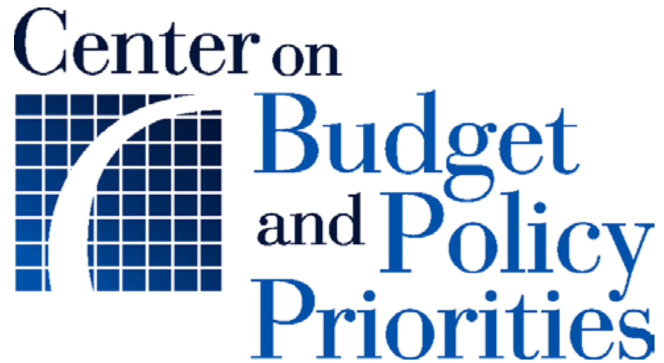


Dual Eligible and Low-Income Medicare Beneficiaries and Part D

Presentation to

National Medicaid Congress

by

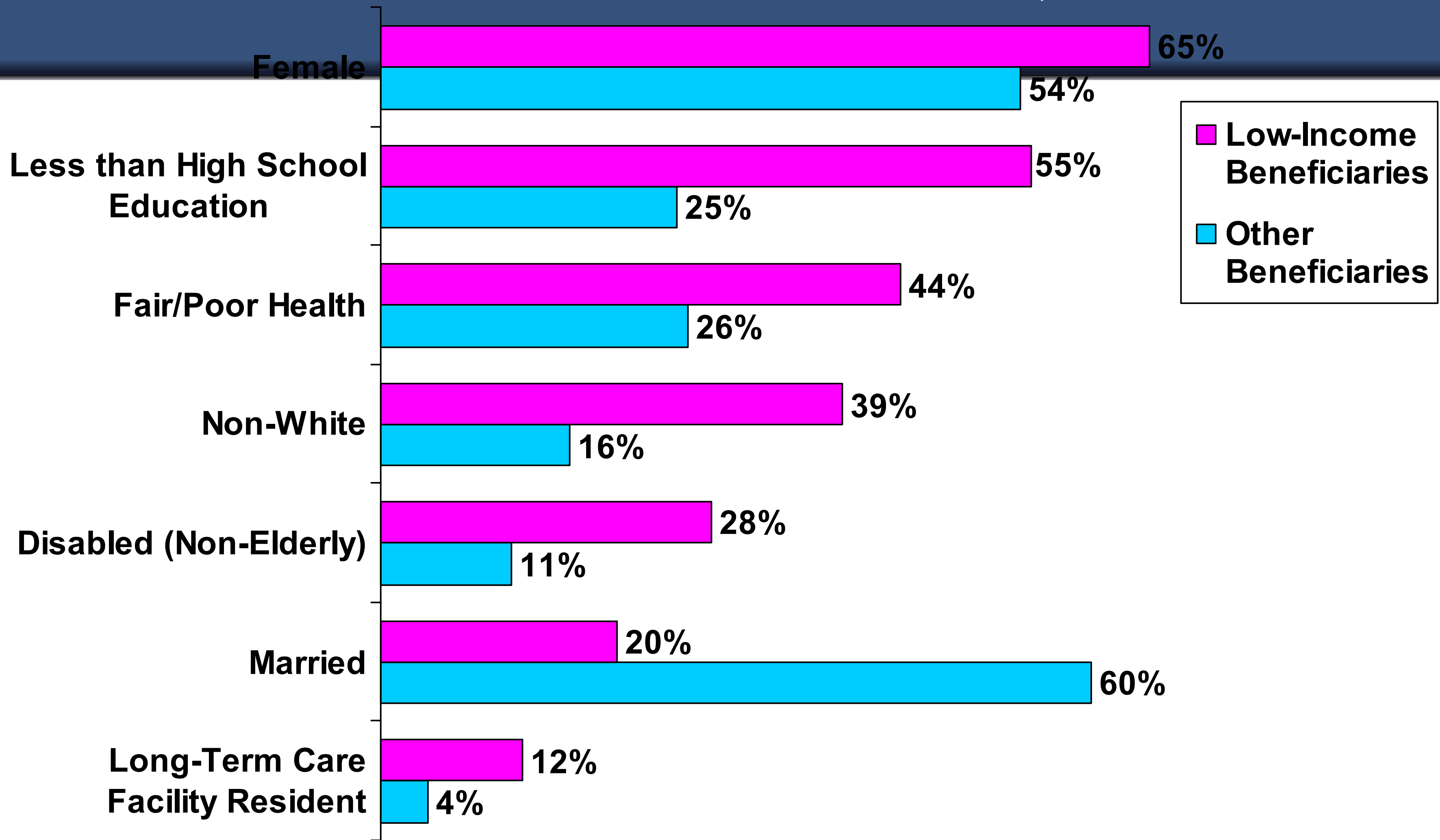
Andy Schneider, Senior Advisor

June 5, 2006

What is the Experience of Dual Eligible and Low-Income Medicare Beneficiaries with Part D to date?

