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Question: I have a number of clients who are dual eligibles, that is, eligible for both Medicare and Medicaid. How will they be impacted by the Medicare Part D prescription drug benefit? Is there anything I can do before it is implemented in January 2006?

Answer: The new Medicare Prescription Drug benefit will have a huge impact on dual eligibles, moving them into federally-regulated, private prescription drug plans and possibly imposing greater cost-sharing and a more limited array of drugs to cover their health care needs. There are several advocacy steps you can (and should) take now— before Medicare Part D goes into effect.

Background on Medicare Prescription Drug Benefit

On January 1, 2006, Medicare will begin providing payment for outpatient prescription drugs through private plans. This change comes as a result of the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.[1] The Medicare Modernization Act will fundamentally alter the Medicare program for 35 million elderly Americans and will also have a dramatic impact on the over six million seniors and individuals with disabilities who receive Medicaid as well as Medicare benefits and are known as dual eligibles. The law adds coverage of outpatient prescription drugs to Medicare, but also terminates federal funding of Medicaid prescription drug coverage for all dual eligibles.

Medicare Part D, as the Medicare prescription drug benefit is called, will provide coverage of medications through prescription drug plans. What drugs will be covered, however, depends on the plan. While there are certain federal requirements on plans, they have been given broad flexibility to choose which drugs to include in their formularies. Moreover, plans are allowed to limit the number of drugs available in a therapeutic class to two and may even define what constitutes a therapeutic class for purposes of developing their formularies.

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[1] *See* 42 U.S.C. 1395w-101 *et seq.*

In obtaining medications through Medicare Part D, beneficiaries can challenge plan decisions to deny coverage of a particular prescription drug on its formulary. Beneficiaries can also appeal denials of coverage for those drugs not on the formulary if the prescribing physician has determined that no drugs on the formulary are as effective as the prescribed drug or if the drugs in the formulary have adverse side-effects for that particular beneficiary.

While Medicare Part D will pay for prescription drugs, many beneficiaries are likely to have significant cost-sharing obligations. Dual eligibles and other low-income Medicare beneficiaries may apply for subsidies to pay many of these costs. Beneficiaries who are not eligible for low-income subsidies will have to pay the first $250 in prescription drug costs, known as their deductible. They will also have to pay for 25% of total drug costs between $250 and $2250 and 100% of drug costs between $2250 and $5100, the latter of which is commonly referred to as "the donut hole." Dual eligibles, however, will not be affected by the donut hole. Additionally, beneficiaries who are not low-income will have to pay the higher of $2 for generic drugs and $5 for brand name drugs or 5% coinsurance after they reach the $3600 out-of-pocket limit.

Impact on Dual Eligibles

As mentioned above, dual eligibles, like other Medicare recipients, will obtain their prescriptions through the new Medicare program beginning January 2006. In other words, the Medicaid program will no longer cover most prescription drugs for individuals who receive Medicare. While all Medicare beneficiaries will be affected by Medicare Part D, there will be a greater impact on dual eligibles because they are much poorer and tend to have more significant health care needs than other Medicare beneficiaries. In order to qualify for Medicaid coverage, seniors and individuals with disabilities must have incomes below the federal poverty level and very few assets; because of this, more than 70 percent of dual eligibles have annual incomes below $10,000.[2] Furthermore, dual eligibles are more than twice as likely to be in fair or poor health as other Medicare beneficiaries.[3] Their lower income and greater health care needs mean that any increases in co-payments or limitations in coverage will likely result in less access to medically necessary medications.

Currently, under Medicaid, dual eligibles have access to a full range of drugs and have minimal co-payments because of federal Medicaid mandates. Federal law requires states covering prescription drugs to provide access to FDA-approved drugs of manufacturers that have agreed to state rebates.[4] In terms of co-payments, states can only charge "nominal" amounts, which usually range from $1 to $3, depending on the type of

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[2] Jocelyn Guyer and Andy Schneider, *Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers*, The Kaiser Commission on Medicaid and the Uninsured, January 9, 2004.
[3] *Id.* at 2.
[4] *See* 42 U.S.C. § 1396r-8(d)(4).

