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The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans

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Executive Summary

I. Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 establishes a new "Part D" in Medicare that gives people access to a private Medicare prescription drug plan. The new Medicare law has particular relevance for the six million low-income Medicare beneficiaries also enrolled in Medicaid. These Medicare beneficiaries – often referred to as "dual eligibles" – typically have income of less than $10,000 a year and often face serious health challenges such as diabetes, heart disease, dementia or a severe mental illness. Close to one in four dual eligibles lives in a nursing home.

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Like all other Medicare beneficiaries, dual eligibles will have access to the universal Medicare prescription drug benefit when it goes into effect on January 1, 2006. However, dual eligibles are the one group whose current drug coverage is directly terminated by the MMA. Medicaid will no longer pay for prescription drugs for dual eligibles as of January 1, 2006. They are to obtain their drug coverage by enrolling in one of the new Medicare drug plans. Dual eligibles can sign up for a Medicare drug plan on their own, but, if they do not do so, the Secretary of Health and Human Services is required to automatically enroll them in a plan on a random basis.

As with any major shift in health care services for a vulnerable population, there is some concern about potential glitches as dual eligibles transition from Medicaid to Medicare for their drug coverage. The purpose of this issue paper is to identify "risk points" in the transition that if addressed upfront could minimize disruptions in drug coverage. It is based on a review of the MMA, along with the proposed regulations on the MMA released in August of 2004 by the Department of Health and Human Services. The report describes the characteristics of dual eligibles and then discusses four key elements of the transition:

- Timeframe for Education and Enrollment
- The Automatic Enrollment Process
- Assistance for Dual Eligibles After Enrollment
- Ongoing Education and Outreach Efforts

II. Timeframe for Education and Enrollment

More than 6 Million Dual Eligibles Must Be Enrolled in Six Weeks

Under the Medicare drug law, people will first be provided with information on the private drug plans available to them beginning on October 15, 2005. They can begin signing up for a private Medicare drug plan on November 15, 2005, the first date of an initial enrollment period that ends six months later on May 15, 2006. For dual eligibles, however, they effectively must enroll in a Medicare drug plan by January 1, 2006 since Medicaid drug coverage ends the same day. To avoid gaps in drug coverage, this means that over six million dual eligibles must be enrolled in the new Medicare drug plans and begin using them for coverage just six weeks after they become available.

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III. The Automatic Enrollment Process

Dual Eligibles Will Have Less Time Than Other Beneficiaries to Pick a Medicare Drug Plan on Their Own

The short time frame in which dual eligibles are expected to sign up for a private Medicare drug plan will make a deliberate and voluntary choice of plans difficult. While most Medicare beneficiaries will have the full six-month initial enrollment period to select a plan, dual eligibles need to enroll within six weeks to avoid a disruption in drug coverage. CMS has suggested it may need to begin automatic enrollment of dual eligibles as early as late November of 2005, just a few weeks after the initial enrollment period begins, in an attempt to minimize coverage gaps for dual eligibles.

Automatic Enrollment May Prove Essential, but Also Problematic

If, as expected, the vast majority of dual eligibles do not understand they should select a private Medicare plan on their own, automatic enrollment becomes an essential mechanism for attempting to reduce the extent to which dual eligibles are without any drug coverage. At the same time, automatic enrollment raises several issues:

- **Reaching, informing and enrolling *all* dual eligibles by January 1, 2006 pose, serious challenges.** Gaps in data and information, or inaccurate data, could mean that some dual eligibles will not be picked up by the automatic enrollment process, at least initially. The high volume of assignments made in a short period of time provides little room for error, and could exacerbate potential problems with the data and systems used.

- **Dual eligibles may be confused or unaware that they have been automatically enrolled.** If they are automatically enrolled, many dual eligibles may not realize

that they have been signed up for a private Medicare drug plan or may not understand how to use it. This has been the experience under Medicaid with mandatory enrollment in managed care.

- **Dual eligibles may end up in plans that do not cover the medications that were previously covered under Medicaid.** Dual eligibles randomly assigned to a Medicare drug plan are at particular risk of finding that the drugs they need are not covered by their new plan. If they sign up on their own, they have a greater chance of selecting a plan that covers the drugs that they need. While the law allows duals to switch plans throughout the year, it may be some time before they learn about this option. The extent to which this is an issue will become clearer in the Fall of 2005 when new Medicare drug plans become available and details pertaining to their formularies are known.

IV. Assistance for Dual Eligibles After Enrollment

Once Enrolled in a Medicare Plan, Dual Eligibles Are Likely to Need Ongoing Assistance

Even if all of the dual eligibles are signed up for private Medicare plans by January 1, 2006, the loss of Medicaid drug coverage could raise significant transition issues, including:

- Learning how new Medicare drug plans work and which drugs they cover;
- Securing physicians' help in rewriting prescriptions to match drugs covered by new plans;
- Navigating a Medicare drug plan's prior authorization requirements; and
- Working with their physician to secure an exception, in cases where a drug they need is not covered by their plan.

While other Medicare beneficiaries also will need time to get accustomed to using their Medicare drug plans, dual eligibles are in a particularly high stakes situation because they will lose their current drug coverage on the first day that the private Medicare drug plans begin operating.

