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policy brief

MEDICARE MODERNIZATION ACT:

IMPLICATIONS FOR CONNECTICUT'S DUAL ELIGIBLES

KEY QUESTIONS FOR CONNECTICUT

An estimated 65,000 of Connecticut's 536,000 Medicare beneficiaries are "full-benefit dual eligibles," low-income seniors and people with disabilities who are enrolled in both Medicare and Medicaid.[1] The Medicare Modernization Act (MMA), which established a prescription drug coverage option in Medicare, ends dual eligibles' current prescription drug coverage under Medicaid on Dec. 31, 2005, and moves them into new Medicare prescription drug plans ("Part D" plans). The state is to be lauded for many of its education and outreach efforts surrounding Part D implementation. Nonetheless, to ensure that adequate access to prescription drugs is maintained for dual eligibles, many of whom rely heavily on medications to function and survive, Connecticut policymakers will need to determine:

- What steps will the state take to ensure that dual eligibles do not face new cost-sharing obligations or gaps in coverage under their Medicare drug plans?
- What steps will the state take to prevent interruptions in access to prescription drugs during the initial transition period to Medicare drug coverage?
- In the long-term, what plans does the state have for monitoring the impact of Medicare drug coverage on dual eligibles, as well as coordinating services between Medicaid and Medicare drug plans?

Connecticut Health Foundation

WHO ARE THE "DUAL ELIGIBLES"?

Full-benefit dual eligibles are seniors and people under age 65 with serious and persistent disabilities who receive Medicare and, on the basis of having very low incomes and minimal assets, also qualify for full Medicaid coverage. Dual eligibles rely on Medicare as the primary payer for their health care services, and Medicaid fills in for gaps in Medicare coverage. Gaps include prescription drugs (until Medicare drug coverage begins), long-term services and supports, and other services which Medicare covers incompletely or not all, such as vision, dental, durable medical equipment (DME), and physical and occupational therapy services. For dual eligibles, Medicaid also pays Medicare premium and cost-sharing obligations.

Since they generally must be impoverished to qualify for Medicaid, dual eligibles by definition have little or no income with which to pay for medications on their own. At the same time, they often have one or more serious medical conditions such as Alzheimer's disease, Parkinson's disease, heart disease, diabetes, HIV, or a serious mental illness such as schizophrenia that cause them to rely heavily on medications to function or stay alive. Compared to other Medicare beneficiaries, dual eligibles in Connecticut are far more likely to be disabled, age 85 or older, female, and a racial or ethnic minority (Figure 1). On average, dual eligibles in Connecticut fill prescriptions for seven different medications a year, and more than a third (36 percent) use 11 or more different medications. On a monthly basis, dual eligibles in Connecticut fill more than a quarter million prescriptions.[2]

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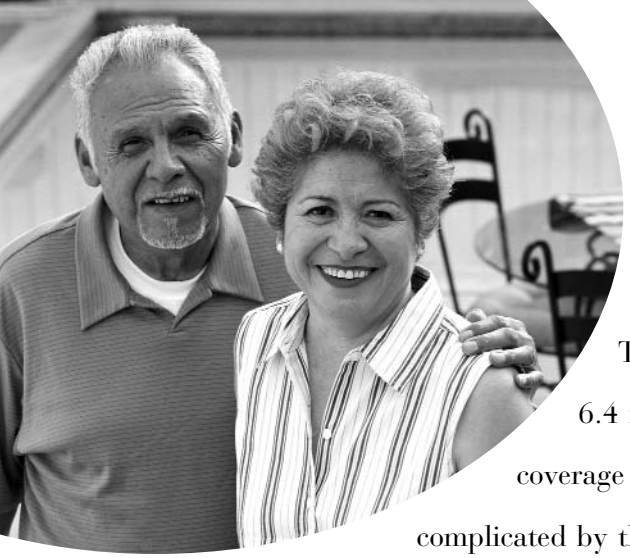