Medicaid service.[5] This stands in sharp contrast to co-payments charged by private health plans, as evidenced by a study conducted by the Kaiser Family Foundation. In their eight state survey, seniors receiving Medicaid prescription drug coverage reported fewer out-of-pocket expenses than those with employer sponsored coverage, HMO plans with drug coverage, Medi-gap and state pharmacy benefits.[6]

Implementation of Medicare Part D

To access Medicare prescription drug benefits, dual eligibles can receive medications through a private, stand-alone prescription drug plan or they can join an integrated Medicare Advantage plan, the Medicare managed care plan previously called Medicare + Choice which will provide all covered benefits. Medicare will pay the Part D deductibles or premiums for dual eligibles enrolling in average or low-cost prescription drug plans. Additionally, dual eligibles can obtain subsidies for other cost-sharing obligations associated with Part D. This means that they will not be subject to 100% of the costs exceeding $2250 that apply to other Medicare beneficiaries. However, non-institutionalized dual eligibles with incomes below 100% of the federal poverty level will have to pay co-payments of $1 for each generic drug and $3 for each name brand drug and those with incomes above that amount will have to pay $2 copays for generic drug and $5 copays for name brand drugs.[7]

The Medicare Modernization Act requires that the Secretary of Health and Human Services set up a process for enrolling Medicare beneficiaries, including dual eligibles, in Part D plans. Information on Part D plans will be made available to all Medicare beneficiaries on or around October 15.[8] All dual eligibles will be automatically enrolled in a prescription drug plan, but will be able to switch plans before Medicare Part D benefits begin in January. Initially individuals wishing to change plans can do so during open enrollment from November 15 through December 31, 2005, and at least once a year in subsequent years.

Because of these limited periods, beneficiaries will have little time to learn about their options and even less time to make a choice. While information about Medicare Part D is supposed to be provided to dual eligibles by the Social Security Administration and state agencies, many beneficiaries may still try to obtain prescription drugs with their Medicaid cards after January 1, 2006. Others may not understand how to use their new prescription drug cards or realize that they can no longer go to the same pharmacies as before. Providers who do not know which plan a beneficiary is in will not know what formulary applies or whether a new treatment regimen should be considered. These beneficiaries may experience treatment interruptions resulting in severe health complications. For these reasons, it is critical that health and disability advocates

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[5] *See* 42 C.F.R. § 447.53.

[6] *Id.*

[7] *Id.* at 6-7.

[8] Materials regarding the low-income subsidy will be mailed to Medicare beneficiaries beginning in May 2005. For more information, refer to the timeline on the next page.

conduct beneficiary outreach, plan ahead with state Medicaid officials and coordinate with providers.

Timeline for Selecting and Enrolling in a Medicare Part D Plan[9]

March 2005:	To test its materials, the Social Security Administration (SSA) will mail a low-income subsidy letter and application to 2000 beneficiaries in 41 zip codes.
May – August 2005:	SSA will send notices to half of all Medicare beneficiaries informing them of the low-income subsidy to provide premium and co-payment assistance.
June 2005:	Those who are deemed eligible for the low-income subsidy will be notified that they do not have to apply.
July 1, 2005:	State Medicaid agencies and SSA offices will begin making eligibility determinations on applications for the low-income subsidy. Individuals can also apply on line or by phone.
October 15, 2005:	Materials describing Part D plans provided to all Medicare beneficiaries. Dual eligibles may receive materials about the Part D plan in which they have been auto-enrolled earlier in the Fall.
November 15 – December 31, 2005:	Open enrollment period for dual eligibles initially seeking to switch prescription drug plans.
January 1, 2006:	Medicare Part D prescription drug benefits begin. Dual eligibles can no longer use Medicaid coverage to obtain most prescription drugs.