V. Education and Outreach Efforts

Due to the special challenges that many dual eligibles face, ongoing, targeted education, outreach and user-support efforts could be especially helpful in the early years of the new Medicare drug benefit. Dual eligibles are generally sicker and more disabled than other Medicare beneficiaries, they face more language and cultural barriers, and many of them live in nursing homes. All of these factors create barriers to educating them about the new Part D drug program and how the changes will affect their access to prescription drugs. CMS has indicated it will conduct a broad public information campaign for all Medicare beneficiaries, and that a special effort will be made to educate low-income

beneficiaries. Special effort focused on dual eligibles needs to be included as part of the drug law implementation.

VI. Conclusion

The transition of prescription drug coverage for dual eligibles from Medicaid to Medicare represents a major shift in care for a particularly vulnerable population. Given their poorer health status and heavier reliance on prescription drugs, special attention needs to be given to assisting duals in the transition, especially since the consequences of gaps in coverage and missed medications can be severe for this group. The tight timeframe in which dual eligibles are to be enrolled in the new private Medicare drug plans and to become adept at using them raises concern that many of them will experience disruptions in access to prescription drugs during the transition. Efforts to smooth the transition could include major education and outreach efforts aimed at dual eligibles and backup drug coverage during the initial months of the transition. Such efforts should be a high priority in MMA implementation.

The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003[1] moves over 6 million dual eligibles (i.e., low-income elderly beneficiaries and persons with disabilities who are enrolled in both Medicare and Medicaid)[2] from Medicaid to Medicare drug coverage. At the same time that the new Medicare prescription drug plans become operational on January 1, 2006, Medicaid prescription drug coverage will end. As with any major shift in health care services for a vulnerable population, the movement of dual eligibles from Medicaid to Medicare drug coverage can be expected to run into some glitches. The purpose of this issue paper is to identify "risk points" in the transition that if addressed upfront could minimize disruptions in drug coverage.

The enrollment process is particularly important for dual eligibles because they tend to be a sicker and more disabled population, and more in need of health services than the average Medicare beneficiary.[3] This is particularly true of the drug benefit. Dual eligibles tend to need more prescriptions than other Medicare beneficiaries. Due to several factors, however, dual eligibles are less likely to understand the new Medicare program and the choices they need to make. Adequately educating them and assisting them with such a choice presents a major challenge to both the federal government and the states. It is also important that the transition occur quickly and relatively smoothly because many dual eligibles conditions require an uninterrupted supply of drugs.

The transition to Medicare, however, may limit access for this population. Whereas under Medicaid their benefit coverage was automatic, under Medicare dual eligibles will be required to go through a multi-step process to obtain drugs. This includes learning about the program and plans; making a selection and enrolling in a plan; and then learning how the plan operates and dispenses drugs. If a dual eligible does not choose a drug plan within the prescribed time frame, they will automatically be enrolled in a drug plan to ensure that the benefit continues after the Medicaid drug benefit expires. Such a process for this population will almost certainly lead to some individuals falling between the cracks and not receiving their drugs.

After presenting some background information, this paper will focus on four topics and discuss the key issues in enrolling the dual eligibles into Medicare Part D plans:

- Timeframes for Education and Enrollment
- Automatic Enrollment Process
- Assistance for Dual Eligibles after Enrollment
- Ongoing Education and Outreach Efforts

The paper will conclude with a discussion of policy implications of the proposed enrollment process.

I. Background

Timeframe for Part D Enrollment

The general enrollment periods for Part D include: (1) the initial enrollment period, (2) the annual coordinated election period, and (3) the special enrollment periods.[4] Initial enrollment periods in the future will be seven months long, but for beneficiaries who are already eligible for Medicare by November 15, 2005, there will be an initial enrollment period of six months from November 15, 2005 through May 15, 2006. The annual coordinated period for 2006 will run concurrently with the initial enrollment period, i.e., November 15, 2005 through May 15, 2006. In subsequent years the annual coordinated election period will be from November 15 through December 31 for coverage beginning on January 1 of the following year.

The statute and proposed rule establish special enrollment periods (SEPs) that allow an individual to disenroll from one drug plan and enroll in another at any time under certain circumstances including:

- Involuntary loss, reduction of non-notification of creditable coverage
- Erroneous enrollment
- Any dual eligible, and
- Exceptional circumstances as defined by CMS.

The provision of a special enrollment category for dual eligibles is particularly important as they are the only Medicare recipients who, if they don't enroll on their own, will automatically be assigned to an average or low-cost Part D plan on a random basis. A SEP will provide dual eligibles that are automatically enrolled in a plan the opportunity to change plans at any time.

In addition, dual eligibles are deemed eligible for a full premium subsidy equal to 100 percent of the cost of enrolling in an average or low-cost plan. They will also not be subject to any deductible and most other cost sharing requirements. They will be subject to nominal co-payments unless they are institutionalized.

