sponsors to test connectivity; CMS did not test end-to-end processing of file transmissions to CMS from PDP sponsors and vice-versa. Humana created its own test files following the file formats that CMS documented for each process to ensure we could process the new data files. Since we were unable to test our new files prior to production, changes had to be made after the program began. At the outset, we experienced errors in our pricing files and CMS provided immediate technical assistance. Additionally, there were, and continue to be, data issues surrounding subsidized beneficiaries.

The Part D program marks the first time that a new benefit under the Medicare program offers differing levels of subsidies to individuals based on income, institutional status and Medicaid eligibility. All of us have had to rely on data transmissions from various state and federal agencies to identify those beneficiaries who are dually-eligible or who qualify for a low-income subsidy or state pharmacy assistance wrap-around program benefits. CMS has had to rely on states' information, information from the Social Security Administration and internal information to reach out to low-income beneficiaries. This has proven to be quite a challenge since data is collected in various forms. Once the data is transmitted to CMS, it must flow to plan sponsors and other CMS vendors, who, in

turn, transmit that data to their vendors for pharmacies and others to process claims. Because of these data translation issues, many dually-eligible and low-income beneficiaries have experienced access to care issues. These issues increased both the volume of customer service calls and the length of each call. And, as previously noted, these issues caused us to have to reformat and or re-process data files once we received the information, causing processing delays.

CMS has been extremely responsive and has diligently worked with PDP sponsors to expeditiously resolve these and other program challenges, including access to care issues, predominantly driven by eligibility and subsidy data for dually-eligible and low-income seniors. When it became apparent that more needed to be done, we, along with all the other plans, worked with CMS to strengthen transitional policies to ensure that enrollees in our plans, including dual-eligibles and low-income seniors, receive their medications on a timely basis.

Understanding the potential impact of these and other start-up issues, we implemented an outreach strategy designed to address implementation challenges. We reached out to pharmacists, physicians, long-term care facilities, beneficiaries, community leaders, beneficiary counseling programs and CMS partners and various, related trade associations to educate those groups on pathways to smoother transition and to ensure program implementation barriers continue to be identified and addressed.

Largely due to data translation issues, but also related to benefit questions and administrative problems we encountered, we expanded our call center capabilities. In January, we experienced 40 calls per thousand members—50% higher than expected. The same situation occurred with respect to average length of calls. The actual call

length was 30% longer than expected. The combination of the volume of calls and the length of calls led to our implementing our contingency plans: we trained and moved staff from other areas of our service operations; we extended overtime hours; we prioritized calls related to access to care and eligibility issues; and, we used innovations in voice technology, including inbound call-messaging that contained answers to frequently-asked questions and other routine issues. Our call volume has decreased over the month as members' eligibility issues have been resolved and they have begun to understand and use their benefits. However, end-of-the-month enrollments for the next month caused initial February call volumes to increase due to eligibility issues. This week those volumes should also abate.

Let me talk about some specific implementation issues and how we and our partner, CMS, have worked together to address the issues outlined above:

Beneficiary eligibility information

As mentioned, there have been challenges in identifying dually-eligible beneficiaries and in determining eligibility for beneficiaries who qualify for low-income subsidies. The systems and standards used to transmit this data vary and cause end-users to experience data translation issues. (This is a key reason why Humana urges Congress to swiftly enact legislation that establishes a uniform interoperable health information system.) As an example of a work-around to a data translation issue, Humana noted that many pharmacies were having difficulty accessing the CMS eligibility system to determine member eligibility. Partnering with our claims processor, Argus, we built a "look-alike" telephonic system that replicates the eligibility system delivered via the TrOOP

Facilitator hired by CMS. Our system ensures that pharmacies receive real-time verification of eligibility and coverage at no cost and allows beneficiaries to receive their medications.

Pharmacy outreach

As discussed, Humana set out to develop a strong network of pharmacies--over 53,000 in total--including thousands of independent pharmacies. In fact, in some states, like my own, we have more independent pharmacies contracted than retail chains. We have established special call lines for pharmacists with real-time IVR messages to speed problem resolution or contact with live representatives. We issue regular pharmacy bulletins to all contracted pharmacies, long-term care pharmacies and pharmacy trade associations. We've fax-blasted 11 bulletins to date. State pharmacy associations are posting these bulletins on their web sites. We've reached out to 9 national pharmacy associations, 46 state pharmacy associations (all states in which we do business) and offered to participate in open door calls responding to local pharmacists' questions. We're working through calls to the top 50 pharmacies that fill our members' prescriptions in each state, and will have completed this initiative in 14 states, representing nearly 2/3rds of our prescription volume, by the end of this week.

