



DUAL ELIGIBLES AND PART D:

CONSIDERATIONS FOR
FEDERAL AND STATE
POLICYMAKERS

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PREFACE

On January 1, 2006, the prescription drug benefit, known as Part D, was added to Medicare by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. With the addition of Part D, private insurers provide drug coverage for the more than 40 million elderly people and disabled individuals of all ages who are eligible for the federally funded health insurance program, Medicare. This change has critical implications for people of color. African American and Latino beneficiaries, who comprise significant portions of those eligible for Medicare, disproportionately have incomes below 150 percent of the federal poverty level and suffer higher rates of chronic illnesses and permanently disabling conditions (before age 65) than white beneficiaries. As a result, these individuals are especially vulnerable to changes in healthcare policy that may introduce obstacles to their receipt of the treatment they need.

This report addresses some of the significant concerns that have arisen as a result of the implementation of Medicare Part D. It focuses particularly on the population of low-income and/or disabled beneficiaries eligible for both Medicaid and Medicare whose drug coverage was shifted from Medicaid to Medicare. As the authors of the report document, the shift in drug coverage for dual eligibles has presented myriad problems for this population of the poorest and sickest individuals—in which African Americans and Latinos are disproportionately represented—including more limited coverage, organizational barriers to care, and lack of uniformity among the hundreds of prescription drug plans.

The many problems that dual eligibles and other Medicare Part D beneficiaries are encountering are not without solutions. This report offers a number of key policy recommendations to help policymakers at the state and federal levels address the situation into which Medicare Part D beneficiaries have been thrust by the new prescription drug benefit policy. These recommendations complement the other research that the Joint Center has completed on Medicare Part D, which has focused on assessing the knowledge and perceptions of African American elderly about Medicare Part D and on disseminating useful information about the new program. A summary of the major findings from our 2005 survey and a document detailing regional differences

in survey responses are available on the Joint Center's website (www.jointcenter.org). The Joint Center's website also provides useful information for people who might be signing up for or assisting others who are signing up for Part D.

This work reflects the Joint Center's commitment to providing analytical information and useful policy options on issues of concern to communities of color. It also supports the mission of the Joint Center Health Policy Institute "to ignite a 'Fair Health' movement that gives people of color the inalienable right to equal opportunity for healthy lives." The Joint Center thanks the W. K. Kellogg Foundation for its generous support, which made this publication possible. We also are grateful to Patricia B. Nemore, Diane Lewis, Alfred J. Chiplin Jr., and Jacqueline A. Bender for authoring this report. It is the Joint Center's hope that this publication will serve to support the efforts of health advocates and government agencies from the local to the federal level to ensure that Medicare beneficiaries—particularly dual eligibles, the most vulnerable population—receive the prescription drugs they need.

Margaret C. Simms
Interim President and CEO
Joint Center for Political and Economic Studies

INTRODUCTION

January 1, 2006, heralded a dramatic change in the delivery of health care to over six million of the nation's poorest and sickest individuals who are dually eligible for Medicare and Medicaid. On that date, these individuals ceased to be eligible for prescription drug coverage from Medicaid¹ and began to receive coverage from Medicare Part D,² coverage provided through hundreds of private plans to which these beneficiaries were randomly assigned.

For years, states had wished for this population's coverage to shift to Medicare. In FY 2004, expenditures for Medicaid were 16.9 percent of state general fund expenditures and were increasing at more than twice the rate of inflation.³ The exponential growth of Medicaid costs, fueled in part by the cost of prescription drugs, posed an increasing threat to state budgets in a time of declining revenues. Specifically, Medicaid-covered prescription drug costs for the elderly increased dramatically during the last decade and represented a growing percentage of state healthcare expenses. States therefore largely welcomed the Medicare Part D prescription drug benefit as a strategy to address their escalating costs and to reduce liability. States officials saw Medicare Part D as a way to shift from the state to the federal government costs related to the growth of a population that is living longer, with chronic illness and a continuing need for prescription drug and long-term care services.

However, the shift of drug coverage from Medicaid to Medicare for dual eligibles is not without financial and other costs to both states and beneficiaries. Under what the Medicare Part D law refers to as the "phased-down State contribution," colloquially known as "the clawback," starting January 1, 2006, states were required to make a monthly payment to the federal Medicare program. This payment goes toward the cost of their dually eligible Medicaid beneficiaries receiving prescription drug coverage under the Medicare program. For the most part, a state's payments reflect its per capita prescription drug costs for its dually eligible population in 2003, trended forward and applied to its current dually eligible population. The law includes a specific "clawback" formula that states are to use. Based on this formula, state costs, estimated at about \$6 billion for 2006, will rise to approximately \$15 billion in 2013.⁴

Beneficiaries lost several important protections that exist in Medicaid and are absent or optional in Medicare Part D. Medicaid's required universe of covered drugs is broader, and cost-sharing is optional and more limited than under Part D. Under Medicaid, co-payments generally must be waived if the beneficiary cannot pay. In addition, an emergency supply of drugs must be provided pending appeal.

Perhaps the most destabilizing aspect of Part D is that it allows plans to remove drugs from their formularies at any time during the year with only 60 days notice to enrollees taking the drug. This feature, together with the absence of Medicaid protections and other features of Part D, make the circumstances of dual eligibles precarious with respect to getting access to needed prescription drugs.

Because Part D's coverage is generally more limited than Medicaid's, states may find they have costs in addition to the clawback to the extent that they step forward to provide coverage needed to fill the gaps left by Part D.

As Part D implementation proceeds, policymakers must continue to evaluate the appropriateness of this shift from Medicaid to Medicare, including its impact on beneficiaries, on state budgets, and on the ability of states to ensure appropriate access to necessary prescription drugs for their low-income and vulnerable elderly and disabled populations.

Understanding the demographics and healthcare needs of the dually eligible population is essential to good decision making. This paper sets out such information for the Medicare population in general and for the dually eligible population in particular, describes aspects of Part D's structure and implementation that affect dual eligibles, and presents considerations and options for federal and state policymakers. Policymakers with an interest in minority health issues and health disparities should look especially closely at issues affecting the dually eligible population, since minorities are disproportionately represented among dually eligible beneficiaries. They are thus likely to be disproportionately affected by problems encountered by the whole group.

Persons Eligible for Medicare

Of the 41.8 million Medicare beneficiaries in 2002, 33.1 million are white, 3.9 million are African American, 3.1 million are Latino, and 1.7 million are of other racial and ethnic groups, including Asian/Pacific Islander and American Indian/Alaska Native.⁵ Further statistical findings show that:

- African Americans and Latinos make up 27 percent of Medicare’s disabled beneficiaries under age 65 and 15 percent of Medicare’s beneficiaries over age 65.⁶
- Sixty-four percent of African American and 62 percent of Latino beneficiaries have incomes below 150 percent of the federal poverty level (FPL), compared with 32 percent of white beneficiaries. (The FPL was \$8,860 for an individual and \$11,940 for a couple in 2002).⁷
- African American beneficiaries suffer from chronic illness at higher rates than whites—e.g., diabetes (30 percent vs. 18 percent) and hypertension (71 percent vs. 59 percent). Latinos have higher rates of diabetes (28 percent vs. 18 percent) and cognitive impairment (32 percent vs. 25 percent) than whites.⁸
- Permanently disabling conditions for Medicare beneficiaries before age 65 are more prevalent among African Americans and Latinos than whites. Twenty-six percent of African American and 19 percent of Latino Medicare beneficiaries are under age 65 and have a permanently disabling condition, compared with 12 percent of white beneficiaries.⁹
- More than a third of African Americans on Medicare relied on Medicaid for their prescription drug coverage prior to January 1, 2006.¹⁰
- Forty-three percent of African Americans and 37 percent of Latinos with Medicare lacked coverage for their prescription drugs for all or part of 2002.¹¹

In an examination of the profile characteristics of African American and Latino Medicare beneficiaries, it is important to note that the high incidence of poverty, chronic illness, and disability support the likelihood

THE DISPROPORTIONATE NUMBER OF MEDICAID DOLLARS DIRECTED TOWARD SERVING THIS POPULATION IS EVIDENCE OF ITS SIGNIFICANT HEALTHCARE NEEDS. OVER HALF OF DUAL ELIGIBLES ARE IN FAIR OR POOR HEALTH, TWICE THE RATE OF OTHERS IN MEDICARE, WHILE A THIRD HAVE SUBSTANTIAL LIMITATIONS IN ACTIVITIES OF DAILY LIVING, COMPARED TO 11 PERCENT OF OTHER MEDICARE BENEFICIARIES.

that they will be disproportionately represented in the dual eligible population. This conclusion is confirmed by data on dual eligibles, as noted below.