Experience with Enrollment and Dual Eligibles

Both the federal government and the states have significant experience with enrolling beneficiaries into managed care plans. In Medicare, this experience has been with beneficiaries who voluntarily enrolled and usually does not involve the dual eligibles. The states, however, have had considerable experience with enrolling populations into mandatory managed care programs. While the vast majority of such enrollments have involved low-income women and children, several states have experience enrolling dual eligibles into managed care plans.

Successful state experiences with enrolling beneficiaries into managed care plans has identified certain factors that lead to a successful program:

- A strong education program prior to enrollment to help beneficiaries understand the managed care program in general and the choice of managed care plans;
- Multiple methods for education, including mailings, telephone calls, presentations and face-to-face meetings;
- Choice counseling as part of the enrollment process to assist beneficiaries in making a choice among managed care plans and providers;
- Active outreach during the enrollment period to maximize the voluntary choice of health plans.

States often hire private companies to carry out these functions. These companies, known as enrollment brokers, were originally sought by states to provide an alternative to the biased marketing information that was provided to beneficiaries by Medicaid health plans. The enrollment broker role has evolved over time to include education, outreach and enrollment services that employ a variety of approaches including mailings, call centers, community-based outreach and websites. Using enrollment brokers, states have been able to achieve high levels of voluntary choice, but such efforts require significant resources devoted to the task throughout the enrollment period.

Only about 17 states have enrolled dual eligibles into managed care programs. Several of these states have enrolled significant numbers into managed care. The experience of states that have successfully enrolled dual eligibles is that this is a very challenging population to contact and engage. A substantial outreach effort is needed in order to educate the population and make them aware of their choices.

Timeframes for Education and Enrollment are Very Tight

Because Medicaid will cease to provide them a drug benefit on January 1, 2006, dual eligibles will have only six weeks beginning with the open enrollment period on November 15, 2005 to enroll in a drug plan before they will find themselves without any drug coverage. The proposed rule states that dual eligibles will have the entire 6 months of the initial enrollment period to make a choice, but the early date for the termination of the Medicaid coverage, January 1, 2006, is the relevant deadline. According to the proposed rule, the short enrollment window for dual eligibles will be preceded by a one month period for education and marketing that will begin October 15, 2005 when CMS will provide all Medicare beneficiaries information on the new drug program and on the drug plans they will be able to choose from in their region.

The preamble to the proposed rule says that CMS, in addition to its general effort to educate all Medicare beneficiaries, will undertake a substantial outreach effort to assist low-income beneficiaries. Beyond a general description of the types of approaches that will be used, however, few details on this effort are provided. Unlike enrollment in Medicaid managed care, the proposed rule does not mention the use of an enrollment broker with an incentive to assist the beneficiary in making a voluntary choice among drug plans. All dual eligibles that fail to choose a health plan will be automatically enrolled in a drug plan.

Issues

The short timeframe provided for education and enrollment raises issues regarding: (1) the ability of dual eligibles to make a voluntary choice, (2) the adequacy of information provided about each drug plan, and (3) how dual eligibles residing in institutions will be assisted.

- Dual eligibles unlikely to have enough time to learn about the Part D drug program, and to make an informed choice of drug plans.

The short time frame available to enroll dual eligibles into a private Medicare drug plan would seem to preclude the possibility that they are likely to make a deliberate and voluntary choice among plans. A timeline of events shows that education, outreach, enrollment and transition are being compressed into a short timeframe. This will make it very difficult for this vulnerable population to voluntarily select a Part D drug plan (see Table 1).

Table 1: Timeline for Dual Eligible Enrollment

Date	Requirement/Event
October 15, 2005	CMS Sends out Information on Specific Drug Plans
November 15, 2005	Enrollment in Part D Drug Plans Begins
January 1, 2006	Medicaid Drug Benefit for Dual Eligibles Ends
May 15, 2006	Initial Enrollment Period for Part D Ends

The short length of time for enrollment is striking for two reasons. First, unlike other Medicare beneficiaries for whom enrollment in a drug program is voluntary, dual eligibles must enroll in a drug plan. The decision to choose a plan is effectively a mandatory decision, and therefore, should require that dual eligibles be given a reasonable amount of assistance and time to make the choice. Second, because they are a sicker and more vulnerable population that most Medicare beneficiaries, dual eligibles need more information, assistance and time to enroll than other Medicare beneficiaries. Yet they are the one group of Medicare beneficiaries who will have less time for making a choice. This is particularly striking because they will be experiencing a major transition in their prescription drug coverage and making choices that were not required of them in the past.

The transition process will begin with dual eligibles obtaining information on the program and learning about their choice of drug plans. Then they must choose a plan and enroll in it. Finally, they have to learn how to access the benefit within their drug plan and which drugs are covered by their plan's formulary. If any drugs that they currently use are not covered by the plan, they will probably need to make a visit to their proscribing physician to find a substitute drug that is on the plan formulary. In some cases, they may need to seek exceptions from their plan's formulary.

The outcome of the tight timeframes for the education and enrollment process will undoubtedly be very high levels of automatic enrollment rates among dual eligibles. In fact, because of the loss of the Medicaid drug benefit on January 1, 2006, the required enrollment of so many dual eligibles and the need for some kind of transition period, automatic enrollment may have to begin soon after the enrollment period begins November 15, 2005 in order for the transition to occur in time.