We understand the need of all pharmacies, but especially independent pharmacies to be paid promptly. We pay pharmacies every 10 days and to date, have made three such payments totally over $330 million. Finally, we are working with our claims processor, Argus, to see if we can begin the process of paying pharmacies electronically, allowing physicians and pharmacies to refill online and perform other manual functions, electronically.

Finally, we are working through our trade association to try to standardize some of the forms and codes that we require pharmacies to use. We believe that this type of standardization can relieve pharmacies, especially independent pharmacies, of unnecessary administrative burdens, increase productivity and lower costs.

Transitional Policies

As CMS continues to work hard to address underlying systems issues, we understand that other Part D plans across the nation are taking strong measures – much like Humana – to promote a smooth transition for beneficiaries. For example, to meet the needs of the most vulnerable beneficiaries, sponsors have implemented expedited procedures and expanded teams of customer service representatives to ensure that dually-eligible and low-income beneficiaries receive the benefits to which they are entitled, including cost sharing support. Sponsors worked with CMS to develop transitional policies which include initial coverage for covered Part D drugs beneficiaries have been taking that otherwise would be subject to formulary rules. In addition, sponsors are working to ensure that beneficiaries and their providers have the opportunity to pursue exceptions before formulary rules take full effect. We have added transition periods to our agreements with CMS to smoothly move toward full implementation. These transitional policies are especially important for dually-eligible and low-income subsidy beneficiaries.

Let me describe Humana's transition policy:

- On January 1, 2006, Humana's transition policy provided for 30 day coverage of current prescription of a Part D covered drug for enrollees to consult their physician. As part of this policy, Humana sends a weekly letter to affected

beneficiaries providing them with information to share with their physicians to smooth the transition process the next time they need a refill.

- Long-term care facility residents receive coverage for 90-days.
- On January 26, 2006, Humana extended the transition period to 60 days from date of enrollment and long-term care facility residents continue to receive a 90-day transition period from date of enrollment.
- Last week, CMS announced that all sponsors must offer a 90-day transition period through March 31, 2006 for beneficiaries effective January 1; a 60-day transition period for beneficiaries effective February 1 and a 30-day transition period for beneficiaries effective March 1.
- Humana intends to maintain our more liberal transition policy as well as ensure that our members who enrolled on January 1 receive a 90-day transition period through March 31.

Call Center Staffing and Service Improvements

I've described above our increased staffing plans due to call volume and length of calls. Since August, we have increased call center workforce to more than 1,125 full-time employees (FTEs) who are dedicated to calls from beneficiaries, pharmacies and physicians. Over the next few months, that number will continue to grow as new service representatives complete training.

Our ability to effectively increase our call center staffing is tied to our ability to have well-trained staff. We require a minimum of 6 weeks of training for customer service representatives who respond to calls from members to ensure customer satisfaction. Representatives are expected to possess expertise in their professional area and are

trained to communicate with the Medicare population, understand the rules of the Medicare program, and fully understand our benefit and plan design.

We believe that increased call volumes are related to three issues: 1) beneficiary understanding of his/her Part D benefit and how it works; 2) data transmission issues with CMS related to eligibility; and 3) Humana administrative issues we encountered with beneficiary mailings and duplicate issuance of ID cards.

Part D is a new benefit for beneficiaries, and it will take some time for beneficiaries to understand how to use the benefit. While some calls are related to what benefits are covered and at what cost, the greatest number of calls have been from beneficiaries who are either dually-eligible or qualify for low-income subsidies. We have been working with CMS to resolve these issues and believe that issues relating to dual-eligibles have been largely resolved. We are working to resolve remaining low-income subsidy level data issues. We believe these issues will soon be resolved. We note that end-of-the-month enrollments will continue to cause a slight delay in entering subsidy information into the system.

Let me briefly describe the various call center phone lines we have in place and what we are doing to respond to the high usage of these lines:

Pharmacy call lines – Our claims processor, Argus, runs our Pharmacy Help Desk and responds to calls from pharmacies. These call lines, available 24 x 7, are equipped with both interactive voice technology for routine questions and live representatives to answer specific questions.

Physician call lines – We have a clinical hot line in place to assist physicians with coverage criteria, exceptions or authorizations. Over 30 percent of the calls

from physicians and pharmacists to this line concern whether a drug is covered under Part B versus Part D.