Persons Dually Eligible for Medicare and Medicaid

Dually eligible persons are low-income seniors and people with disabilities who are enrolled in both Medicare and Medicaid. They comprise a diverse population that nonetheless shares major health and well-being indices in common. Almost 6.2 million beneficiaries receiving full Medicaid services are dually eligible. (An additional 1.3 million beneficiaries receive limited Medicaid assistance with Medicare cost-sharing; this population is not the subject of this paper.)

In 2003, dually eligible persons represented 13.6 percent of the Medicaid population but 40 percent of total Medicaid spending.¹² Medicaid expenditures for those dually eligible included 66 percent for long-term care services; 14 percent for prescription drugs; 15 percent for other acute care services to supplement Medicare; and 5 percent of spending accounts for payment of Medicare premiums.¹³

The disproportionate number of Medicaid dollars directed toward serving this population is evidence of its significant healthcare needs. Over half of dual eligibles are in fair or poor health, twice the rate of

others in Medicare, while a third have substantial limitations in activities of daily living, compared to 11 percent of other Medicare beneficiaries.¹⁴

In 2002, the statistical picture revealed the following:

- Seventy-three percent of dual eligibles had incomes below \$10,000, compared to 12 percent of other Medicare beneficiaries;
- Almost two-thirds of dual eligibles are without a high school diploma;
- Dually eligible beneficiaries are disproportionately black and Latino, compared to other Medicare beneficiaries;
- Fifty-two percent have fair/poor health status, compared to 26 percent of other Medicare beneficiaries;
- Twenty-seven percent have diabetes, compared to 18 percent of other Medicare beneficiaries;
- Fourteen percent had a stroke, compared to 11 percent of other Medicare beneficiaries;
- Ten percent were diagnosed with Alzheimer’s disease, compared to four percent of other Medicare beneficiaries; and
- Nineteen percent reside in long-term care facilities, compared to three percent of other Medicare beneficiaries.¹⁵

Medicaid spending for dual eligibles is concentrated among younger beneficiaries with disabilities and beneficiaries over age 75. In 2001, data from Medicaid Statistical Information System (MSIS)¹⁶ outlined spending for dual eligibles by age and service as follows.

- For disabled dual eligibles younger than age 65, spending was \$28.3 billion, 61.5 percent of which was for long-term care services.

- For dual eligibles between ages 65 and 75, expenditures were 13.6 billion, 39.8 percent of which was for acute care services, while about 17 percent was for prescription drugs and 37.5 percent was for nursing home care.
- For dual eligibles ages 75 and over, spending was 43 billion—more than half of all spending on dual eligibles. 81.6 percent of that amount went to long-term care and 18.4 percent was for acute care services, half of which was spent on prescription drugs.¹⁷

THE FUNDAMENTAL STRUCTURE AND DESIGN OF THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT RAISE THE QUESTION OF WHETHER IT HAS IMPROVED ACCESS TO CARE FOR THOSE WHO MOST NEED IT: A POPULATION WITH A GREATER INCIDENCE OF ILLNESS AND DISABILITY.

Access-to-Healthcare Concerns for Dually Eligible Beneficiaries

While the following data reflect beneficiaries’ self-assessments, they nonetheless suggest that dually eligible persons may have greater difficulty accessing some of the care they need than other beneficiaries.

In two surveys administered by the Centers for Medicare & Medicaid Services (CMS), the Consumer Assessment of Health Plans (CAHPS) and the Medicare Current Beneficiary Survey (MCBS),¹⁸ beneficiaries assessed their own care. When asked the question, “Did you usually or always get care as soon as you wanted when you needed care right away?” 88.1 percent of dual eligibles answered positively, as opposed to 90.3 percent of the Medicare-only beneficiaries. When asked the question, “Did you usually or always get an appointment for regular or routine care as you wanted?” 86.5 percent of dually eligible persons answered positively, as opposed to 90.7 percent of the Medicare-only beneficiaries. However,

when responding to the question, “Do you have one person you think of as your personal doctor or nurse?” 84.0 percent of those dually eligible responded positively, while 74.6 percent of Medicare-only beneficiaries responded positively.¹⁹

Further indications that access to care disproportionately affects dually eligible persons, and African Americans in particular, emerged from a study by M. Niefeld and J. Kasper published in June 2005. The study examines data from six states of 2,128 community-resident Medicare beneficiaries ages 65 years and older who were continuously enrolled in Medicaid for the previous 12 months. Their findings include the following:

- Overall, 33 percent of elderly dual enrollees who needed a service experienced an organizational, geographic, or financial access-to-care barrier. Only six percent experienced financial barriers, while 14 percent had geographic barriers, and 29 percent experienced organizational barriers.²⁰
- Following a pattern found in many other studies, elderly dual enrollees who were African American were more likely to experience barriers to obtaining needed services.²¹
- Results also indicate that organizational²² and geographic barriers to receiving care disproportionately affect African American elderly dual enrollees compared to other dual enrollees.²³

Data relating to organizational barriers to care are especially relevant to Part D since the structure and design of the program is extremely complex and requires each beneficiary to take multiple steps to ensure access to all needed prescription drugs.

When access to care comes into question in the initial implementation of a major program like the prescription drug benefit, supporters seek to dismiss it as a “minor glitch” and “incidental” to the major benefit. The fundamental structure and design of the

Medicare Part D prescription drug benefit, however, raise the question of whether it has improved access to care for those who most need it: a population with a greater incidence of illness and disability.

The complexity and lack of uniformity of the program place dually eligible beneficiaries at risk and prevent them from effectively advocating for their care. Moreover, Medicare Part D exacerbates what is already fragmented healthcare delivery, given that it is a system in which different rules on coverage, payment, and provider certification leave us with more of a labyrinth than an integrated system of health care.

Questions raised for dually eligible beneficiaries trying to navigate Part D include how to determine which plan is best suited to their prescription drug requirements, how to change plans if they have been auto-enrolled in one that does not meet their prescription drug needs, and how to navigate the maze of “prior approvals” or “exceptions” for physician-prescribed medications.

Random Auto-Enrollment

To avoid loss of prescription drug coverage, dually eligible beneficiaries needed to enroll in Medicare Part D by December 31, 2005. If they did not select a plan, beneficiaries were auto-enrolled by the Center for Medicare & Medicaid Services (CMS) into a Part D plan with a premium at or below the average for their region.²⁴ When more than one such plan exists, CMS randomly assigned beneficiaries to one of those plans.²⁵ As the program continues, newly dually eligible beneficiaries will also be randomly assigned to plans. Significantly, a dually eligible beneficiary retains the right to switch plans at any time, and thus has the flexibility to switch plans where an auto-enrollment has resulted in an assignment to a prescription drug plan (PDP) that does not cover necessary prescription drugs. This is discussed in more detail below.

Randomly assigning Part D plans is beneficial to the plans, especially at the initial roll-out of the benefit, since it guarantees them an equal portion of the enrollment of the dually eligible population without burdening any of them with too large a portion. But because random assignment includes no effort to match individuals to plans that best serve their needs, it does not benefit beneficiaries, except to ensure that they have *some* coverage rather than none.