THE MULTIPLE ACTIONS NEEDED TO TRANSITION DRUG COVERAGE FOR DUAL ELIGIBLES CREATE RISKS

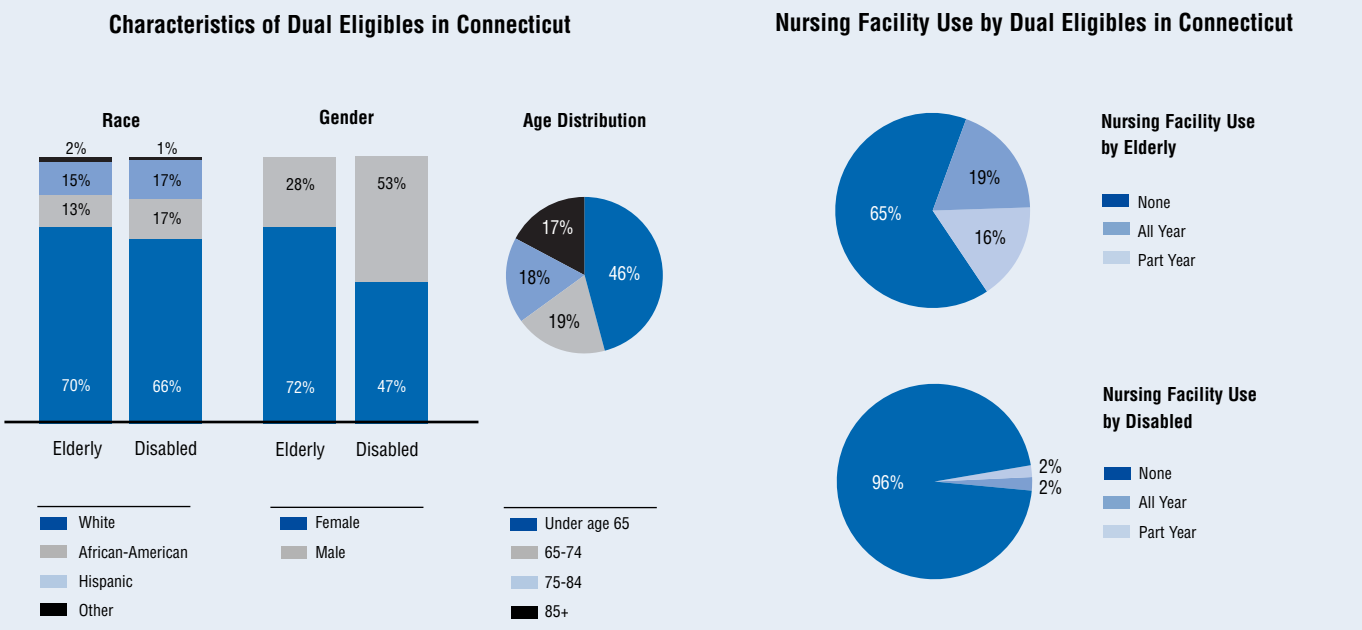
The movement of more than 65,000 dual eligibles in Connecticut — 6.4 million people nationwide — from Medicaid to Medicare Part D drug coverage would be a daunting task under any circumstances, but will be greatly complicated by the limited amount of time that federal policymakers have allowed for the transition. The transition, which involves multiple steps (Table 1), must take place by Dec. 31, 2005, less than two months from now. Complicating the transition is the decision of federal policymakers to end Medicaid drug coverage on the day before the Medicare drug plans become operational. The lack of any "backup" coverage for dual eligibles through Medicaid during the initial transition period means that there is no margin of error if problems arise.

Early Implementation Glitches: Empty Envelopes and Errors in Medicare Handbook

In May 2005, the federal government sent a letter to all dual eligibles about the upcoming changes to their prescription drug coverage. In an unknown number of instances, dual eligibles were mistakenly sent empty envelopes. If such a glitch were to arise later this year, the consequences could be severe.

In September 2005, the federal government sent its *Medicare and You Handbook: 2006* to all Medicare beneficiaries. It erroneously told all low-income Medicare beneficiaries that they can enroll in any Part D plan for free. According to Part D, low-income beneficiaries are restricted to an average or low-cost plan unless they can afford to pay the premium above the average cost plan. Although this has been corrected online, there are no plans to fix this mistake in the printed copies of the handbook.

Figure 1



Source: Center for Medicare Advocacy, Inc., analysis of claims data for Medicare beneficiaries who were eligible for Medicaid on Dec. 31, 2004, and who received at least one Medicaid paid service during calendar year 2004.