- Dual eligibles provided limited assistance to enroll in drug plans.

Most dual eligibles will need special assistance if they are to make a voluntary choice among drug plans. To choose among plans, dual eligibles need to understand what drugs are on the formularies; how drugs will be ordered and delivered; and how this plan is related to their other providers.

Beyond the general outreach program mentioned in the proposed rule for low-income beneficiaries there are no details on how dual eligibles will receive assistance with enrolling. The task of selecting a plan will rest with the beneficiary, family and other informal support. Under the proposed rule, it appears there will not be any independent entity to provide choice counseling, nor incentives for that independent entity to increase the voluntary choice rate. Several of the activities that have increased voluntary choice rates within state Medicaid managed care programs, such as follow-up mailings and phone calls, appear not to be included in the Part D enrollment process for dual eligibles.

- In the proposed rule, there is no special plan to assist enrollment of the more than 1.5 million institutionalized dual eligibles.

In the proposed rules, there is no special plan outlined for assisting institutionalized dual eligibles with enrollment into drug plans or for how to handle automatic enrollment if they do not make a choice. The proposed rule does not clarify who has authority to act when the eligible individuals are not capable of enrolling themselves, although one would assume residents would be dependent on facility staff and their families to make a selection. These parties will need to be informed to provide the beneficiary with good advice. All of these issues are magnified by the short period provided for enrollment.[5]

Currently, most nursing homes use institutional pharmacies that specialize in long-term care facilities. They tailor their services to nursing home residents by providing each resident's prescriptions in individual blister packs, which are designed to avid error in administration of the medication by nursing home staff. These institutional pharmacies also provide additional services such as the monthly review of each resident's medication by a consultant pharmacist to avoid adverse drug interactions.

Clearly, the implementation of a Medicare drug benefit has the potential to disrupt current administrative and commercial arrangements among Medicaid, Medicare, nursing facilities and institutional pharmacies. If a dual eligible selects a drug plan that does not include the nursing facilities pharmacy, it is not clear how drugs will be provided. It is also not clear what will happen if dual eligibles in the same facility are automatically

enrolled in different drug plans. Such arrangements will require new methods of control and oversight in order to ensure residents are receiving the drugs they need in a timely manner.

In summary, the limited timeframe for educating and enrolling dual eligibles will lead to high levels of automatic enrollment. The next section explores some of the issues raised by autoenrollment.

II. The Automatic Enrollment Process

Automatic enrollment will play a very important role in the enrollment process for dual eligibles as it likely to be the method for assigning a high proportion of dual eligibles to Part D drug plans. Dual eligibles that do not select a Part D drug plan during the enrollment period will be automatically enrolled in a drug plan within their region.[6] There is an effort to ensure that all dual eligibles will be enrolled in a drug plan before Medicaid coverage for dual eligibles ends. The choice of assignment is limited, however, in that only drug plans that have monthly premiums at or below the subsidy amount available to low-income beneficiaries will be assigned dual eligibles. Automatic enrollment of dual eligibles will be random among the drug plans that meet the premium criteria. Once assigned to a drug plan, dual eligibles will have the ability to change plans at any time under a special enrollment period (SEP).

A high level of voluntary selection of health plans in Medicaid managed care is considered by many state officials and experts to be essential to the operation of a Medicaid managed care program. It's a confirmation that the beneficiary understands how the program works and how to access services. Conversely, a low voluntary choice rate is a sign that a large part of the beneficiary population does not understand the program and will not understand how to gain access to services. High automatic enrollment of dual eligibles in the Medicare Part D program may signal similar problems.

The statue says that the Secretary of HHS will be responsible for automatic enrollment. However, the proposed rule leaves open the question of whether the federal government or the states will actually perform the process. There are positive and negative reasons for having either carryout the task. It will be a major challenge for either or both levels of government to complete the automatic enrollment simply because of the significant number of dual eligibles and tight time frames. In addition, the decision on which level of government handles the operation should be considered in the context of other changes occurring between the federal and state governments in the administration and financing of healthcare for the dual eligibles, such as the new responsibilities that states have under the MMA for sending "clawback" payments to the federal government to help finance Part D drug coverage for dual eligibles and for processing applications for the Part D low-income subsidy program.[7]

Issues

The automatic enrollment process outlined in the proposed rule brings up several issues:

- Automatic enrollment may have a negative impact on dual eligibles.

While the automatic enrollment process is intended to ensure that every dual eligible has uninterrupted drug coverage, it also may prove problematic. Dual eligibles, even more than other Medicare beneficiaries, are used to obtaining their services in a certain way, usually from a particular provider. By assigning them to a drug plan they are not familiar with, dual eligibles are likely to face problems in obtaining drugs for several reasons. First, if they are autoenrolled, it may mean that they do not understand one or more of the following:

  - How the new Part D benefit operates in general,
  - How their private Medicare drug plan operates, and
  - Which drugs are available to them through their plan and how they can obtain those drugs.