Formulary Limitations

Under the random assignment system, dual eligibles have been assigned to plans whose formulary may not include some or all of their drugs or whose pharmacy network does not include their pharmacies. The Office of the Inspector General (OIG) of the Department of Health and Human Services examined the 409 plans into which dual eligibles have been randomly assigned.²⁶ Analyzing the 37 unique formularies (some

plans used the same formularies as other plans) used by the 409 plans, the OIG determined that only about one-fifth of dual eligibles (18 percent) were assigned to PDPs whose formularies include all 178 of the most commonly used drugs. In contrast, one-third of dual eligibles (30 percent) were assigned to plans that included less than 85 percent (151 or fewer) of those drugs.²⁷

Significantly for the African American population, the OIG found that certain drugs are more commonly absent from plan formularies. Specifically, 21 drugs were omitted from at least a quarter of all plan formularies. All of these were single source drugs, for which there is no generic equivalent. Six of the drugs are for treatment of high blood pressure,²⁸ a condition that occurs disproportionately among African Americans.²⁹

UNDER THE RANDOM ASSIGNMENT SYSTEM, DUAL ELIGIBLES HAVE BEEN ASSIGNED TO PLANS WHOSE FORMULARY MAY NOT INCLUDE SOME OR ALL OF THEIR DRUGS OR WHOSE PHARMACY NETWORK DOES NOT INCLUDE THEIR PHARMACIES.

In its review, the OIG looked only at which drugs are included in the formularies; it did not analyze formularies with respect to the use of utilization management tools such as prior authorization, step therapy, or tiered co-payments—tools that can have an adverse impact on access to necessary drugs.

Special Enrollment Periods

As noted above, to avoid remaining in an ill-fitting plan, a dual eligible can choose a different plan at any time. This is because dual eligibles, unlike most other Medicare beneficiaries, have an ongoing Special Enrollment Period (SEP) that allows them to change plans on a monthly basis, with coverage effective the following month.³⁰ This is a significant protection for dual eligibles, both because they may be randomly

assigned to a plan that does not suit them and because plans can change their formularies at any time during the year.³¹

Choosing a Plan

Too Many Plans from which to Choose

The process of changing plans, however, has its own challenges and is not without perils. First, changing plans requires choosing a new plan, and this can be a daunting process. Each region has at least 40 stand-alone prescription drug plans (PDPs); depending on the region, between 6 and 18 of those have premiums at or below the benchmark.³² Factors for beneficiaries to consider in choosing a plan include the following:

- The specific drugs covered by the plan (“formulary”);
- The specific strengths and dosage forms of drugs listed on the formulary;
- The utilization management tools (such as formularies, tiered cost sharing, prior authorization, and step therapy) used by the PDP;
- The transition process used by the PDP;
- The exceptions process used by the PDP; and
- Whether the beneficiary’s pharmacy (or the one used by the facility in which an institutionalized beneficiary resides) participates in the PDP.

Using the Internet in Making Plan Choices

Choosing the most suitable plan thus requires a comparison of formularies, pharmacy networks, and other salient features of each plan, a task best done with access to CMS’s plan finder tools on the Internet.³³ However, few older people, and proportionately even fewer dual eligible beneficiaries, are Internet users.³⁴ Among those who are, fewer still are African Americans.³⁵

A study by the Kaiser Family Foundation found that among seniors, the Internet is least used by seniors with incomes *below \$20,000* (15 percent).³⁶ Nearly 75

percent of dual eligibles have incomes below \$10,000. Only 18 percent of seniors with a high school diploma or less education use the Internet; about 65 percent of dual eligibles have no high school diploma. Twenty-one percent of all seniors have gone online for health information, but over a nine-month period in 2004, only between two percent and eight percent of all seniors used Medicare.gov, the website that houses the Part D decision-support tools.

A study by the Pew Internet & American Life Project shows that Internet use was much lower among African American seniors (11 percent) compared to white seniors (22 percent) in 2003.³⁷ This disparity exists across all age groups, but is most stark among seniors. Pew also found, as the Kaiser survey confirms, that Internet use is lower among seniors with less education and lower incomes.

As a result, older people must rely either on incomplete information sent by CMS through the mail or on assistance provided by family, friends, or organizations designed to provide such help. The process is time-consuming and labor intensive, and the organizations providing this kind of assistance have been stretched thin by assisting so many people both with enrolling and in obtaining their medications.

Effectuating Enrollment in the New Plan

The complex design of Part D requires time-consuming multi-agency information sharing to complete the enrollment process. Information is passed from the plan to CMS, back to the plan, back to CMS, and finally to a CMS contractor whose job is to track all plan transactions with respect to beneficiary out-of-pocket spending. If a beneficiary changes plans late in one month and has to fill a prescription early the following month, she may find that the pharmacist has no information on her plan enrollment for billing purposes and she may be required to pay out-of-pocket. Such a requirement may be nearly impossible for dual eligibles and may instead result in their going without a prescription drug.

Potentially Ephemeral Salutary Effects of Choosing a New Plan

Because Part D plans are permitted to change their formularies at any time during the plan year, with 60 days' notice to affected enrollees, even the most intelligent, thoughtful, and well-timed selection of a new plan does not guarantee the beneficiary access to all necessary drugs for the duration of the year.

Additional Formulary Issues

Excluded Drugs

Certain categories and types of drugs are excluded entirely from Part D coverage.³⁸ While they might be covered by some PDPs as part of an enhanced benefit, for which an additional premium is required, they will not be covered by any plan into which a dual eligible is auto-enrolled. The Inspector General's study found that 22 of the 200 drugs most commonly used by dual eligibles are excluded from Part D coverage.³⁹ Twelve of these are non-prescription drugs, five are benzodiazepines (for anxiety and insomnia, among other indications), three are prescription vitamins, one is a barbiturate, and one is a prescription cough or cold remedy.⁴⁰

Because state Medicaid programs can continue to cover drugs excluded by Part D and receive federal funding for such coverage, dually eligible beneficiaries may be in a better position than other Medicare beneficiaries with respect to these drugs. But since states are not required, but merely permitted, to cover the drugs, access to these drugs for dual eligibles will depend on choices made by individual state Medicaid programs. For 2006, most states are covering all excluded benzodiazepines and barbiturates and most states are covering at least some drugs in each of the other categories.

Alabama, for example, with 23 percent of its Medicare population also eligible for Medicaid⁴¹ and a high African American population,⁴² will cover at least some drugs in all excluded categories except cosmetic drugs.⁴³ Similarly, California, which has over a million dual eligibles (comprising 24 percent of its Medicare population, a high proportion of whom are Latinos),⁴⁴ will cover all benzodiazepines, barbiturates and weight

FOR DUALLY ELIGIBLE BENEFICIARIES, ACCESS TO DRUGS THAT ARE EXCLUDED FROM PART D DEPENDS ON THEIR STATE OF RESIDENCE. AT LEAST 11 STATES, FOR EXAMPLE, WILL NOT COVER PRESCRIPTION VITAMINS, EVEN THOUGH THEY ARE THREE OF THE TOP 200 DRUGS USED BY THIS POPULATION.

drugs, and some over-the-counter prescription vitamins and prescription cough and cold remedies.

For dually eligible beneficiaries, access to drugs that are excluded from Part D depends on their state of residence. At least 11 states, for example, will not cover prescription vitamins, even though they are three of the top 200 drugs used by this population.

