

The New Medicare Law for Dual Eligibles

The following information is based largely on a paper by the Kaiser Commission on Medicaid and the Uninsured, entitled “Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers,” January 9, 2004.

Dual Eligibles

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) institutes the new Medicare prescription drug benefit called “Part D”. This legislation marks a significant policy change affecting an estimated 115,000 full-benefit dual eligible individuals in Wisconsin. Full-benefit dual eligible individuals are those low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare, and who currently receive Medicaid covered prescription drugs, nursing home and other long-term care services, and health care services not covered by Medicare. In addition, Medicaid pays for Medicare premiums and cost sharing for full-benefit dual eligibles. Full-benefit dual eligibles will include those individuals served by Medicaid waiver or buy-in programs, regardless of income or assets, if they are also eligible for Medicare benefits. Individuals who are in a waiting period for Medicare benefits must fulfill that two-year requirement before enrolling in Part D. For the purposes of this paper, these full-benefit dual eligible individuals will be referred to as “dual eligibles.”

Medicare Part D Enrollment

On January 1, 2006, all Medicare beneficiaries, including dual eligibles, will become entitled to receive coverage for outpatient prescription drugs by enrolling in a Medicare Part D plan. At the same time, prescription drug coverage through Medicaid will end for those individuals who are also eligible for Medicare. States will no longer be able to receive federal Medicaid matching funds to provide any drugs that could be provided through a Part D plan. This termination of federal matching funds extends to all dual eligibles who could enroll in a Part D plan, even if they have not yet done so. Dual eligibles *do not* have the option of remaining in their current Medicaid coverage as of January 1, 2006.

Dual eligibles will be expected to enroll in a Part D plan. However, the new Medicare law also directs the Secretary of Health and Human Services to develop procedures for automatically enrolling dual eligibles in a Part D plan, should they not do so themselves. In areas where there is more than one choice of Part D plans, the legislation directs the Secretary to randomly assign dual eligibles to one of the available plans. In preparation for the January 2006 start date, it is likely that all existing dual eligibles will be automatically enrolled beginning in mid-2005 in order to avoid a gap in coverage. Participants will then have the option of changing their enrollment if they want to select a different plan.

Part D Drug Plans

The Medicare Part D plan will offer dual eligibles the choice of receiving their prescription drug coverage either through “Medicare Advantage” plans that offer a comprehensive array of Medicare benefits, including prescription drug coverage, or through private stand-alone drug-only plans. The specific drugs that are covered will depend on the policies of each plan. Part D plans will largely have the prerogative to determine the array of drugs that they will cover. Although there are some rules in place if they want to establish formularies, they are explicitly authorized to limit the number of drugs that they cover in any given therapeutic class to two drugs per class. Each Part D plan may determine what comprises a therapeutic class. At this time, plan formularies have not yet been determined.

Part D Cost-Sharing Obligations

Dual eligibles who require a drug that is not covered by the Part D plan in which they enroll will have to pay the entire cost of the drug themselves. For those drugs that are covered by the Part D plan, the legislation has established a low-income subsidy program that will make cost sharing available to all dual eligibles. Dual eligibles will have no deductible and no premium if they enroll in an average or low-cost Part D plan. If a dual eligible chooses a plan that charges a premium in excess of the average for that region, the enrollee must pay the difference in premium costs out of pocket. The subsidy on deductibles and premiums will be available to all full benefit dual eligibles regardless of income or assets. This means that dual eligibles who “spend down” to Medicaid eligibility after medical bills are taken into account will be eligible for the subsidy, even if their income does not meet the low-income threshold for those Part D enrollees who are not dual eligibles.

Currently in Wisconsin, dual eligibles are required to make a co-payment of \$0.50 per over the counter drug and \$1 per legend (brand) prescription. Under Part D, dual eligibles will be required to make a co-payment for their prescription drugs as follows.

- Dual eligibles residing in nursing homes or other institutions are fully exempt from cost-sharing obligations and will not have to contribute a co-payment.
- Dual eligibles with income up to 100% of the federal poverty level (\$8,980 per individual or \$12,120 per couple in 2003) will have Part D co-payments at no more than \$1 per generic drug and \$3 per brand name drug in 2006. This obligation will rise with inflation as measured by the Consumer Price Index.
- Dual eligibles with income above 100% of the federal poverty level (not residing in institutions) will pay up to \$2 per generic drug and \$5 per brand name drug in 2006. These co-payment obligations will be indexed over time to the growth in per capita Part D drug costs.

- If a dual eligible is not able to meet the co-payment requirement, he or she may be denied the prescription until the payment is made. The Medicaid rule that currently prohibits pharmacists from denying prescriptions to those who cannot make the co-payment will not apply to dual eligibles enrolled in Part D plans.

Part D Appeals Process

Part D plan enrollees will have the right to ask their plans to reconsider a decision to deny a drug only when the plan fails to provide or pay for a drug that *is* on the plan's formulary. This appears to include circumstances where a beneficiary presents a prescription to a pharmacy, but that prescription is not filled.

The legislation also includes provisions for the establishment of an "exceptions process" for enrollees to request that a prescription drug plan provide a drug that is not on the plan's formulary. Such a request would be invoked when the prescribing physician determines that none of the drugs on the formulary would be as effective as the prescribed drug, or if the drug on the formulary would have adverse side effects. The exceptions process should also include similar provisions to allow an enrollee to request a more expensive, non-preferred drug for the cost of a less expensive, preferred drug. This request would also require a physician's determination regarding the necessity of the drug. Plans will have the discretion to approve or deny requests for any exceptions.

The Secretary is directed to develop appeal procedures that work similarly to those for Medicare + Choice. The Medicare + Choice appeals procedures limit the right to a hearing before the Secretary to those enrollees with disputed claims of \$100 or more. The right to judicial review is limited to claims involving \$1000 or more. It is unclear whether the Medicare + Choice right to expedited review will be extended to Part D enrollees. The new legislation does specifically bar doctors from pursuing appeals on behalf of their patients.

States' Role

Under the new legislation, states will be barred from supplementing the Part D prescription drug benefit by using federal Medicaid matching funds. The states will have the option to use general purpose revenue to supplement Part D costs.