Simply enrolling an individual in a drug plan does not remove the barriers to obtaining drugs that existed before enrollment. The dual eligibles, in particular, still will need significant assistance in understanding how the Medicare Part D benefit works and the steps they must take to obtain their drugs from the proper source under their Medicare drug plans. Even more than other dual eligibles, institutionalized dual eligibles will have difficulty understanding how the program works and how drugs will be distributed within their facilities. Overall, without additional assistance, dual eligibles that have been automatically enrolled may fall between the cracks and not get the drugs they need.

Providing dual eligibles the option to disenroll at any time and choose another plan through a special enrollment period (SEP) is good protection for dual eligibles who find themselves automatically enrolled in a plan they don't like or enrolled before they understand the new program and their choices. However, the SEP for dual eligibles will be helpful only if they are made aware that it gives them the option to switch plans and if they reside in a region that has more than one drug plan that meets the low-income subsidy criteria. Some experts believe that many regions of the country are likely to have only one or two plans that are average or low-cost and, therefore, fully subsidized for dual eligibles.

- Automatic enrollment will be a major undertaking and the roles of the federal government and states in automatic enrollment are not yet clear.

If a majority of dual eligibles need to be automatically enrolled in a short time, it will be a major undertaking by either the federal government or state governments, or both. This is particularly true with so many other changes going on in the Medicare program. Substantial upfront planning and coordination will be necessary so that the operational capacity to carry out the process is in place.

The proposed rule leaves open the question of what role the federal government and states will play in automatic enrollment. There are positive and negative reasons for having either the federal or state governments carry out automatic enrollment. If the federal government handles the process it is likely to be a uniform process throughout the country. In addition, some would argue that the federal government has more resources to handle the operation.

There are, however, a few reasons why the federal government might not be the best choice for carrying out automatic enrollment. The federal government is not as familiar with the dual eligible population as are the states. Further, to carry out the process, the federal government would still depend on receiving eligibility data from the states. Also, the federal government does not have any experience with an automatic enrollment process for selecting plans.

In some respects, States would be a good choice to operate automatic enrollment because they are more familiar with the dual eligible population, and many of them have experience with automatic enrollment processes from their Medicaid managed care programs. States also have much of the data that would be needed to carry out automatic enrollment for dual eligibles in their states.

On the other hand, there are reasons states might not want to handle automatic enrollment. While some states have experience with automatic enrollment, many smaller states do not. In addition, states would still have to work with the federal government on data issues, as they do not have all the necessary data needed for automatic enrollment (e.g., they would not necessarily know if a dual eligible already had voluntarily signed up for a Part D plan and, thus, should not be auto-enrolled). It is likely that gaps in data and information, or inaccurate data, will result in at least some dual eligibles not being picked up by the automatic enrollment process, at least initially. For example, inaccurate information on dual eligibles in the databases may lead to them not being matched to an appropriate drug plan. Some states that automatically enrolled people on state-funded pharmacy programs into the temporary discount cards established by the Medicare drug law found that a small number of the assignments initially did not work due to data issues. The high volume of assignments being made in a short period of time will exacerbate problems with the data used.

An additional reason why states may not be the appropriate entities for conducting autoenrollment is that the size of the clawback payments they must send to the federal government increase with the number of dual eligibles enrolled in Part D plans. States, therefore, appear to have a fiscal incentive to decrease, rather than increase, the number of dual eligibles enrolled in Part D plan.

Perhaps the biggest impediment from the states' perspective in taking on the task of autoenrollment is the additional mandate it could present. The states are already taking on a role in the enrollment of beneficiaries into the low-income subsidy program, as was mandated by the statute. Automatic enrollment would be an additional burden for which

they may have to pay half of the costs. Also, states have said they will need to make systems changes to carry out automatic enrollment—changes that have not been planned or budgeted for in 2005. The states' position, as detailed in their comments to the proposed rule, is that states should have the option as to whether they manage the automatic enrollment process, but if they take up the option it should be fully paid for with federal funds.[8]

In addition, states officials are also concerned that to the extent the enrollment and automatic enrollment of dual eligibles does not occur smoothly, dual eligibles will be unable to obtain needed drugs. In order to alleviate some of these problems, the states have called for a phased in enrollment process, rather than having so many dual eligibles enrolled at one time. If this population finds itself without a source for drugs, state officials believe they will request assistance from state or local governments or health care providers.

III. Assistance for Dual Eligibles after Enrollment

The swift enrollment of dual eligibles into Part D drug plans raises another set of issues. If dual eligibles are enrolled before they understand how the program works and how they will obtain drugs through their drug plan, they will need to get assistance after enrollment. Dual eligibles will require significant education after they are automatically enrolled if they are expected to understand and use the program properly. Specifically, such assistance needs to assist dual eligibles with the transition to the new program and with obtaining access to needed drugs.

Issues

- Dual eligibles need assistance with the transition into the Part D drug program.