The impact of plan formulary limitations and excluded drugs on low-income persons may be more severe in the American South, given demographic concentrations. Current statistics reveal that in 2002-2003, the South contained seven of the eleven states in which more than 13 percent of Medicare beneficiaries live below the federal poverty level. In Texas and the District of Columbia, 17 percent of Medicare beneficiaries lived below the poverty level.⁴⁵

Categories of Drugs Mandated by CMS

Based on research about usage of certain categories of drugs, CMS directed that in 2006 plans must include in their formularies all or substantially all drugs in the following six categories: anti-psychotic, anti-depression, anti-convulsive, anti-cancer, anti-retroviral, and immunosuppressive.⁴⁶ These drugs, moreover, cannot have any utilization management tools, such as prior authorization or step therapy, attached to them for beneficiaries stabilized on the drug at the time of plan enrollment,⁴⁷ although plans can use such "tools" for a beneficiary who later starts taking the drug (except for anti-retrovirals). This requirement is an important protection for users of these drugs, which often require intensive monitoring and adjusting to get combinations and dosages correct. CMS has issued final guidance with similar protections for 2007.⁴⁸

Transition Processes

Transition policies govern both the initial start-up of Part D in January 2006 and any time a beneficiary newly joins a plan. Every plan must have a process to address the needs of new enrollees who are using medications not included on the plan's formulary.⁴⁹ Dually eligible beneficiaries who are auto-enrolled into a plan are explicitly identified as a population needing attention.⁵⁰ Plans have the flexibility to design their processes, and most of CMS's guidance is suggestive rather than prescriptive. For example, for 2006, CMS recommends, but does not require, that plans consider filling a temporary one-time supply of the non-formulary medication: 30 days for those in the community, 90-180 days for residents of long-term care facilities taking multiple medications.⁵¹

INABILITY TO GET A TRANSITION SUPPLY OF NON-FORMULARY DRUGS OR DRUGS REQUIRING PRIOR AUTHORIZATION CREATES SPECIAL HARDSHIPS FOR DUAL ELIGIBLES, WHO GENERALLY CANNOT AFFORD TO PAY OUT OF POCKET WHILE REIMBURSEMENT ISSUES ARE BEING RESOLVED.

The result of this *laissez-faire* approach by CMS is that each plan's process is different, and beneficiaries and pharmacists are experiencing difficulty in using them. Inability to get a transition supply of non-formulary drugs or drugs requiring prior authorization creates special hardships for dual eligibles, who generally cannot afford to pay out of pocket while reimbursement issues are being resolved. In February 2006, after a rocky beginning for dual eligibles in Part D, CMS called on plans to voluntarily extend their transition through March 31.⁵² For 2007, CMS issued final guidance requiring specific transition processes, including a guaranteed 30-day supply of non-formulary drugs, without any utilization management tools applied to any drugs.⁵³

Plan Exceptions Process

The Medicare Modernization Act requires that all PDPs establish an exceptions procedure. Medicare beneficiaries may use these procedures under various circumstances to try to persuade the plans to provide them with a prescription drug that is not otherwise available (on the plan's formulary) to plan members.⁵⁴ For example, a beneficiary may use the exceptions process to try to get coverage for a necessary non-formulary drug or for particular strengths or dosages of necessary prescription drugs or to get relief from co-payments at a high tier.

Although the PDP must grant an exception "whenever it determines that the non-preferred drug for treatment of the enrollee's condition is medically necessary," each PDP establishes its own procedures for making that determination. In all instances, the rules require that a resident's physician provide an oral or written statement that all of the covered drugs on any tier of the formulary would either not be as effective for the beneficiary as the requested drug or would have adverse effects on the beneficiary, or both. It is up to each PDP to decide whether it will require written statements and written follow-up information from the physician.

Beneficiaries are experiencing resistance from physicians who find the plans' exceptions processes burdensome. Heavy documentation requirements are discouraging physicians from filing or supporting beneficiaries' requests for exceptions. In addition, some physician groups are beginning to explore the possibility of charging their patients or the Medicare program (if legally possible) for this additional level of physician support. While efforts are underway in the provider and advocacy communities to advocate for a standardized exceptions process, at this writing the process remains individualized with each plan.

Cognitive Difficulties in Decision Making

For individuals with cognitive impairments, the effective use of Part D poses added challenges. The myriad affirmative decisions and actions required by Part D will be difficult for the many beneficiaries who lack capacity, either in a strict legal sense or

in a practical sense, because they are confused and disoriented, or do not have family members or friends who are knowledgeable or available—or both—to assist them in making necessary choices. This situation raises the question of who has authority to make Part D-related decisions for a beneficiary. Dually eligible beneficiaries, who have a substantially higher incidence of Alzheimer’s disease than the general Medicare population, will be disproportionately affected.

Concerns for Institutionalized Individuals

For residents of nursing homes (including both skilled nursing facilities and nursing facilities) and of assisted living and board-and-care facilities, Part D poses additional issues.⁵⁵ For example, Part D includes special protections for nursing home residents and residents of other institutions that do not apply to residents of board-and-care or assisted living facilities.⁵⁶

Transition guidance to plans, for example, encourages PDPs to offer an 180-day transition supply of drugs to residents of nursing homes, and they must offer an emergency supply of non-formulary drugs in other situations where an exceptions request is pending.⁵⁷ In addition, the Nursing Home Reform Law offers protections to residents to ensure that they get prescription drugs they need regardless of source of payment.⁵⁸ Such protections are not available to residents of board-and-care or assisted living.

Another protection for dually eligible nursing home residents is their exemption from co-payments. Regardless of their place of residence, dually eligible beneficiaries receiving long-term care services must pay nearly all of their income to the provider of their care, leaving just a small allowance—about \$30—for personal needs. Congress acknowledged this dearth of disposable income for nursing home residents but failed to do the same for board-and-care or assisted living residents. These latter beneficiaries will have to pay co-payments for all of their drugs.

Gaps in Coverage

Individuals with only Medicaid lose their Medicaid drug coverage on the first day of the month in which they become eligible for Medicare, even if they have

not enrolled in a Part D plan. The state transmits information about them to CMS when the state becomes aware of their new status as dual eligibles. It is unclear, however, whether and when states will have that information. In addition, states often send information to CMS about new dual eligibles only once a month, generally at the end of the month. Although CMS has recently changed its policy to ensure that Part D coverage is effective on the date they become eligible for Medicare, beneficiaries may not actually show up in the system for some period of time.

Those dually eligible individuals whose auto-enrollment has not occurred for some reason can use the Point of Service option at the pharmacy that facilitates enrollment into the point of service contractor. The contractor will then inform CMS so that the individuals can be enrolled into a plan. Under this option, the pharmacy distributes a 14-day supply of medicine to the individual, with the possibility of an additional 14-day refill. However, individuals who try to get prescriptions under this option at the beginning of a month might not have sufficient medicine to last until they are enrolled in a Part D plan.

EVEN THE MOST GENEROUS OF PART D SUBSIDIES LEAVES MOST DUAL ELIGIBLES WORSE OFF IN TERMS OF OUT-OF-POCKET COSTS THAN THEY WERE UNDER MEDICAID, WHICH HAS NO PREMIUM, NO DEDUCTIBLE, NO COVERAGE GAP, AND ONLY OPTIONAL AND NOMINAL CO-PAYMENTS.

The Low-Income Subsidy for Dually Eligible Beneficiaries

Dual eligibility entitles the beneficiary to the best subsidies available under Part D to low-income individuals. Whereas most individuals without Medicaid must pass income and resource tests, all dual eligibles, regardless of their income or resources, are entitled to the full low-income subsidy:⁵⁹

- No premium if they choose a plan at the benchmark level or lower⁶⁰

- No deductible (Standard deductible is \$250)
- No gap in coverage—the so-called “doughnut hole” (Standard coverage gap is \$2,850)
- Fixed dollar co-payments based on income and/or institutional status (Standard benefit has 25 percent coinsurance)
 - \$0 co-payments for dual eligibles who are institutionalized
 - \$1 (generic/preferred)/\$3 (non-preferred) for dual eligibles with incomes up to 100 percent of the federal poverty level
 - \$2 (generic/preferred)/\$5 (non-preferred) for all other dual eligibles

Even this most generous of Part D subsidies, however, leaves most dual eligibles worse off in terms of out-of-pocket costs than they were under Medicaid, which has no premium, no deductible, no coverage gap, and only optional (at the state’s choosing) and nominal co-payments (these were unenforceable).⁶¹

Dually eligible beneficiaries are deemed eligible for the full subsidy without having to apply for it.⁶² They receive notices from CMS of their entitlement to the subsidy without application.