Table 1

Key Steps in the Transition from Medicaid to Medicare Drug Coverage for Dual Eligibles

Key Step	Potential Challenges
State identifies all dual eligibles	Experience with an earlier Medicare discount drug card program suggests there may be non-trivial discrepancies between the number of dual eligibles identified by states versus the federal government.
Federal government enrolls dual eligibles in "Extra Help" program that subsidizes Part D costs for low-income individuals	Requires coordination among a state, the Centers of Medicare & Medicaid Services (CMS) and the Social Security Administration; data systems not always compatible.
Federal government randomly assigns dual eligibles to a Part D plan	If the federal government's list of dual eligibles is incomplete, some dual eligibles will not be assigned to a plan; random assignments may not meet individual needs.
Medicare, Social Security, Part D plans, community-based organizations mail enrollment and marketing information to Medicare beneficiaries	Individuals may be overwhelmed by the complexity of the transition, which could be exacerbated by receiving large volumes of information from multiple sources.
Dual eligibles given opportunity to select their own Part D plan (cancels random assignment to a plan)	Comparing plans for coverage of multiple drugs is time-consuming and difficult; potential for large numbers of plans could lead individuals to take no action; potential for mistakes if a dual eligible's plan selection cancels auto-assignment to a plan.
Part D plan mails membership card to individuals	Some individuals may not receive a plan membership card, may not know how to use a membership card, or may confuse a membership card with unsolicited marketing information.
Medicaid drug coverage ends for dual eligibles on Dec. 31, 2005	People may be unaware of or confused about their loss of Medicaid drug coverage.
Drug coverage begins through a Part D plan on Jan. 1, 2006	Absence of a transition period when Medicaid provides backup coverage could lead to confusion, with significant treatment interruptions for some dual eligibles in early 2006.

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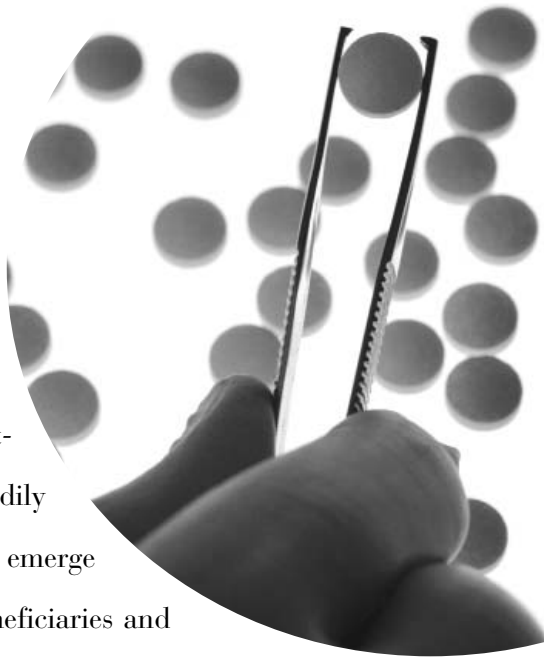
Part D Plan Options in Connecticut	
Number of Stand-Alone Prescription Drug Plans:	**44**
Number of Stand-Alone Plans with no premium for dual eligibles:	**11**
Number of Medicare Advantage Health Plans:	**16**
Number of Medicare Advantage Plans with no premium for dual eligibles:	**16**
Monthly premium subsidy for dual eligibles:	**$30.27**

KEY DIFFERENCES BETWEEN MEDICAID AND MEDICARE DRUG COVERAGE FOR DUAL ELIGIBLES



The prescription drug coverage provided to dual eligibles under Medicare drug plans is likely to fall short of what they currently receive under Connecticut's Medicaid program because they will be required to pay more out-of-pocket for their medications and their Medicare drug plans may not readily cover all of the medications that they need (Table 2). Any shortcomings that emerge in drug coverage under Part D plans could pose a threat to the health of beneficiaries and increase costs for Connecticut's Medicaid program causing some dual eligibles to end up institutionalized or in the hospital, for example.