Most dual eligibles will need more time to transition to the new program and to new drug providers than other beneficiaries, yet they will be provided far less time to make the transition. A recent report by the Medicare Payment Advisory Commission identified several tasks that must take place when an individual with employer-based prescription drug coverage is moving from one plan to another.[9] Dual eligibles will face such a transition at the beginning of the program as they already have established a process for obtaining their drugs and will see that arrangement change with enrollment into a Part D drug plan. Some of the tasks identified by the Commission include:

- Educating beneficiaries,
- Communicating with relevant physicians and pharmacists,
- Distributing new drug benefit cards,
- Transferring data on eligibility and enrollment, and
- Additional processes to minimize problems for beneficiaries arising form disruption of pharmacy networks and formulary systems.

These are important steps that most dual eligibles will face. Hopefully, the drug plans can assist with this effort. If problems arise, many dual eligibles are likely to return to their Medicaid drug provider and seek assistance with the new system. Pharmacists and prescribing physicians around the country need to be educated about the Part D drug program and the pending switch in the source of drug coverage for dual eligibles from Medicaid to Medicare. While some states have decided to take on this responsibility, it is not clear there will be a national effort.

- Access to needed drugs may not be assured.

Depending in part on the way in which the MMA is implemented, dual eligibles may not have access to all needed drugs after enrollment in a Medicare drug plan.[10] Dual eligibles have a range of disabilities and conditions. The most effective drugs for certain conditions, such as mental disorders, are among the most expensive drugs. Under the statute, drug plans will have incentives to limit drug costs and they will not be responsible for increased costs resulting from hospitalizations (except for people who secure their drug coverage through Medicare Advantage plans). Further, in designing formularies for the general Medicare population, drug plans may exclude certain high price drugs that are not commonly needed by people without disabilities or chronic conditions. Such restrictions may limit the number and types of drugs available to dual eligibles. To the extent the formularies of the different drug plans are not provided to dual eligibles prior to enrollment, the ability to secure needed drugs will be further compromised if they end up in a plan that does not include their medications on its formulary. Beneficiaries can, however, appeal a plan's formulary coverage if they believe a drug they need has not been included.

Access to drugs may also be compromised for dual eligibles after enrollment as they adjust to the new system. As has already been pointed out, dual eligibles are very likely to try to obtain drugs from the same provider they used when they had Medicaid coverage. At this point, it is not clear whether dual eligibles will always be able to continue to use their current providers.[11] They will, however, serve as an important player in the informal transition process.

IV. Ongoing Education and Outreach Efforts

Beyond the initial enrollment, dual eligibles will need to receive ongoing education about the new Part D program. As has already been described, this is a new program for them, which requires more decisions and actions than under the Medicaid program. Education and outreach efforts need to be established and operate on an ongoing basis to continue to support dual eligibles enrolling in the next year as well as for educating new enrollees to the program.

As described in the proposed rule, the education of all Medicare beneficiaries will be carried out through activities designed to broadly disseminate the information through several avenues.[12] CMS will conduct a broad public information campaign to educate beneficiaries about the program. In order to maximize enrollment in the program, the

agency envisions using outreach, mailings and enrollment assistance from state and federal agencies. CMS has said the campaign will include comparative information with respect to participating drug plans to promote informed beneficiary choice. This information will include:

- Benefits and prescription drug formularies;
- Monthly beneficiary premiums;
- Quality and performance;
- Beneficiary cost-sharing; and
- Results of consumer satisfaction surveys.

CMS will disseminate information about the Part D benefit to beneficiaries at least 30 days prior to the initial enrollment period, i.e., around October 15, 2005, and coordinate these activities with similar activities for the Medicare Advantage program. It is assumed that the same type of information will be available over time prior to all subsequent enrollment periods.

The dual eligibles will need a special educational effort that goes beyond the effort for most Medicare beneficiaries because the dual eligibles have a more difficult time understanding information presented to them and this is a complex topic. The proposed rule states that special outreach efforts will be undertaken targeted at disadvantaged and hard-to-reach populations which will be coordinate with a broad array of public, voluntary and private community organization that serve Medicare beneficiaries. According to the preamble, this campaign will "equip full benefit dual eligible individuals with information designed to explain options and encourage these individuals to take an active role in their enrollment rather than wait to be automatically enrolled."[13]

The law also provides special education grants to states with state pharmacy assistance programs (SPAPs) to educate enrollees about the new Medicare Part D drug benefit. This program will provide a total of $125 million in grants during 2005 and 2006 to states with SPAPs. The grants awards go to the 21 states that had programs on October 1, 2003 with funds apportioned based on the number of Medicare beneficiaries enrolled in each program. An equal amount ($62.5 million) is to be distributed in both 2005 and 2006. The first awards were made by the Department of Health and Human Services (HHS) in October 2004. These first awards to the states ranged from a high of $17 million for New York to a low of $50,782 for Wyoming. While it appears possible that outreach and education efforts undertaken with these SPAP funds could prove useful to some dual eligibles, the funds are not specifically aimed at an education and outreach campaign for dual eligibles and are not available in states without an SPAP.

Issues

An ongoing education and outreach program needs to address several issues including:

- Barriers to educating the dual eligibles may not be fully addressed

Dual eligibles appear to have limited knowledge of their service coverage or how benefits between Medicare and Medicaid are coordinated.[14] They will need to understand who covers the new benefit and how it will be delivered. However, there are many barriers to educating the dual eligibles about how the Part D drug benefit program works, how it affects them and the choices they need to make. These barriers include language and cultural, health and functional status, and living situation.