An individual deemed eligible for the subsidy at any point during a year will remain eligible for the duration of that year, regardless of a change in the status that resulted in the eligibility.⁶³ This will be important for beneficiaries who go on and off of Medicaid during the year.

A Medicare-only beneficiary who is later found eligible for Medicaid and who thus becomes dually eligible and eligible for the low-income subsidy will be subsidy-eligible for the first month in which he or she is eligible for Medicaid. Thus, if entitled to retroactive Medicaid benefits for three months prior to application for Medicaid, his or her subsidy would also be effective during those three months, *if the individual had been enrolled in a Part D plan during that three-month period.*⁶⁴ Plans are required to refund any payments made by such an individual that are covered by the subsidy.⁶⁵

ALTHOUGH MOST STATES HAVE TAKEN AN EMERGENCY ACTION, FEWER HAVE STEPPED IN WITH LONG-TERM PROPOSALS TO HELP DUAL ELIGIBLES WITH THEIR MEDICARE PRESCRIPTION DRUG COSTS.

Using State Funds to Wrap Around Medicare Part D

States can use their own money—without a federal match—to fill in the gaps (wrap-around) in coverage that will be experienced by dual eligibles: premiums for plans with premiums above the regional benchmarks, mandatory co-payments for all but institutionalized individuals, and drugs excluded from plans’ formularies or subject to quantity limits. A very few states have enacted or are working to pass legislation that would allow them to provide such wrap-around coverage for their dual eligibles and other low-income beneficiaries, and to ensure that dual eligibles are enrolled in plans that cover their drugs.

In addition, most states stepped in after January 1, 2006, to help their dual eligibles make the transition to Medicare, many declaring a public health emergency as a result of the difficulties that beneficiaries were experiencing. These states are still providing temporary assistance as of this writing, and several are looking to extend it until they are certain that dual eligibles will be able to get their prescriptions filled through Medicare. The following states provide three examples.

Maine

Maine has been a leading state in acting to protect its 45,000 dual eligibles. Before January 1, 2006, Maine received approval from CMS to “intelligently reassign” the one-quarter of its dual eligibles who were auto-enrolled into plans that covered less than 60 percent of their drugs. Maine evaluated these beneficiaries’ drug regimens and plan options, and then reassigned them to plans that covered 95 percent of their drugs. Maine also provided emergency assistance during the first months by allowing pharmacies to bill the state for claims from dual eligibles that were not processed correctly. The state had spent \$6 million on 115,000 prescriptions as of March 2, 2006. It provided a

toll-free hotline for low-income beneficiaries to offer assistance when plans' call centers were closed for holidays or were only available during business hours. Legislation is proposed to allow the state to assist dual eligibles with Part D co-payments on an ongoing basis. The state has already agreed to cover certain Medicare-excluded drugs, including drugs for weight loss or weight gain, barbiturates, and benzodiazepines.

Connecticut

Connecticut has also taken significant action on behalf of its 65,000 dual eligibles. In addition to providing emergency coverage during the transition from Medicaid to Medicare, the state will, on an ongoing basis, help duals with premiums, co-payments, and non-formulary drugs.⁶⁶ Connecticut will also continue to provide coverage for benzodiazepines and barbiturates, as well as some drugs in other Part D-excluded drug categories. And, like Maine, it plans to review the appropriateness of dual eligibles' plan coverage based on beneficiaries' drug needs. The state has been particularly effective in keeping communication fluid between the Department of Social Services, pharmacists, and advocates to quickly identify issues and to ensure continued access to drugs for dual eligibles.

California

California has over one million dual eligibles, with 10,000 new dually eligible beneficiaries each month. The crisis of the transition from Medicaid to Medicare led the state to step in and provide \$385 million in transitional drug coverage for the 188,000 dual eligibles as of March 14, 2006. The state has extended this coverage through April 16. There are no proposals for California to provide any long-term wrap-around coverage, but like most other states, California will cover certain excluded drugs, including weight loss and weight gain drugs, certain vitamins and minerals, some over-the-counter drugs, and all barbiturates and benzodiazepines. The governor's office has also been particularly active at the federal level in advocating on behalf of its dually eligible population.⁶⁷

Although most states have taken emergency action, fewer have stepped in with long-term proposals to help dual eligibles with their Medicare prescription drug costs. Of all the regions, the southern states were the least active in providing emergency coverage, and none have proposals to wrap-around Part D.⁶⁸

The situation of dual eligibles has policy implications at both the federal and state levels. The following are ten recommendations to improve this situation.

1. Benefits must be uniform.

The single most important change in the law to improve access to prescription drug coverage for dually eligible beneficiaries would be the creation of a single, standard Medicare prescription drug benefit administered by the Medicare program and uniform nationwide.

Many of the problems and issues described above arise from or are complicated by the large number of plans available and the fact that each plan has its own design, including formulary, transition processes, exceptions, and appeals processes. Virtually no uniformity is required in plan design. Until such a uniform benefit is created, improvements can be made to the existing program, as noted below.

2. Auto-enrollment must be accomplished with more attention to the needs of the individual beneficiary.

In assigning beneficiaries to plans that they have not chosen, more attention must be given to matching individual beneficiaries' drug usage and pharmacy preferences with the formulary and pharmacy networks of individual plans. While the law directs that auto-enrollment must be done randomly among the standard plans at or below the benchmark premium, many of those commenting on federal regulations proposed that CMS define random as "random among those plans that met the individual beneficiary's prescription drug and pharmacy needs."⁶⁹ While CMS chose not to do so when it published final regulations in January 2005, it could, in the future, modify those regulations. If CMS does not act, Congress could amend the legislation to require that auto-enrollment include attention to individual beneficiary needs. To the extent that states have information about their dually eligible residents' pharmaceutical use, they can play a role in the auto-assignment to ensure that the most effective plan is chosen.

3. Plan processes for transitions, exceptions, and appeals must be standardized.

More than other beneficiaries, dual eligibles, with their greater frailty, higher incidence of cognitive impairments, and lower education level, need clearly understandable and easy-to-navigate systems available to them in using their benefits. They, their pharmacists, their physicians, and other helpers should not have to learn different systems for getting assistance from a plan, depending on the plan in which the beneficiary is enrolled. The systems should not entail onerous paperwork that will make pharmacists and physicians reluctant to offer assistance, but should rely as much as possible on spoken assurances.

4. Plans should be required to retain all drugs on their formularies for the entire plan year.

Part D creates an unfair contract between beneficiaries and plans by allowing plans to remove drugs from their formularies at any time during the year but requiring most beneficiaries to stay in the plan for the entire year. Although dually eligible beneficiaries are excused from "lock-in" requirements, they are nonetheless considerably inconvenienced and possibly even harmed by the process of changing plans when their drugs are removed from their current plan's formulary. Plans should be required to retain all drugs on their formulary at least during the entire plan year.

5. Greater clarity is needed about who can act on behalf of a beneficiary.

A major contribution from state policymakers and lawmakers would be to identify state requirements with respect to surrogate decision making as it relates to Part D activities. Many dually eligible beneficiaries have cognitive impairments that make it impossible for them, as a practical matter, to make decisions about their Part D plans, including choosing a plan and pursuing exceptions and appeals. The Part D rules and informal guidance allow an "authorized representative," defined as a person who has legal authority under state law to act on the beneficiary's behalf, to assist a beneficiary in enrolling in a Part D plan. Authorized representatives and the prescribing physician may pursue exceptions and appeals on the beneficiary's behalf. Many people

with cognitive impairments, however, have not been adjudicated incompetent and do not have court-appointed guardians.

Some states have laws that authorize surrogate decision makers to make healthcare decisions for incapacitated individuals who have not been adjudicated incompetent. In these states, the question will arise as to whether Part D-related activities are considered healthcare decisions. To address this issue, the state of Oregon has passed emergency rulemaking to identify surrogate decision makers for Part D enrollment and appeals for clients of the Department of Human Services.⁷⁰ Oregon's action might serve as a model.