Table 2

Medicaid and Medicare Drug Coverage Policies Compared

Benefit	Medicaid	Medicare
Drugs Covered	Formularies permitted, but all FDA-approved drugs must be provided with prior authorization.	Formularies permitted, but must cover at least two drugs per class, and must operate "exceptions process" to consider coverage of non-formulary drugs. Substantially all drugs in six classes must be covered: anticonvulsants, antidepressants, antineoplastics (cancer), antipsychotics, antiretrovirals (HIV), and immunosuppressants (organ transplant recipients).
Prior Authorization (PA)	Permitted. To date, limited, but increasing use of PA in Connecticut.	Permitted except that people already stabilized on medications in one of substantially all drugs in six key classes cannot be subject to prior authorization.
Cost-Sharing	Federal law permits nominal cost-sharing (up to $3/Rx). Connecticut Medicaid does not charge cost-sharing.	Dual eligibles residing in institutions are exempt from cost-sharing. Dual eligibles with income below poverty pay $1/Rx for preferred drugs and $3/Rx for non-preferred drugs. Dual eligibles with income above poverty pay $2/Rx for preferred drugs and $5/Rx for non-preferred drugs. No monthly cap on cost-sharing, even for people who may take 5 to 10 or more drugs per month.
Drugs Provided When Unable to Pay Cost-Sharing	Yes	No
Emergency Supply Required if Delay in Approving Coverage	Yes	No

Notes: A formulary is a list of drugs covered by a plan. Prior authorization is the process wherein a plan requires clinical evidence or other data to justify dispensing certain drugs.

MAJOR POLICY ISSUES

To safeguard that dually eligible Connecticut residents are protected during the transition to the Medicare Part D program and ensure that this program meets their needs over the longer term, policymakers in Connecticut should consider the following questions:

What steps will the state take to ensure that dual eligibles do not face new cost-sharing obligations or gaps in coverage under their Medicare drug plans?

Some other states in the mid-Atlantic region, including Maine, New Jersey, and New York, are setting up systems to minimize the extent to which dual eligibles face new cost sharing obligations and/or gaps in coverage of medications as a result of the transition to Medicare drug plans.

Figure 2

Easing the Transition for Dual Eligibles: Examples from Other States

A number of states around the country are taking action to ease the transition of dual eligibles into Medicare prescription drug plans. These strategies include:

Serving as a "backup" source of drug coverage. New York has opted to maintain Medicaid as a backup source of drug coverage for dual eligibles. Dually eligible New Yorkers will be required to enroll in a Part D plan, but if their plan does not cover all necessary medications, the state will use its own funds to do so. New Jersey also plans to use state funds to fill prescriptions that are medically necessary for dual eligibles when they are not covered by Medicare. For a six-week transitional period, beginning on Jan. 1, 2006, North Dakota has decided to assist dual eligibles if they have problems with their Medicare drug plans.

Making co-payments on behalf of dual eligibles. New Jersey has decided that it will cover any co-payments that dual eligibles face under Medicare Part D. Vermont plans to "hold harmless" dual eligibles by picking up any co-pay expenses they face under Medicare in excess of charges currently required in Medicaid. Maine will cover co-payments on behalf of dual eligibles in assisted living facilities who subsist on a small personal needs allowance.

Helping dual eligibles navigate the complex new world of Part D plans. Maine has compiled information on dual eligibles' current use of medications in Medicaid to help dual eligibles identify the Medicare drug plan that is best for them. The state also will serve as an "authorized representative" for dual eligibles, allowing it to help them file the paperwork needed for appeals if they are denied necessary medications by their Medicare drug plans. Massachusetts also has begun to "flag" dual eligibles who use a significant number of medications in order to allow the state to take steps to help them get enrolled in an appropriate Medicare drug plan.

In their spring legislative session, Connecticut's legislators decided to cover "Medicaid excludable drugs" for dual eligibles, classes of drugs that Part D plans generally cannot cover. These include benzodiazepines and barbiturates, two classes of mental health drugs that are widely prescribed. The legislature opted, however, not to cover non-formulary drugs or to fill in for other gaps in coverage. Now that information on Part D plans is available, and it is possible to review plan formularies, the state may wish to revisit the issue of filling in gaps in coverage for dual eligibles. Given that Medicaid does not charge cost-sharing in Connecticut and the state has implemented relatively few pharmacy restrictions, in the absence of action by the state, dual eligibles are likely to face new costs or new barriers to accessing certain drugs.

What steps will the state take to prevent interruptions in access to prescription drugs during the initial transition period to Medicare Part D drug coverage?