Many dual eligibles do not speak or read English, which limits the effectiveness of written material sent to them. Others may have literacy problems particularly in understanding a written description of the Part D program and the choices they need to make. Any materials provided to dual eligibles must take this into account to be effective.

Dual eligibles with disabilities may have difficulty understanding the program. For example, a person with cognitive impairments or dementia will have to have assistance in reviewing and assessing information on the program. Accommodations, beyond what is described in the proposed rule, will be needed.

As has already been discussed, more than 1.5 million dual eligibles are institutionalized. These beneficiaries need assistance in understanding the program. Assuming family members or facility staff is able to assist them, they have to be educated also. Similarly, for the substantial number of dual eligibles with significant impairments who live alone, a strategy to reach out to them is needed.[15]

The proposed rule does not provide details on how it will address the barriers outlined above. For example, the proposed rule mentions mailings to beneficiaries and the availability of information on the web site. While this will help educate some dual eligibles and their family members, these approaches will be of very limited benefit to dual eligibles with language or literacy barriers.

The dual eligibles need frequent and varied communication in order to understand. Experience with transition in drug programs among the general population has shown that simple messages need to be repeated multiple times before the target population understands.[16] This is especially true for the dual eligibles. Beyond an enrollment packet, additional literature will be needed. Dual eligibles are used to getting information from professional and personal sources and they will probably seek out assistance from these sources when making decisions about drug plans.[17]

- Dual eligibles, or someone acting on their behalf, need to receive the right information to make an informed choice among drug plans.

The dual eligibles require certain pieces of information in order to make an informed choice among Part D drug plans. First, dual eligibles, or family members making decisions for them, need to be informed that they are only being allowed to select among plans with a premium at or below the average for all plans being offered in the region if they want a full subsidy. In other words, they only have a choice among certain lower

cost plans. This is particularly important for a population that has high drug utilization and high drug costs.

Second, dual eligibles need to receive information on the formulary of each plan in their region. Because each plan will have a closed formulary with certain drugs, this is critical information for the dual eligible if they are going to make an informed choice among plans. This is even more important as the dual eligibles are already limited in drug plan selection by the premium cost. The proposed rule, however, is ambiguous on this point. The preamble states that the formulary for each plan will be provided to beneficiaries before they enroll, however, the regulatory language being proposed does not address the issue.

- Drug plans have obligations to educate all Medicare beneficiaries

Drug plans are obligated to inform all Medicare beneficiaries they contact, not just the dual eligibles, about the program and the products they are offering. However, in order to provide unbiased information and to allow Medicare beneficiaries to make a choice without facing undue pressure, they are restricted in the methods they use to market to all Medicare beneficiaries. First, all of their marketing material must be reviewed and approved by CMS. Second, door-to-door marketing is prohibited. Third, drug plans may not discriminate against low-income beneficiaries in their marketing practices.

In summary, the education and outreach effort for the dual eligibles need to be conducted on an ongoing basis and will require significant planning and resources in order to prepare this population for the choices they make in the enrollment process.

V. Facilitating the Transition

The education of dual eligibles about the Part D drug program and their enrollment into drug plans is a major change in the way this population receives care. As outlined by the statute and proposed rule, several issues arise which raise concerns about the ability of CMS and the states to transition the dual eligibles to the new program effectively, especially with regard to the timeframe for enrollment and the impact of automatic enrollment on dual eligibles. Approaches that could be considered to smooth the transition include:

- Providing some backup drug coverage during the initial transition

The most obvious problem confronting the enrollment of dual eligibles is the short time period in which it will have to take place. The six weeks from the beginning of the enrollment until the dual eligibles lose there Medicaid drug benefit is too short a time to allow a credible voluntary selection process to take place. This problem can be avoided by extending the Medicaid benefit for a period of time, while the enrollment of dual eligibles continues. Such an extension would allow dual eligibles more time to compare and consider their choice of drug plans. In addition, even after choosing a drug plan, it

would provide dual eligibles a safety net while they transition to the new Medicare program.

- Effort can be made early to mitigate the negative impact of automatic enrollment

There are several actions that might be taken before and during enrollment to mitigate the impact of the automatic enrollment. First, the Social Security Administration and states are working on a major effort to educate and sign up Medicare beneficiaries for the low-income subsidy for program premiums. As part of this effort, information on enrolling in drug plans could be included.

Second, CMS could undertake a multi channel approach to educating and counseling dual eligibles with enrollment. For example, CMS could implement a major community outreach effort through CMS regional offices that targets nursing homes, foster homes, senior groups, groups for people with disabilities and advocates. The purpose of the outreach effort would be to make all stakeholders aware that there is a new program being implemented that will require the dual eligibles to make a decision or face automatic enrollment. Such a direct outreach effort could alert many of the parties that are going to assist or make the decision for dual eligibles regarding the enrollment in drug plans.