6. *Enforcement action must be taken against non-complying plans.*

Beneficiaries' experience during the roll-out of Part D in January suggested that plans were not complying with their obligations under the law. Transition supplies of drugs were not made available to beneficiaries, plan call lines were backed up for hours, and beneficiaries and pharmacists were not able to get problems solved expeditiously. Higher income beneficiaries can handle such difficulties by paying out-of-pocket and seeking reimbursement later. This is not likely to be an option for dual eligibles. Systems must work for them to ensure that, at the pharmacy, dually eligible beneficiaries are neither financially burdened nor turned away for inability to pay for drugs. State and local lawmakers and policymakers may find it in their interest to ensure that CMS uses its full authority to take actions against plans that do not meet their obligations; clear and swift action against such non-compliance will help develop public trust in the program and will protect dually eligible beneficiaries.

7. *Additional resources must be provided to assist dually eligible beneficiaries in navigating their plans' systems to ensure that they get needed drugs.*

State and federal lawmakers and policymakers could work to ensure more money and training for the State Health Insurance Programs (SHIPs), federally funded entities whose mandate is to assist Medicare beneficiaries with their health insurance questions and plan choices. SHIPs need additional financial resources

to provide the labor-intensive, one-on-one counseling required by the design of Part D. Because Part D, unlike the rest of Medicare, is provided exclusively through private plans, counseling requires familiarity with the plans and the time and the ability to walk the beneficiary through her various options using Internet-based decision-support tools such as Medicare's plan finder. SHIPs have received additional funding since the passage of Part D, but funding remains significantly below the level needed to do their job.⁷¹

SYSTEMS MUST WORK FOR THEM TO ENSURE THAT, AT THE PHARMACY, DUALLY ELIGIBLE BENEFICIARIES ARE NEITHER FINANCIALLY BURDENED NOR TURNED AWAY FOR INABILITY TO PAY FOR DRUGS.

8. *Equity must be established between dually eligible beneficiaries in various care settings.*

Dually eligible residents of nursing homes and assisted living facilities must pay most of their income to their care providers before Medicaid pays the difference, but Part D excuses only nursing home residents from co-payment requirements. Moreover, while the needs of both populations are similar, Part D guidance does not accord the same protections with respect to transitions or the provision of an emergency supply of drugs pending an exceptions request. Some protections may be provided through agency action; others may require changes in the law.

9. *Data-sharing systems need to be improved to prevent gaps in coverage and to promote real-time solutions to problems.*

Current systems used by CMS, states, and plans to share information about dual eligibility and plan enrollment cause delays in identifying beneficiaries as dually eligible and in enrolling them in plans. The result is periods of as long as three months before a newly dually eligible individual is auto-enrolled in a plan. When a Medicare beneficiary becomes newly eligible for Medicaid (and thus newly dually eligible) toward the end of the month, the information will

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not be transmitted to CMS/Medicare until later the following month, although Medicaid eligibility may actually be retroactive to three months prior to the application. CMS must then assign the beneficiary to a Part D plan, if the beneficiary is not already enrolled in one, but Part D coverage will only be prospective. When a Medicaid beneficiary becomes newly eligible for Medicare (and thus newly dually eligible), her Medicaid drug coverage will end immediately, even though CMS's systems might not yet have her enrolled in a Part D plan. In both situations, the beneficiary will experience a period without drug coverage. Modern technology should allow for a dramatic reduction—if not elimination—of the delays that will lead to such coverage gaps.

10. States can provide full wrap-around coverage for dual eligibles.

Using state-only funds, states can help ensure that dual eligibles have access to all needed medications by paying for: (a) premiums above the benchmark for plans with better formularies; (b) all co-payments required for formulary drugs; and (c) Part D-covered drugs that are excluded from formularies. In addition, states can cover Part D-excluded drugs and receive federal matching funds through their state Medicaid program.

To date, most states are covering many Part D-excluded drugs but only a very few states are covering any other costs of Part D for dual eligibles. States' responses to the crisis that arose at the initial transition to Part D suggest that they are aware of the importance of ensuring that this vulnerable population has easy access to needed medications.

For dually eligible beneficiaries, ongoing issues under Part D center on how to pay for costs incurred due to co-payments and non-formulary drugs. Other issues include how this population will get the information it needs to enroll in and disenroll from a plan, as well as how to seek coverage determinations when prescribed drugs are not covered under the plans to which they have been assigned.

UNTIL A UNIFORM, STANDARD, NATIONWIDE MEDICARE

PRESCRIPTION DRUG BENEFIT IS AVAILABLE, FEDERAL AND STATE POLICYMAKERS MUST PROMOTE AND ENFORCE SIMPLIFICATION OF PLAN PROCESSES, MORE RELIABLE PLAN INFORMATION, AND GREATER ACCESS TO COVERED DRUGS.

For state and federal policymakers, Part D must be viewed in the context of the larger “system” of providing care to this frail and vulnerable population. It is therefore important to ask whether the current healthcare environment is conducive to imposing a “system” in which dually eligible beneficiaries are assigned to one of 409 PDPs that use 37 unique formularies. While states may have hoped for relief from providing prescription drug coverage to dual eligibles, the confusion and fragmentation promoted by Part D is resulting in pressures for them to “step up,” as many have done during the initial roll-out, to fill the gaps in coverage. We fear, nonetheless, that this need to step up will not be isolated to the roll-out. Until a uniform, standard, nationwide Medicare prescription drug benefit is available, federal and state policymakers must promote and enforce simplification of plan processes, more reliable plan information, and greater access to covered drugs.

NOTES

- ¹ Medicaid law is found at 42 U.S.C.A. § 1396. It is part of the “great society” legislation of the 1960s and was created at the same time as the Medicare program (42 U.S.C.A. § 1395). The Medicaid program is a federal-state partnership in which states receive federal funds through a federal-state matching formula. Medicaid services include prescription drug coverage for program beneficiaries, who must meet strict eligibility requirements, including limits on both income and resources.
- ² Medicare Part D, the prescription drug benefit, was added to the Medicare program through the Medicare Prescription Drug, Improvement, and Moderation Act of 2003 (MMA), Pub. L. No.108-173 (Dec. 8, 2003), and codified at 42 U.S.C.A. § 1395w-101 et seq., (West Supp. 2005). Prescription drug benefits are provided through private insurance plans: stand-alone plans that offer only prescription drug coverage (PDPs) and Medicare Advantage (MA) plans (such as HMOs) with a drug benefit (MA-PDs). Beginning January 1, 2006, any individual eligible to enroll in a Part D plan who is receiving “full Medicaid” services cannot receive prescription drug coverage through Medicaid (42 U.S.C.A. §1396u-5(d)(1)). This is true regardless of whether the individual has actually enrolled in a Part D plan and regardless of whether the plan covers the specific drug needed. Concomitantly, the state cannot receive federal matching payments for such services. “Receiving full Medicaid” refers to persons who are receiving Medicare Part A or B, or are enrolled in a Medicare Advantage plan under Medicare Part C, and are determined to be eligible by their state for medical assistance for full benefits under a state medical assistance program, including spend down provisions, as provided in 42 U.S.C.A. § 1396u-5(c)(6)(A)-(B) (West Supp. 2005).
- ³ National Association of State Budget Officers, 2004 State Expenditure Report (January 2006); D. Solomon, “Politics & Economics: Wrestling with Medicaid Cuts – States Face Difficult Choices Amid Shrinking Federal Funds,” *Wall Street Journal*, February 16, 2006.
- ⁴ See 42 U.S.C.A. §1396u-5(c)(2). See also, the Kaiser Family Foundation, “Revised Per Capita Monthly Clawback Payments, 2006,” <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+percent26+SCHIP&subcategory=Medicare+Drug+Benefit+percent3a+Clawback+Payments&topic=Per+percent2dCapita+Monthly+Clawback+Amounts> (accessed March 28, 2006).
- ⁵ Kaiser Family Foundation, “A profile of African Americans, Latinos, and Whites with Medicare: Implications for Outreach Efforts for the New Drug Benefit” (November 2005), <http://www.kff.org/minorityhealth/upload/A-Profile-of-African-Americans-Latinos-and-Whites-with-Medicare-Implications-for-OUtreach-Efforts-for-the-New-Drug-Benefit-Chartpack.pdf> (accessed April 25, 2006).
- ⁶ Ibid.
- ⁷ Ibid.
- ⁸ Ibid.
- ⁹ Ibid.
- ¹⁰ Ibid.
- ¹¹ Ibid.
- ¹² J. Holahan and A. Ghosh, “Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003” (Kaiser Commission on Medicaid and the Uninsured, July 2005). Dual eligibles also consume a disproportionate share of Medicare dollars. Although 15 percent of the Medicare population in 2001, they used 22 percent of the dollars. Medicare Payment Advisory Commission [MedPAC], “A Data Book: Healthcare Spending and the Medicare Programs” (June 2004), www.medpac.gov (accessed March 16, 2006).
- ¹³ Holahan and Ghosh, “Dual Eligibles.”
- ¹⁴ Kaiser Family Foundation, “A profile of African Americans, Latinos, and Whites with Medicare”; Kaiser Family Foundation, *Medicare Chart Book 2005* (July 19, 2005), <http://www.kff.org/medicare/7284.cfm> (accessed April 25, 2006).
- ¹⁵ Ibid.
- ¹⁶ Ibid.
- ¹⁷ Holahan and Ghosh, “Dual Eligibles.”