Beneficiary call lines – As discussed, we have increased FTEs to respond to requests by Medicare beneficiaries and have also implemented interactive voice technology if a beneficiary has a routine question that can be responded to quickly. As previously mentioned, we are adding staff as quickly as possible, ensuring that each person is adequately trained. We have separated our call lines in such a way that access to care and eligibility calls are first priority. During the last weeks of January, we averaged about 42,000 unique calls per day on our pharmacy and customer service lines. And, Humana's website, www.humana-medicare.com, received 500,000 hits per day from beneficiaries and their families seeking information on lower cost alternatives and drug information.

Like Humana, many Part D plans have added additional staff to handle the high volume of pharmacist calls during the start-up period. At the same time, plans have extended the hours of their customer service lines and have conducted outreach activities to ensure that pharmacists' questions are answered promptly.

BENEFIT PACKAGES IN THE PART D PROGRAM

We have provided each member of the Senate Finance Committee with the Part D prescription drug plans that Humana offers Medicare beneficiaries in your state. In addition, we have attached to this testimony our three general designs: *Standard*, *Enhanced*, and *Complete* coverage. These three designs offer Medicare beneficiaries with choices of premium and benefit coverage, and we worked to make these options easier to understand. The benefit structure in the law can be complicated, and all PDP

sponsors have worked to structure what they believe is best for Medicare beneficiaries. For example, Medicare beneficiaries have options in every state to select a plan that provides coverage during the coverage gap. We, too, offer such a plan.

One important development is that beneficiary premiums are much lower than Congress originally anticipated. According to CMS, the average premium for all prescription drug plans nationwide is $32.20 per month[1] – more than 15 percent lower than the $38 monthly premiums that were projected at the time the bill was enacted. Overall, beneficiaries in 49 states (all but Alaska) have Part D options with monthly premiums of less than $20. Humana offers plans below $20 in the states in which we operate, and as low as $1.87 for our Standard Plan in the region that includes Montana, North Dakota, South Dakota, Wyoming, Iowa, Minnesota and Nebraska. In addition, many plans have deductibles below the $250 maximum standard, including 58 percent of all stand-alone prescription drug plans that offer zero deductibles.[2]

Humana and other Part D prescription drug plans can offer quality coverage that is affordable to beneficiaries, because we have developed tools and techniques to reduce out-of-pocket costs for beneficiaries, improve quality by reducing medication errors and encourage clinically-appropriate drug use.

With regard to coverage of drugs, Humana made a business decision to have a single, broad formulary that covers all top 100 drugs used by seniors that are not excluded by the Part D requirements. The excluded drugs are those that are statutorily excluded from coverage, like benzodiazepines. We negotiate with drug manufacturers to receive the best price for covered prescription drugs. Besides making it simple for beneficiaries,

[1] CMS Press Release, August 29, 2005, Medicare Drug Plans Offer Premiums of $20 Per Month or Less Lower Deductibles, Enhanced Coverage Also Available.
[2] AHIP analysis of CMS data, November 2005.

physicians and pharmacists, we have early indications that our single formulary strategy may result in additional program efficiencies. At the same time, when a generic product is approved by the Food and Drug Administration, we make that product available to our beneficiaries. To ensure appropriate utilization, we have adopted four primary tiers for coverage of drugs, and have only adopted prior authorization (or step therapy) for a small number of drug categories, including proton pump inhibitors and Cox2 inhibitors. In addition, we have protections in place for certain categories of drugs, including monitoring the quantity of drug product dispensed on a monthly basis (i.e. dispensing limits).

A number of studies demonstrate that these strategies are highly effective in making prescription drugs more affordable for consumers. For example:

- A 2003 Lewin Group study[3] for the Center for Health Care Strategies found that Medicaid managed care plans reduced prescription drug costs by 15 percent below the level states would otherwise have experienced under Medicaid fee-for-service.
- In addition, the Government Accountability Office (GAO) has reported[4] that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

[3] Center for Health Care Strategies, January 2003, Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting.
[4] Government Accountability Office, January 2003, Federal Employees' Health Benefits: Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies (GAO-03-196).

These findings clearly demonstrate that the private sector has a strong track record of using its experience and capabilities to deliver affordable prescription drug benefits. At a time when federal resources are severely strained, it is important for policymakers to recognize the ability of health insurance plans to implement strategies that are enabling Medicare beneficiaries to receive the greatest possible value for the dollars the Medicare program is spending on their prescription drug coverage.