Third, CMS could execute a national media campaign to alert beneficiaries that a program change is occurring and they will be responsible for taking some action. Such a campaign would serve as a means to educate both the dual eligibles, their families' health care professionals, nursing facility administrators and other parties involved in the decision making process.

- Effort to mitigate negative impact of automatic enrollment can be made after the fact.

Dual eligibles that have been automatically enrolled and have little or no understanding of the new program are likely to go back to their Medicaid provider for drugs when they need a refill. One of the best ways to assist them is to implement a national information campaign targeted to pharmacists around the country. Such a campaign would provide instructions on how to assist customers who were on Medicaid but now must enroll in the Medicare drug program. Pharmacists could be provided details on how dual eligibles are enrolled and be given contact points and telephone numbers where they or their customers could obtain further information. In addition to educating pharmacists, other parties need to be educated, or further educated, through a campaign aimed at family members, health care professionals, nursing facility administrators, and other groups that have contact with dual eligibles.

VI. Conclusion

The transition of prescription drug coverage for dual eligibles from Medicaid to Medicare represents a major shift in care for a particularly vulnerable population. Given their

poorer health status and heavier reliance on prescription drugs, special attention needs to be given to assisting duals in the transition, especially since the consequences of gaps in coverage and missed medications can be severe for this group. Efforts to address these issues need to be a priority of implementation to assure as smooth a transition as possible for Medicare's poorest and often sickest beneficiaries. These could include maintaining Medicaid as a backup source of coverage on a temporary basis or devising special outreach and education efforts aimed at dual eligibles and the people who help them with health care decisions.

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[1] Public Law 108-173. For additional information and resources related to the Medicare prescription drug law, see the "Resources on the Medicaid Prescription Drug Benefit" section of the Kaiser Family Foundation website at www.kff.org/medicare/rxdrugdebate.cfm.

[2] For the purposes of this paper, dual eligibles refers to full dual eligibles as defined in MMA. These are beneficiaries who are currently entitled to all Medicare and Medicaid benefits and will be deemed eligible for the full premium subsidy. It does not include QIMBs and SLIMBs. It is estimated that there will be 6.4 million full dual eligibles out of approximately 41 million total Medicare beneficiaries by 2006.

[3] For a detailed discussion showing that dual eligibles are among the most vulnerable and highest cost beneficiaries in both programs see *Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps*, Judy Kasper, Risa Elias and Barbara Lyons, Kaiser Commission on Medicaid and the Uninsured, March 2004.

[4] Proposed Rule §423.36

[5] For discussions of the impact of MMA and the proposed rule on institutionalized beneficiaries see, *Issues for Medicare Beneficiaries in Long-Term Care Settings: An Analysis of the MMA and Proposed Regulations*, Vicki Gottlich, Kaiser Commission on Medicaid and the Uninsured, September 2004; or *Dual Eligibles in Nursing Facilities and Medicare Drug Coverage*, Andy Schneider, Kaiser Commission on Medicaid and the Uninsured, November 13, 2003.

[6] Proposed Rule §423.34(d) describes the automatic enrollment requirements.

[7] States are required by the MMA to send monthly payments to the federal government to help pay for the Part D prescription drug benefit for dual eligibles. The payments often are referred to as clawback payments. See *The "Clawback": State Financing of Medicare Drug Coverage,* Andy Schneider, Kaiser Commission on Medicaid and the Uninsured, June 2004.

[8] Letter from National Association of State Medicaid Directors to Dr. Mark McClellan, Administrator, CMS, regarding Proposed Rule, Medicare Program: Medicare Prescription Drug Benefit (October 4. 2004).

[9] *Report to Congress: New Approaches in Medicare,* pp. 24, Medicare Payment Advisory Commission, June 2004

[10] For a full discussion on the availability of drugs under MMA see, *The New Medicare Prescription Drug Law: Issues for Dual Eligibles with Disabilities and Serious Conditions*, Jeffrey C. Crowley, Kaiser Commission on Medicaid and the Uninsured, June 2004.

[11] In general, Part D plans can charge higher co-payments if people use pharmacies outside of their preferred network. But, given that dual eligibles are limited to paying no more than nominal co-payments under the Part D low-income subsidy, it is not clear where Part D plans will be able to use fiscal incentives to support the use of preferred networks of pharmacies among dual eligibles.

[12] Proposed Rule §423.48 (Preamble p. 46642)

[13] Proposed Rule Preamble, Federal Register August 3, 2004, p. 46638

[14] *Case Studies of Managed Care Arrangements for Dually Eligible Beneficiaries*, Edith G. Walsh, Angela M Greene, Sonja Hoover, Galina Khatutsky, Christine Layton, Erin Richter, RTI International, September 25, 2003.

[15] *Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps*, Judy Kasper, Risa Elias and Barbara Lyons, Kaiser Commission on Medicaid and the Uninsured, March 2004

[16] *Report to Congress: New Approaches in Medicare,* pp. 24, Medicare Payment Advisory Commission, June 2004

[17] Evaluation of Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs, Susan G. Harber, Walter Adamache, Edith G. Walsh, Sohja Hoover, Anupa Bir, Cheryl Caswell, Henry Simpon, Kevin Smith, RTI International, October 1, 2003.

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