- ¹⁸ CAHPS, the Consumer Assessment of Health Plans, has been administered by CMS to between 168,000 and 178,000 fee-for-service beneficiaries annually since 2000 (70 percent to 80 percent response rates). MCBS, the Medicare Current Beneficiary Survey, has been conducted by Westat, with CMS sponsorship, to 12,000 beneficiaries three times a year since 1991. CMS is the agency (or division) within the United States Department of Health and Human Services (DHHS) that is responsible for the administration of the Medicare and Medicaid programs.
- ¹⁹ MedPac, “Report to Congress: New Approaches in Medicare” (2004), <http://www.aamc.org/advocacy/teachhosp/medpac/newapproaches.pdf> (accessed April 25, 2006).
- ²⁰ M. Niefeld and J. Kasper, “Access to Ambulatory Medical and Long-Term Care Services Among Elderly Medicare and Medicaid Beneficiaries: Organizational, Financial, and Geographic Barriers,” *Medical Care Research and Review* 62, no. 3 (June 2005).
- ²¹ *Ibid.*
- ²² Organizational access barriers included: not knowing how to make appointments or arrangements, lack of referral for needed services, waiting list or failure to obtain an appointment, language or communication difficulties, caregiver support needed, care not available, told not sick enough to qualify for service, or given conflicting treatment options.
- ²³ Niefeld and Kasper, “Access to Ambulatory Medical and Long-Term Care.”
- ²⁴ 42 U.S.C.A. § 1395w-101(b)(1)(C) (West Supp. 2005).
- ²⁵ 42 U.S.C.A. § 1396u-5(c)(6) (West Supp. 2005); 42 C.F.R. §423.34 (2005). The roughly ten percent of dual eligibles enrolled in a Medicare Advantage plan were and will continue to be auto-enrolled in a Medicare Advantage Prescription Drug plan (MA-PD) offered by their MA plan, even if the only MA-PD offered has a premium above the benchmark (i.e., subsidized) amount. CMS does not address the question of how a person who is dually eligible could pay for the unsubsidized premium amount.
- ²⁶ Office of the Inspector General, U.S Department of Health and Human Services, *Dual Eligibles’ Transition: Part D Formularies; Inclusion of Commonly Used Drugs*, OEI-05-06-00090 (January 2006), <http://oig.hhs.gov/oei/reports/oei-05-06-00090.pdf>. The Inspector General actually looked at the 200 drugs most commonly used by dual eligibles, but determined that 22 of them are excluded from Part D coverage. Plans were then analyzed for their coverage of the remaining 178 drugs.
- ²⁷ *Ibid.*
- ²⁸ *Ibid.*, 12.
- ²⁹ See <http://www.omhrc.gov/templates/content.aspx?ID=3022> (accessed August 11, 2006).
- ³⁰ 42 U.S.C.A. § 1395w-101(b)(3)(D) (West Supp. 2005); 42 C.F.R. § 423.38(c)(4); PDP Guidance: Eligibility, Enrollment and Disenrollment, http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDP_EnrollmentGuidance_08.29.05.pdf, at 20.3.2. Beneficiaries of the three Medicare Savings Programs, QMB, SLMB and QI, also have an ongoing special enrollment period.
- ³¹ 42 U.S.C.A. § 1395w-104(b)(3)(E)(after appropriate notice) (West Supp. 2005); 42 C.F.R. § 423.23.120(b)(5)(i)(A)(60 days notice to enrollees prior to removing drugs from a plan’s formulary) (2005).
- ³² See note 60 for an explanation of the benchmark.
- ³³ See <http://www.medicare.gov>—click on “Compare Medicare Prescription Drug Plans” (accessed February 27, 2006).
- ³⁴ V. Rideout, T. Neuman, M. Kitchman, and M. Brodie, “e-Health and the Elderly: How Seniors Use the Internet for Health Information” (Kaiser Family Foundation, January 2005), <http://www.kff.org/entmedia/7223.cfm> (accessed March 28, 2006).
- ³⁵ Pew Internet & American Life Project, “Older Americans and the Internet” (March 25, 2004), http://www.pewInternet.org/PPF/r/117/report_display.asp (accessed March 10, 2006).
- ³⁶ Rideout et al., “e-Health and the Elderly.”

- ³⁷ Pew Internet, “Older Americans and the Internet.”
- ³⁸ 42 U.S.C.A. § 1395w-102(e)(2) (West Supp. 2005). 42 CFR § 423.100 (Jan. 28, 2005). The excluded categories and types are: weight loss/gain, prescription cough/cold, prescription vitamins/minerals, over-the-counter drugs, benzodiazepines, barbiturates, fertility and cosmetic drugs.
- ³⁹ Office of the Inspector General, *Dual Eligibles’ Transition*, 7.
- ⁴⁰ *Ibid.*, Table 6, 38.
- ⁴¹ Kaiser Family Foundation, “Fact Sheet: Medicare Prescription Drug Plan Information, By State, 2006.”
- ⁴² 2000 U.S. Census/Alabama: Persons ages 65 and over represent 13 percent of the total population. African Americans represent 26 percent of the total population.
- ⁴³ From chart created by CMS in November 2005, formerly available at <http://www.cms.hhs.gov/medicarerereform/states/optdrugcov.asp> and summarized at http://www.medicareadvocacy.org/PartD_ExcludedDrugsByState.htm (accessed February 24, 2006).
- ⁴⁴ 2000 U.S. Census/California: Persons ages 65 and older represent 10.6 percent of the total population. African Americans represent 6.7 percent, Asian Americans represent 10.9 percent, and Latinos represent 32.4 percent.
- ⁴⁵ Henry J. Kaiser Family Foundation, “Kaiser State Health Facts,” www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi (accessed March 21, 2006).
- ⁴⁶ Medicare Modernization Act Final Guidelines – Formularies, <http://new.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FormularyGuidanceAllorSubAll.pdf> (accessed March 28, 2006).
- ⁴⁷ *Ibid.*
- ⁴⁸ CMS, “Medicare Modernization Act 2007 Final Guidelines – Formularies: CMS Strategy for Affordable Access to Comprehensive Drug Coverage,” <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CY07FormularyGuidance.pdf> (accessed August 11, 2006).
- ⁴⁹ CMS, “Information for Part D Sponsors on Requirements for a Transition Process” (March 16, 2005), available from Center for Medicare Advocacy, Inc (contact pnemore@medicareadvocacy.org).
- ⁵⁰ *Ibid.*
- ⁵¹ *Ibid.*
- ⁵² February 2, 2006, memorandum from Mark McClellan, PhD, CMS Administrator, to Medicare Advantage Prescription Drug Plan and Medicare Prescription Drug Plans, “Subject: Extension of Transition Period to March 31.”
- ⁵³ CMS, “Transition Process Requirements for Part D sponsors” (April 2006), <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CY07TransitionGuidance.pdf> (accessed August 11, 2006).
- ⁵⁴ 42 U.S.C.A. § 1395w-104(g) (West Supp. 2005); 42 C.F.R. § 423.578 (2005)
- ⁵⁵ For excellent discussion of issues related to institutionalization and Part D, see T. S. Edelman, Esq., “Medicare Prescription Drug Coverage for Residents of Nursing Homes and Assisted Living Facilities: Special Problems and Concerns,” prepared for the Henry J. Kaiser Family Foundation (November 2005), <http://kff.org/medicare/upload/Medicare-Prescription-Drug-Coverage-for-Residents-of-Nursing-Homes-and-Assisted-Living-Facilities-Special-Problems-and-Concerns-Issue-Brief.pdf> (accessed February 27, 2006); and T. R. Clark, RPh, MHS, “Access to Medications Under Medicare Part D” (American Society of Consultant Pharmacists, November 2005), <http://www.ascp.com/medicarerx/upload/ASCPPartDMedAccess.pdf> (accessed August 11, 2006).
- ⁵⁶ See, e.g., 42 U.S.C.A. § 1395w-114(a)(1)(D)(i) referring to 42 U.S.C.A. § 1396a(q)(1)(B) (West Supp. 2005)

