

Figure 1

Helping Dual Eligibles Navigate the Medicare Prescription Drug Program

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Figure 2

Key features of the Medicare Part D drug coverage program

- Voluntary drug coverage for persons entitled to Medicare Part A or enrolled in Medicare Part B; delivered through private risk-bearing entities
- Drug coverage provided through either stand-alone prescription drug plans (PDPs) or through Part C health plans (Previously called Medicare + Choice and renamed Medicare Advantage) (MA-PDs)
- Choice of at least 2 drug plans Part D coverage option becomes effective on January 1, 2006
- Dual eligibles get drug coverage through Medicare, not Medicaid
- Subsidies for low-income beneficiaries

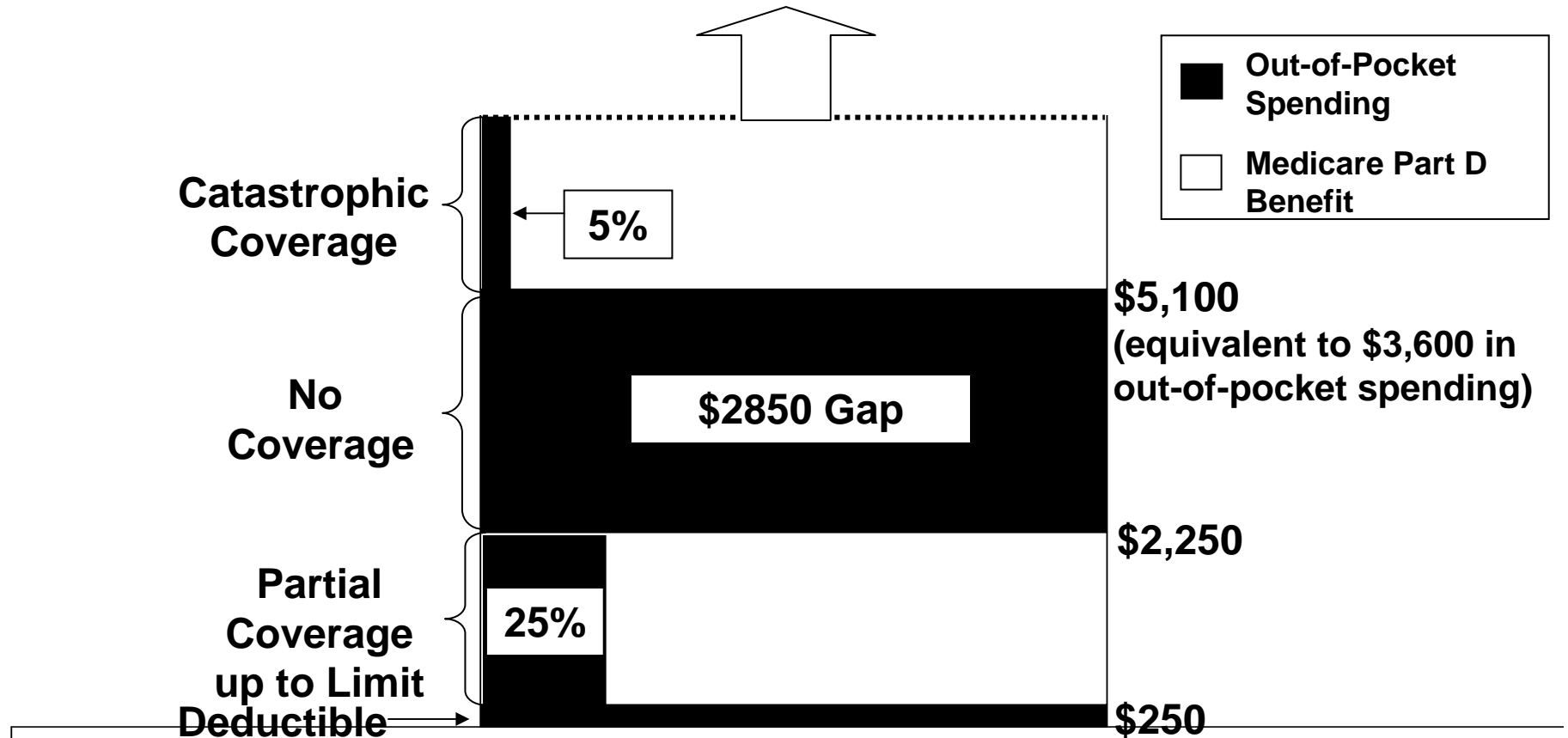
Figure 3

Key requirements for prescription drug coverage

- Covered drugs must be prescription drugs or biological products such as insulin. Medicaid excludable drugs (except for smoking cessation) and drugs covered by Part A or B cannot be covered
- Plan sponsors must cover drugs in each therapeutic category and each class, sponsors define what is a class.
- All PDPs and MA-PDs must offer at least the standard drug coverage or its actuarial equivalent called “basic coverage”.
- Actuarial equivalent plans may not have a deductible larger than the standard deductible and the out-of-pocket threshold must be the same
- PDP and MA-PD plan sponsors may also offer separate plans with richer coverage—and can cover Medicaid excludable drugs
- Part D plans at risk for cost of prescription drugs, although measures in MMA limit that risk somewhat

Figure 4

Summary of out-of-pocket drug spending in 2006



New Medicare Legislation

+ ~\$420 in annual premiums

Note: Benefit levels are indexed to growth in per capita expenditures for covered Part D drugs. As a result, the Part D deductible is projected to increase from \$250 in 2006 to \$445 in 2013; the catastrophic threshold is projected to increase from \$5,100 in 2006 to \$9,066 in 2013.

