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EYE ON WASHINGTON

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implementing the Medicare drug benefit—the first 90 days

The first quarter of experience with the new Medicare drug plan is behind us. Now's a good time to pause and ask, "How are things going?"

Many are reflecting back on whether what we have seen is a prelude to what's to come. And they are looking to see what suggested changes, if any, are emerging.

There's no question that the plan has faced some challenges. Yet, though only a short time has passed, it is easy to forget that before the plan's implementation, many were wondering whether CMS could possibly be ready by January 1 to start administering the benefit. And indeed, the start date did look precarious, given the sheer number of decisions that needed to be made and regulations that needed to be written, and the vast educational strategy that needed to be developed before seniors could enroll.

Also, before the Medicare Modernization Act was enacted in 2003, the concern was whether an adequate number of drug plans would want to participate in the prescription drug program. This concern led to the inclusion of a government "fall-back" plan in case there were not at least two drug plans in each Medicare region. As is now well-known, the actual problem ended up being that so many plans wanted to participate that in some areas of the country, seniors had to choose from as many as 45 plans.

Efforts to Date

There have been widespread efforts to meet the program's challenges. Many groups have come forward to help seniors with the enrollment process. The plans themselves have been using multimedia resources to help seniors understand the Part D benefit in addition to promoting their own products. Pharmacies have scheduled "Medicare days," and healthcare professionals, churches, and aging agencies have helped seniors understand their choices.

The federal government has also committed \$300 million in a major effort to reach out to seniors. Medicare.gov, the CMS web site relating to Medicare, includes a FAQ section and a Medicare prescription drug plan cost estimator that allows seniors to receive guidance about various plan choices, based on their current prescriptions.

Dual-Eligibles—A Special Problem

The dual-eligibles, the approximately 7 million people who are on both Medicare and Medicaid, have presented difficult challenges during their transition from Medicaid at the end of 2005 to Medicare for their drug coverage. Because of the concern that some dual-eligibles might experience a period without Medicare drug coverage, those who had not chosen a plan by a given date were automatically enrolled in a plan through a process of random assignment. Those who wished to change from the assigned enrollment were allowed to do so.

Although a variety of problems were reported for seniors in general during the start-up phase, the dual-eligible population faced the greatest problems, in large part because their use of medicines is so high and many of them found it difficult to cope with the change in coverage. Thirty-seven states implemented temporary coverage programs to make sure the dual-eligibles could continue receiving their medications. These states have been pressing CMS for reimbursement for the money they spent during the transition, and although there have been sporadic attempts to resolve the issue legislatively, it appears that an administrative resolution is possible.

So How Are We Doing?

After dire warnings from those opposed to the Medicare drug plan, echoed by many in the media, an assessment of how Part D is doing seems to depend on the eyes of the beholder. A headline from *The Washington Post* reads "Survey Refutes Criticism of Medicare Drug Plan" (March 13, 2006), while a headline from the *Christian Science Monitor* reads "Confusion Remains as Drug Plan Deadline Nears" (April 12, 2006).

In what may be a classic case of a "glass half-empty/glass half-full," both sides can lay claim to some legitimacy in their views. By the end of the first quarter, some 28 to 29 million people were covered by Part D out of a total Medicare population of about 43 million. Of these, some 7.2 million had individually signed up. The rest were dual-eligibles, military retirees, retirees with employer-sponsored insurance, or individuals who had signed up for Medicare Advantage. This means that there were still about 15 million beneficiaries who could have been on Part D but were not, at least as of April, with a May 15 enrollment deadline looming in their future.

According to a Medicare Rx Education Network poll, three-quarters of the beneficiaries who voluntarily enrolled in Part D say that the program works well and almost 60 percent say that it was

not difficult to enroll. On the other hand, 80 percent have said they would advise others to get help, and about one-half of the beneficiaries actively looking to enroll have said that not enough information is available.

What's Next?

Although many organizations worked hard to get the word out to seniors that they needed to enroll by May 15, those seniors who missed that deadline missed out on the ongoing advantages of timely enrollment. Medicare Today, a 400-organization partnership, sponsored a series of events in late April to encourage enrollment by those not yet enrolled. At press time, the results of those efforts were not yet known, but it's not surprising that some of the media were predicting that they would result in long lines and enrollment delays.

The history with low-income programs is that it typically is difficult to actually enroll more than 60 percent of those who are thought to be eligible—and that frustration has unquestionably accompanied efforts to enroll low-income seniors in Medicare Part D. Just as some of the low-income seniors who would have received \$600 on the prescription drug cards never came forward, it is likely that some of the seniors below 135 percent of the poverty line who would have received the most financial support under the program did not come forward. If the Part D program is to work as intended, more needs to be done to determine how best to reach and enroll this population, even though the May 15 deadline is past.

CMS also needs to set the rules governing next year's enrollment process. There is discussion about simplifying plan choices by limiting plans to two variations. Stay tuned. There's more to come on this issue. ●

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