- ⁵⁷ CMS, “First Fill, What is [Centers for Medicare and Medicaid Services] Policy Regarding Emergency Supply of Medications for Long-Term Care Residents? Are Plans Required to Cover a Temporary/Emergency Supply of Nonformulary Part D Drugs While an Exception Request is Being Processed?” (transitional guidance document from CMS; document is available from the Center for Medicare Advocacy (pnemore@medicareadvocacy.org) and also at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/EmerTLCFill.pdf>).
- ⁵⁸ 56 Fed. Reg. 48826, 48850, preamble to Final Regulations implementing the Nursing Home Reform Law (September 26, 1991).
- ⁵⁹ 42 U.S.C.A. § 1395w-114(a)(1), (3)(B)(v)(I) (West Supp. 2005); 42 C.F.R. § 423.773(c)(1)(i); 70 Fed. Reg. 4368 (Preamble). It is possible to be dually eligible and have income considerably higher than the income limit for the low-income subsidy, especially for individuals receiving costly long-term care services. The subsidy limit for 2006 is about \$1,103 per month; a person with \$1500 of income could qualify for Medicaid services if the cost of the nursing home was \$2000 a month. The individual would pay most of her income to the nursing home and Medicaid would pay the difference.
- ⁶⁰ Benchmark premium is the average weighted premium within an area, so it will differ from one part of the country to another. 42 U.S.C.A. § 1395w-114(b)(2) (West Supp. 2005); 42 C.F.R. § 423.780; 70 Fed. Reg. 4386 (Preamble). Regional benchmarks range from \$25.41 in the region comprising only California to \$36.85 in the region comprising only Louisiana.
- ⁶¹ 42 C.F.R. § 447.53(e)(October 2005)(Applicability; specification; multiple charges). (No provider may deny services to an individual who is eligible for the services on account of the individual’s inability to pay the cost sharing.)
- ⁶² 42 C.F.R. § 423.773(c)(1)(i); 70 Fed. Reg. 4368 (Preamble).
- ⁶³ 42 C.F.R. § 423.773(c)(2).
- ⁶⁴ See 70 Fed. Reg. 4380 (Preamble) for discussion of retroactive eligibility for low-income subsidy by virtue of retroactive eligibility for Medicaid. Medicaid law requires coverage up to three months prior to the date of application if the individual was eligible during that period.
- ⁶⁵ 42 C.F.R. § 423.800(c).
- ⁶⁶ PA 05-2 (signed December 1, 2005).
- ⁶⁷ Governor Arnold Schwarzenegger’s March 16, 2006, letter to Michael Leavitt, Secretary of the Department of Health and Human Services, communicates several important concerns that affect all states regarding the transition of their dually eligible populations from Medicaid to Medicare. See <http://gov.ca.gov/index.php/press-release/252/> (accessed August 11, 2006).
- ⁶⁸ Four southern states (Alabama, Arkansas, Florida, and Texas) provided emergency funding for dual eligibles during the transition. Transition problems in the South have been further compounded by Hurricanes Katrina, Rita, and Wilma. CMS has recognized these problems and is mostly relying on existing protocols to handle problems—i.e., 1-800-MEDICARE and pharmacists to help beneficiaries, and TrOOP facilitators to help people displaced by Katrina access their drugs at out-of-network pharmacies. See CMS, “Outreach Message for Full Duals Displaced by Hurricanes Katrina, Rita, Wilma” (October 3, 2005), <http://www.cms.hhs.gov/Emergency/Downloads/OutreachFullDualsAuto.pdf> (accessed March 28, 2006). See also CMS, “Pharmacy Technical Overview: Access to Medicare Prescription Drug Benefits for Katrina Displaced Beneficiaries” (October 13, 2005), <http://new.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/KatrinaOutOfNetworkOverview.pdf> (accessed March 28, 2006). CMS, by email notification to states on March 9, 2006, announced that certain Katrina evacuees would be entitled to a Special Enrollment Period to change plans. (Email available from Center for Medicare Advocacy, Inc. Contact pnemore@medicareadvocacy.org.)
- ⁶⁹ Medicare Program; Medicare Prescription Drug Benefit; Final Rule 70 Fed. Reg. 4193, 4205, preamble (January 28, 2005).

⁷⁰ Oregon Department of Human Services, Chapter 407, Division 050, Health Services, Medicare Part D Authorized Decision Makers, http://www.oregon.gov/DHS/policy/dwss/temp/407_050.pdf (accessed March 21, 2006). While this rule is limited in its scope to clients of the Department of Human Services, its language could be adopted by states more broadly to apply to all Part D beneficiaries.

⁷¹ E. Leitzer and L. Thompson, “State Health Insurance Programs: A Critical Resource for Medicare Beneficiaries,” Health Assistance Partnership, 2006 (working title, publication forthcoming) identifies at least \$1/beneficiary (~\$42 million) as needed for adequate funding for SHIPs. Current federal funding for year ending March 31, 2006 was \$31.5 million. See also, Office of Inspector General of the Department of Health and Human Services, “Early Implementation of MMA: Status Report of the State of Health Insurance Assistance Programs (OEI-05-05-00190)” (March 16, 2006), <http://oig.hhs.gov/oei/reports/oei-05-05-00190.pdf> (accessed March 28, 2006).

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Ms. Nemore's work includes writing, litigation, testimony, training, and legislative and administrative advocacy. She has authored two reports on the Medicare Savings Programs for the Henry J. Kaiser Family Foundation and most recently she authored an analysis of the eligibility and enrollment processes of Part D low-income subsidy as compared with those processes for states' Medicare Savings Programs. She received her law degree from Catholic University and her BA from Northwestern University.

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The mission of the Joint Center Health Policy Institute (HPI) is to ignite a “Fair Health” movement that gives people of color the inalienable right to equal opportunity for healthy lives. HPI’s goal is to help communities of color identify short- and long-term policy objectives and related activities in key areas. The Joint Center for Political and Economic Studies is a national, nonprofit research and public policy institution. Founded in 1970 by black intellectuals and professionals to provide training and technical assistance to newly elected black officials, the Joint Center is recognized today as one of the nation’s premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color.

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