Figure 5

Subsidies for low-income beneficiaries

	Premium	Deductible	Cost-Sharing (Deductible – Stop-Loss Threshold)	Cost-Sharing (Above Stop- Loss Threshold)
Dual Eligibles Residing in Institutions	\$0 for low-cost plan, 20% of late enrollment penalty for up to 60 months	\$0	\$0	\$0
Dual Eligibles Below Poverty	Same as above	\$0	\$1/preferred + \$3/non-preferred in 2006, indexed to general inflation	\$0
Dual Eligibles Above Poverty + Non-Duals Below 135% of Poverty (Assets below \$6,000/\$9,000)	Same as above	\$0	\$2/preferred + \$5/non-preferred in 2006, indexed to per capita drug cost growth	\$0
Non-Duals Below 135% of Poverty (Assets between \$6,000-\$10,000/\$9,000-\$20,000) + Non-Duals Between 135-150% of Poverty (Assets below \$10,000/\$20,000)	Sliding Scale	\$50	15%	\$2/preferred + \$5/non-preferred in 2006, indexed to per capita drug cost growth

Source: Lambrew, J., George Washington University, 2003.

Figure 6

Policy responses to protect beneficiaries

In Statute

- Therapeutic classification system and incentives for complying with model guidelines
- Actuarial equivalence standard
- Non-discrimination rule
- P&T committee requirements

Subsequent Policy Responses

- Final Rule, including requirement that plans have a transition process
- Formulary review guidelines; assertion that CMS will actively use its legal authority
- Special requirements for 6 drug classes, requiring coverage of “all or substantially all” anticonvulsants, antidepressants, antipsychotics, antineoplastics, antiretrovirals, and immunosuppressants
- Transition process guidelines
- Upcoming guidance on P&T Committees

Figure 7

The implementation timeframe is tight

Key Dates in the Timeline for MMA Implementation	
Date	Activity
May, 2005 – August, 2005	The Social Security Administration (SSA) sends educational information to Medicare beneficiaries who appear eligible for the low-income subsidy program.
July 1, 2005	The Social Security Administration begins processing low-income subsidy applications. Medicaid offices must be prepared to accept applications.
Mid-September, 2005 (tentative)	The federal government makes final decisions on which plans can offer Medicare drug coverage.
October 1, 2005	Drug plans can begin marketing to potential enrollees
October 13, 2005	Information will become available on the plans offering coverage in each region. It will include how much it costs to enroll in a plan and which medications it covers.
November 15, 2005	“Initial enrollment” starts -- people can begin signing up for Medicare drug plans.
December 31, 2005	Last day of Medicaid prescription drug coverage for people who are dually enrolled in Medicaid and Medicare
January 1, 2006	Medicare drug coverage begins. Autoenrollment of dual eligibles into Medicare drug plans takes effect.
May 15, 2006	Last day of the “initial enrollment” period. After this date, late enrollment penalties apply.
Sources: Centers for Medicare and Medicaid Services, “Key Dates in the Implementation of Title 1 and Title 2,” updated May 11, 2005 and “Medicare Prescription Drug Improvement and Modernization Act Implementation Timeline: January 2005 - December 2006 Key Dates,” Kaiser Family Foundation.	

Figure 8

Fixing the Train Wreck

Limited opportunities to exert new influence on the policy process. One big priority:

- **Transition period is needed to prevent a train wreck for dual eligibles**
 - 6.4 million dual eligibles must be identified, enrolled in a Medicare Part D plan, and educated about changes in how they access prescription drug coverage BEFORE they lose Medicaid drug coverage. Even 95% success rate would leave hundreds of thousands at risk
 - In 2005, Congress MUST create a transition period so that Medicaid can serve as a temporary source of back-up to Part D coverage, during the initial transition period
 - **Must become a high priority for the coming year: Congress reluctant to re-open law before 2006, therefore, must be a drumbeat to convince everyone that people could die if this is not addressed**

Figure 9

Medicare beneficiaries will need a great deal of assistance

- Most beneficiaries understand very little about the MMA
- Experience with discount card program shows that many people may do nothing
- In addition to information and outreach, many, many people will need extensive one-on-one assistance
- Information needs are often very specific (*i.e. plan options in a particular community, critical issues for people with various types of disability, helping people understand their personal needs—and how to translate personal needs into a smart plan choice*)
- With so many things happening to implement the MMA, unless there is a public outcry, big issues may be ignored by the feds

Figure 10

Making the law work for beneficiaries

To make the law work for people with disabilities, your help is needed to:

- Get engaged in outreach efforts
- Help constituents on Medicaid and low-income individuals understand that they must enroll in a Part D plan/request low-income subsidy and help constituents evaluate plan options/plan formularies and enroll in a Part D plan
- Allocate new resources to assist people with special needs (i.e. intensive education, staff training, development of educational materials, development of localized plan comparison information, tools to help people use plan comparison information)
- **Consider options for filling in coverage gaps; role of Medicaid medically needy coverage and Medicare Saving Programs may change for some people with disabilities**

Figure 11

Ensuring eligible people with disabilities get “extra help”

Low-income subsidy (LIS)—being marketed as “extra help”—program provides significant subsidies for low-income individuals. To access assistance there are two separate steps:

- 1.) apply for the low-income subsidy; and,
- 2.) enroll in a Part D plan

LIS

- Dual eligibles and Medicare Saving Program (MSP) participants (i.e. QMBs, SLMBs, and QIs) are automatically enrolled in the LIS program
- Other low-income individuals should be encouraged to apply for LIS (through SSA or Medicaid; may wish to encourage applications through Medicaid and encourage people to also apply for MSP). Applications accepted starting on July 1

Enrolling in a Part D plan

- Dual eligibles will be auto-enrolled before January 1; still need to be encouraged to select a plan that meets their needs
- MSP and LIS participants will be auto-enrolled next spring