- Why is this the right question?
- What do the aggregate enrollment data tell us?
- What does public health surveillance tell us?
- What challenges lie ahead?

Comparison of Low-Income and Other Medicare Beneficiaries, 2002



Total = 9.0 Million Low-Income Medicare Beneficiaries, 2002

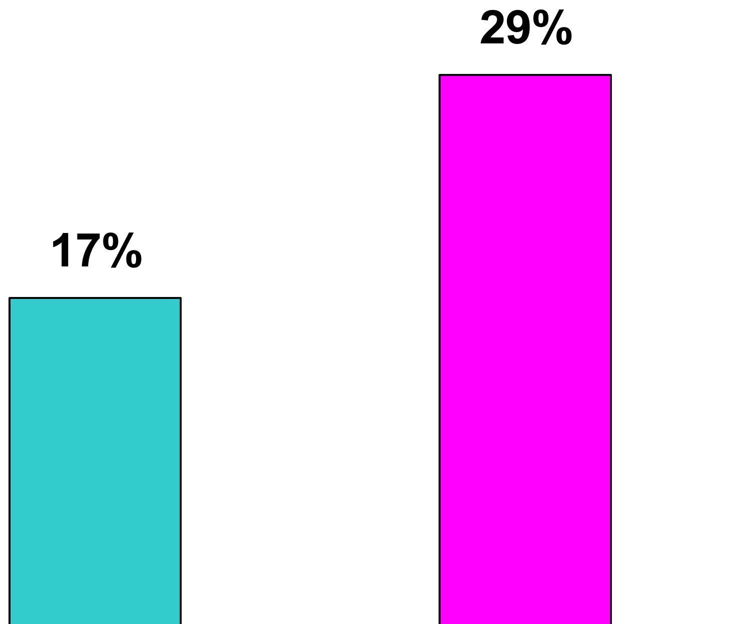
Note: Low-income is defined as having annual family income $10,000 or less, including income of individual and spouse (if applicable) only.

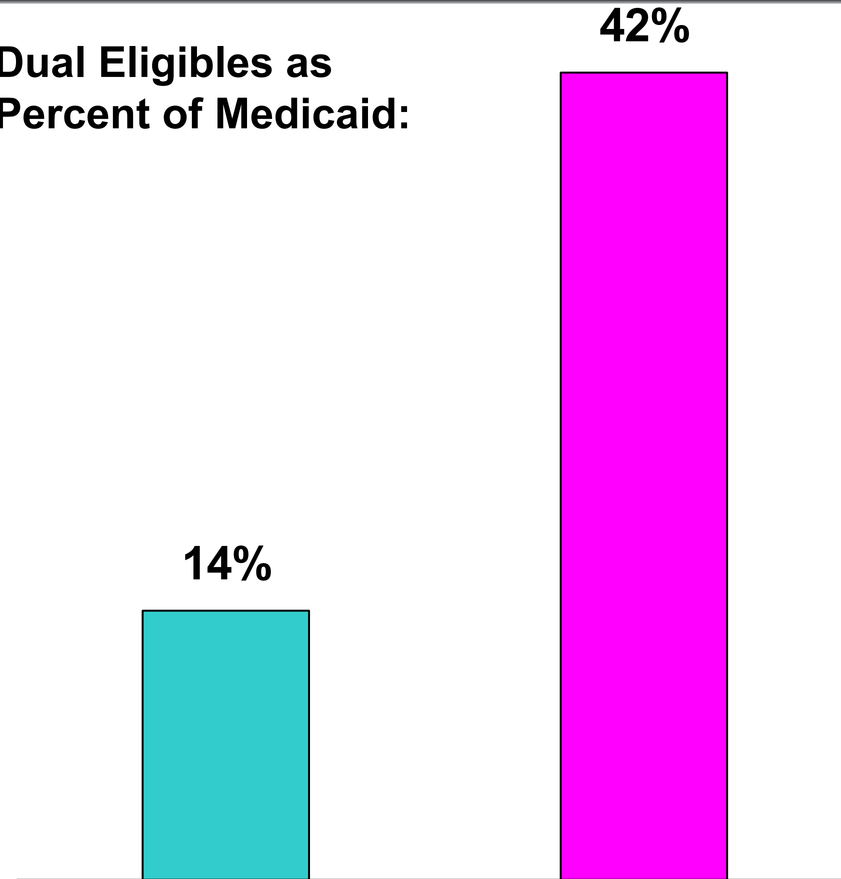
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