OPPORTUNITIES FOR IMPROVEMENT

There are many operational "lessons learned" about the complexity of offering a freestanding Part D prescription drug benefit to Medicare beneficiaries. I offer the following suggestions as to where we believe policy improvements can be made:

1. **Part B versus Part D drug coverage**. This is an enormous source of confusion for Part D sponsors, employer plans, pharmacies, physicians and beneficiaries. The same drug may be covered under Part B or Part D depending on the place of treatment or diagnosis. This means that Part D sponsors must evaluate each potential Part B coverable drug for whether it is Part B or Part D. Let me give you three examples:

   Medicare beneficiary with diabetes: The prescription products that this beneficiary need include a glucose monitor, a lancet, test strips, insulin, syringes, and alcohol swabs. The glucose monitor, lancet and test strip are all billed under Part B and subject to a 20% copayment. The insulin, syringes, and alcohol swabs are billed under Part D and subject to whatever the beneficiary's copayment requires.

*Beneficiary taking prednisone**:*** If an enrollee of a PDP plan is prescribed prednisone, then Humana must determine the diagnosis of the patient. If it is used following a Medicare-approved transplantation (e.g. kidney transplant), then this drug is covered under Part B and subject to a 20% copayment. If it is prescribed for anything else, it is covered under Part D. This product is a good example of a larger problem: that is, the administrative complexity of covering drugs in both Part B and Part D adds unnecessary costs and confusion into the system.

Beneficiary who is in a skilled nursing facility: Plans have received calls from nursing homes related to certain nursing home residents and their prescription drug coverage. Upon examination of these issues, we found that many were related to inhalation drugs. In the ambulatory population, these drugs are covered under Part B; however, in skilled nursing facilities, these drugs are now covered under Part D.

This confusion and concern over Parts B and D is a problem for Medicare beneficiaries who will be frustrated; a problem for PDPs who are working through the coverage criteria; and a problem for pharmacies that may have little experience in dispensing Part B products. CMS is working through some short and long-term approaches to clarify coverage under Part B and D; however, Congress needs to be mindful of the legal and technical issues we face.

2. **Enrollment timeframes**. The law and regulations permit Medicare beneficiaries to enroll or change enrollment up to the last day of the month with an effective date the first day of the following month. If a Medicare beneficiary enrolls in a plan on January 31, it is difficult, even with the most efficient systems, to have

that election effective on February 1. Humana is currently making outbound calls to beneficiaries who enroll at the end of the month, giving them directions on how to handle pharmacy needs the first of the next month. We also post such information on our web site. Through our trade association, we are working with CMS on alternatives.

3. **Reconciliation issues**. Along with our trade association, Humana and other sponsors are working with CMS to reconcile issues including coverage and beneficiary financial accumulators (such as true out-of-pocket costs and prescription drug costs). We're working with CMS to reconcile issues with states as it relates to low-income beneficiaries and we're working with CMS and other plan sponsors to reconcile issues as a result of beneficiaries switching plans and with other government agencies, including CMS.

While these policy areas are being examined, Humana will be taking additional steps to improve our service to our stakeholders using advanced call technology and website development.

CONCLUSION

Thank you again for giving me the opportunity to testify about this important new benefit for Medicare beneficiaries. Over the past 39 days, Humana has filled over 8 million prescriptions for Medicare beneficiaries. We have heard good stories about Medicare beneficiaries reducing their overall costs for prescription drugs. While CMS and all the plans have experienced operational challenges that include data translation issues and the need for more staffing than anyone ever anticipated, we have all reached out to our partners – pharmacists, physicians, long-term care

facilities, state and federal agencies and their partners as well as senior advocacy groups – to work in transitioning to a fully implemented new part D program. I encourage you to be vigilant in monitoring issues that affect your constituents and evaluate which of those issues need system-wide regulatory or implementation changes, versus case-by-case improvements. This program, the first major change in Medicare in over 40 years, has been operating for 39 days. While the first 39 days have had significant issues for some of our most vulnerable beneficiaries, operational and system fixes are in process and have our immediate attention. We urge you to give this program time to improve and to give beneficiaries time to adjust to a new benefit. We know from our initial experience that once a beneficiary has used his/her card, the process begins to work. Part D is an important benefit that Medicare beneficiaries need and want. We commend Congress for establishing this program, and we urge the Committee to support the program, ensure consistency and stabilization while recognizing the tremendous value it is providing to millions of Medicare beneficiaries across the nation.