



CMA Weekly Alert – December 29, 2005

WRINGING HANDS BRING IN THE NEW YEAR FOR DUAL ELIGIBLES: WHAT PEOPLE WITH MEDICARE AND MEDICAID SHOULD EXPECT FROM MEDICARE PART D AFTER JANUARY 1, 2006

This New Year may bring more confusion than joy to the more than 6 million beneficiaries with both Medicare and Medicaid (“dual eligibles”) who will lose their Medicaid prescription drug coverage and be switched to Medicare’s Part D coverage on January 1, 2006. Though the Centers for Medicare & Medicaid Services (CMS) announced contingency plans for those who fall through the cracks and gave assurances that the transition will go smoothly, dually eligible beneficiaries, their caretakers, and advocates are concerned that many will not be able to get the drugs they need this January.

The Center for Medicare Advocacy suggests several questions dual eligibles should ask, and several steps they can take, in order to ensure the smoothest transition possible:

In Which Plan Am I Enrolled?

- If possible, all beneficiaries should have their prescriptions refilled before January 1, 2006.
- Dual eligibles should have received a yellow letter telling them the plan in which they have been enrolled and giving them contact information for the plan. If they have not chosen a different drug plan, they should retain the letter and the contact information in the same place as they keep numbers for the doctor and pharmacy.

NOTE: Everyone who enrolls in a Part D plan will receive an Evidence of Coverage (EOC) document that gives pertinent plans’ phone numbers and procedures. CMS has indicated that plans will not begin to mail out the EOC until the end of January.

- The pharmacy should be able to assist someone in determining the plan in which he or she has been enrolled. The pharmacy can submit an electronic “E1” query to a special Medicare contractor to get the information. The pharmacy may also call 1-800-MEDICARE or use www.medicare.gov.
- If the beneficiary chooses a plan on his or her own, because s/he was not auto-enrolled, or because s/he is choosing to change plans, the beneficiary should verify that the new plan is a “standard” plan, and that its premium is below the “benchmark” premium for the region. Medicare’s low-income subsidy will *not* fully subsidize premiums and cost sharing for plans that are “enhanced,” even if the plan premium is below the benchmark, and it will *not* fully cover costs for plans that have premiums above the benchmark. Thus, dual eligibles could face unexpected costs if they choose a non-standard plan.

- See the Center for Medicare Advocacy's December 8, 2005 *Weekly Alert* for information to help duals who "fell through the cracks" and were not auto-assigned. Beneficiaries should bring their Medicare and Medicaid cards to the pharmacy with them. If they don't have their Medicare card, they can bring a Medicare Summary Notice or other evidence of Medicare coverage. If they have used the pharmacy before to get drugs covered by Medicaid, the pharmacy may have their Medicaid information on file.

NOTE: Advocates should also check with their local communities. Some cities and community mental health centers have established a process to provide prescriptions to duals who are denied drug coverage.

What Should I Do About My Retiree Health Insurance?

- Beneficiaries who have received information from their employer stating that they will lose retiree health coverage if they enroll in a Part D plan should contact their former employer immediately. According to CMS, some former employers are being more flexible, especially in situations where dependent family members will lose their health coverage if the dual eligible retiree keeps Part D. Some employers are giving their retirees more time to determine whether they want to give up all of their retiree health coverage in exchange for Part D. Others are allowing their retirees a one-time return to the retiree health plan. Still others are allowing the retiree's dependents to keep their retiree health benefits if the retiree enrolls in a Part D plan.

NOTE: Each employer can set its own policies, and not all employers are being flexible.

Suppose My Drug Is Not on My Plan's Formulary?

- The Medicare Part D regulations require each Part D plan to have a transition policy to cover non-formulary drugs for people when they first enroll in the plan. Thus, *duals should not be turned away from their pharmacy without any medication*. The regulations do not set out a specific time frame, but *non-binding* CMS policy guidance recommends providing a 30 day supply of the drug for most people and a 90-180 day supply for nursing home residents. Most plans to which duals have been auto-assigned will provide a 30-day supply of drugs, though not necessarily a 90-day supply for nursing home residents. The exception appears to be plans sponsored by PacifiCare, which will only provide a 15-day supply. A CMS summary of PDP transition policies may be found at <http://www.ascp.com/medicarerxdocs/PDPtransitionpolicy.pdf>.
- If a beneficiary requires a drug that is *excluded* from coverage under Medicare Part D, the state Medicaid program may still pay for that drug. A list of the general categories of excluded drugs that each state will pay for may be found at <http://www.cms.hhs.gov/States/EDC/list.asp>.
- If the beneficiary knows or believes that one or several of his or her drugs are not on the formulary, but that the drug is covered under Part D, the beneficiary should speak with his or her doctor as soon as possible. The beneficiary, the doctor, or the beneficiary's appointed representative can file an "Exception" with the plan to ask that the drug be covered. This process can take time and should be done as early as possible.

NOTE: Detailed information about each plan's Exception process will be included in the Evidence of Coverage document that plans are to mail to their enrollees. Beneficiaries will generally not be given this information at the pharmacy counter if the pharmacy determines that a drug will not be covered. Rather, they will need to call the plan to find out how to file the Exception. A beneficiary may request an Exception at the time of this initial inquiry, but the plan will not begin processing the Exception request until the doctor submits a supporting statement.

For further information regarding the transition of Dual eligibles to Medicare Part D, contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington DC office at (202) 216-0028 or attorney Pamela Meliso (pmeliso@medicareadvocacy.org) in the Center for Medicare Advocacy's Connecticut office at (860) 456-7790.