The state has been pro-active in funding the CHOICES program to conduct education and outreach. With state funding, CHOICES and the Center for Medicare Advocacy, Inc., a CHOICES partner, are also operating toll-free lines to answer beneficiary questions — and these lines have been busy. There may be additional actions that are necessary, however, to prevent problems from arising during the implementation of the Part D program.

Under the MMA, states cannot receive federal Medicaid payments for prescription drugs for dual eligibles after the end of this year. Some federal policymakers and consumer advocates have called for a one-time national transition plan, which would permit Medicaid to serve as backup coverage during the first six months of 2006.[3] Although it does not appear likely that this legislation will be enacted before Medicare drug coverage begins, Connecticut could consider providing backup coverage on a temporary basis with its own funds. Alternatively, it could consider other steps to promote a smooth transition and ensure comprehensive drug coverage for dual eligibles. These other steps include:

- Filling a larger than normal supply of drugs under Medicaid for dual eligibles in November and December, such as giving a 90-day supply of maintenance drugs instead of a 30-day supply.
- Ensuring that state law allows the Medicaid agency or other state entities to serve as the authorized representative of dual eligibles, thus allowing the state to pursue medications on an individual's behalf if they find it too difficult to navigate the exceptions process on their own.
- Enacting legislation that would address specific coverage gaps. A coalition of consumer advocates has been pushing the legislature to authorize Medicaid both to pay Part D co-payments for drugs and to provide coverage for non-formulary drugs for dual eligibles.

Coordination with a variety of community stakeholders will also be important. In addition to its partnership with the CHOICES program, the state could create something similar to the Transition Council, which was developed during the transition to Medicaid managed care, that would help dual eligibles transition into Medicare Part D smoothly. Such a group could consist of consumer advocates, pharmacists, Part D plans, physicians and other providers who would meet weekly or monthly to identify problems and seek solutions.

What plans does the state have for monitoring the impact of Medicare drug coverage on dual eligibles, as well as coordinating services between Medicaid and Medicare drug plans?

The state is uniquely situated to monitor the impact on access to drugs for dual eligibles, both because it already has extensive data on current drug use and because it will have data on dual eligibles' use of other services covered by Medicaid, such as hospitalizations and institutionalizations. It also would be mutually beneficial for Part D plans and Medicaid to share data and coordinate services as much as possible. But, establishing these relationships may not come naturally to either Medicaid (which is already understaffed and overextended) or plans (which may have concerns over sharing proprietary data). Therefore, a key question for the state will be how much emphasis to place both on monitoring plan performance and coordinating with plans to achieve optimal levels of services.

CONCLUSION

As the first group of Medicare beneficiaries enrolled in Part D coverage, dual eligibles will serve as the proverbial canaries in the coal mine. Problems will certainly arise with the rollout of the Medicare Part D program, and dual eligibles will be the group that serves as the sentinels for identifying larger problems. Although this is a federal program, subject to federal rules, Connecticut has a significant stake in ensuring the best possible outcomes for dual eligibles — it also has significant resources, including a level of trust and familiarity by many dual eligibles. As Jan. 1, 2006, approaches, given the ongoing debate within the state over providing wrap-around coverage for dual eligibles, state policymakers will likely face state residents who expect them to take all reasonable steps to facilitate a smooth transition and comprehensive prescription drug coverage for dual eligibles.

REFERENCES

1 Some Medicare beneficiaries with too much income to qualify for full-benefit Medicaid receive assistance with paying Medicare Part B premiums, and in some cases, Medicare cost-sharing. These are called partial benefit dual eligibles. They are also referred to as Medicare Savings Program (MSP) participants and include Qualified Medicare Beneficiaries (QMBs), Select Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QI-1s).

2 Center for Medicare Advocacy, Inc., analysis of claims data for Medicare beneficiaries who were eligible for Medicaid on Dec. 31, 2004, and who received at least one Medicaid paid service during calendar year 2004.

3 For example, the Medicare Dual Eligible Prescription Drug Coverage Act of 2005 (S. 566/H.R. 1144) has been introduced by Sen. Jay Rockefeller (D- WV) in the U.S. Senate and Rep. Thomas Allen (D – ME) in the U.S. House of Representatives.

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