Advocacy Steps

Beneficiary Outreach

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[9] Vicki Gottlich, *Mark Your Calendars! A Timetable for Medicare Part D Implementation*, Center for Medicare Advocacy, Inc., February 18, 2005 (www.medicareadvocacy.org/PrescDrugs_PartDTimeline.htm).

Beneficiary outreach will be critical to the ability of dual eligibles to obtain needed medications through Medicare Part D. Beneficiaries will need the information and assistance to make choices that best meet their particular circumstances. They will need to know what changes they may need to make— new drug regimens, different pharmacies, co-payments— and may need assistance with determining how to incorporate the changes into their lives. For example, many dual eligibles will likely have $1-3 co-payments for medications that they previously obtained without co-payments. In addition, their right to challenge plan decisions will probably vary greatly from the Medicaid appeals process they have used in the past.

Dual eligibles must be informed of the following:

- the limited use of their Medicaid cards to cover prescriptions;
- the time frames for switching prescription drug plans after auto-enrollment;
- the Part D plan they are assigned to;
- their prescriptions drugs listed on the new plan formulary;
- the action steps if one or more drugs they take are not on the formulary;
- the co-payment amounts to pay at the pharmacy;
- the procedures to challenge improper denials and delays in necessary coverage.[10]

Plan Ahead

Advocates now should start working with beneficiaries, providers, and state agencies to map out state transition plans and strategies to deal with inevitable problems. You will want to make sure that your state is adequately planning to avoid disruptions in coverage. This might be achieved through working groups with state agencies, physicians, pharmacies and plans. Proper planning might also be achieved through collaboration with your state Medicaid Medical Care Advisory Committee, through a consumer or provider representative on the MCAC or as public comments during MCAC meetings. If your state has a state-funded drug assistance program, there may be mechanisms in place that could guarantee payment of drugs for these individuals while problems are ironed out. For beneficiaries in drug plans that do not cover some of their medications, a state-funded wraparound benefit may be necessary. State agency staff should be encouraged to plan ahead because if they do a poor job of assisting the beneficiaries of the new program the state could end up paying more to cover people's medications or dealing with beneficiaries' health crises.

Coordinate with Providers

Providers, including physicians, nurses, hospitals, pharmacies and community clinics, also will need to understand Medicare Part D and how to assist beneficiaries with potential benefits disruptions. They may need to help beneficiaries understand plan

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[10] Jeffrey S. Crowley, *MMA and Dual Eligibles: A Transition in Crisis,* Health Policy Institute, Georgetown University, February 2005.

formularies and make good choices. To do so, providers will also need training on the new program, available funding streams, and information on where they can obtain reliable assistance for themselves and beneficiaries.

Other Advocacy Tips

- Determine whether dual eligibles in your state have access to other sources of coverage for their medications if certain medications are not covered as of January 1, 2006. States will not be able to get federal funding for Medicaid coverage of prescription drugs for dual eligibles. However, states may be able to cover medications through state pharmacy assistance programs through state-only funds. Advocate for implementing such a program.

- Clients will need to know whether their current drug regimens will be covered by their prescription drug plans. If some are not, beneficiaries can switch plans, pay for medications or change regimens.

- Make sure that providers in your area know what to do and whom to call for assistance on January 1, 2006. Tell your clients to call you if their providers are unclear about the changes or resist prescribing necessary medications that are not on the Medicare prescription drug plan formulary.

- Find out if pharmacies in your client's new drug plan are accessible. Does your client know how to obtain prescriptions at those pharmacies?

- Determine if beneficiaries have accessible means of changing the plan in which they were automatically enrolled. Are there TDD numbers? Language assistance for Limited English speakers? Help for individuals with mental disabilities?

Resources on Medicare Part D

- National Health Law Program
  www.healthlaw.org

- Center for Medicare Advocacy
  www.medicareadvocacy.org

- National Senior Citizens Law Center
  www.nsclc.org

- Kaiser Family Foundation
  www.kff.org/medicare/

- Families USA
  www.familiesusa.org