Center on Budget and Policy Priorities

THE HENRY J. KAISER FAMILY FOUNDATION

Dual Eligibles as a Percent of Medicare and Medicaid Enrollment and Spending, 2002



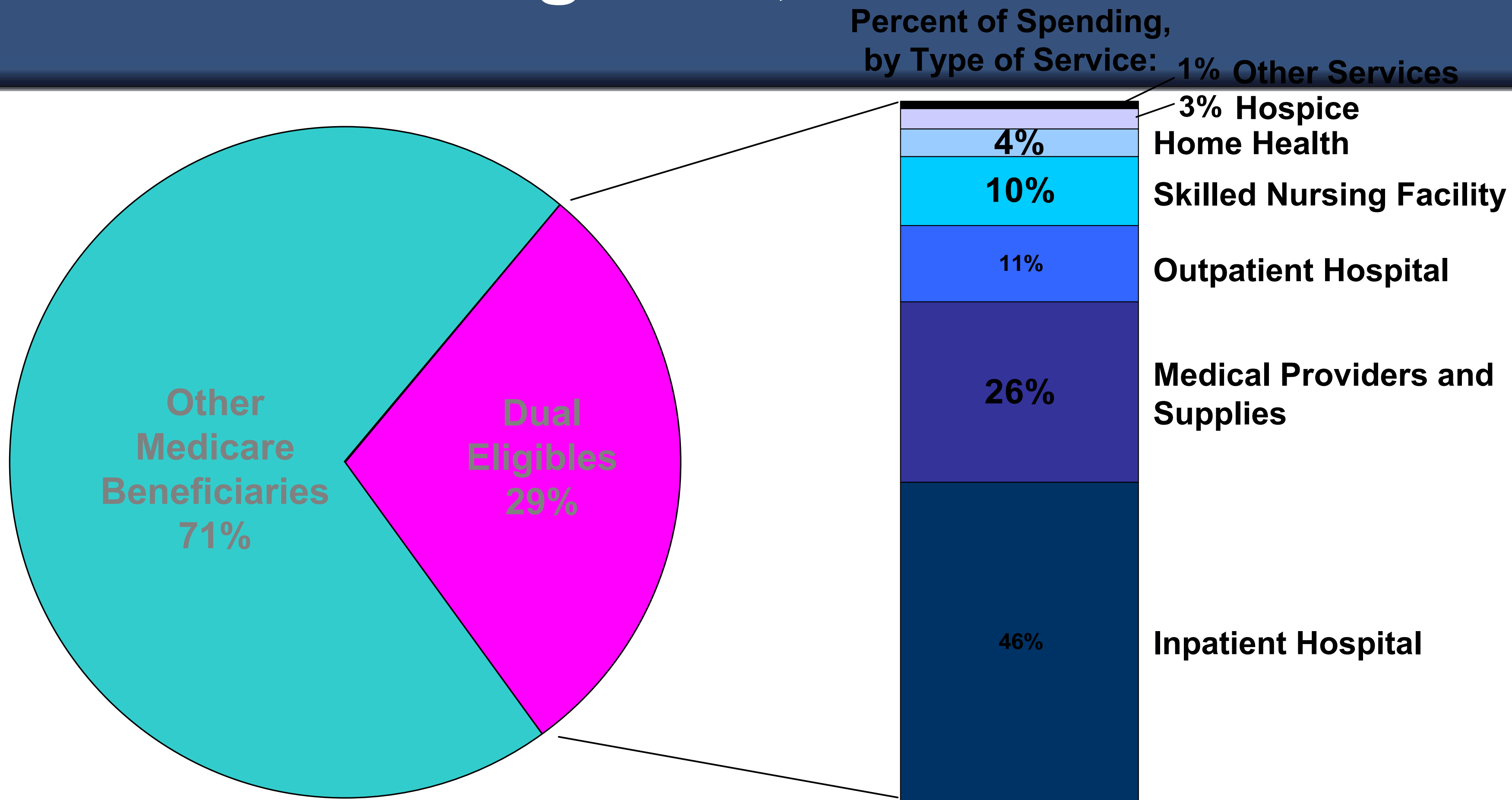


SOURCE: Medicare data are from Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use File. Medicaid data are from KCMU estimates based on CMS data and Urban Institute estimates based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

Center on Budget and Policy Priorities

THE HENRY J. KAISER FAMILY FOUNDATION

Medicare Expenditures for Dual Eligibles, 2002



Total Medicare Spending, 2002 = $224.5 Billion

Total Medicare Spending on Dual Eligibles, 2002 = $64.3 Billion

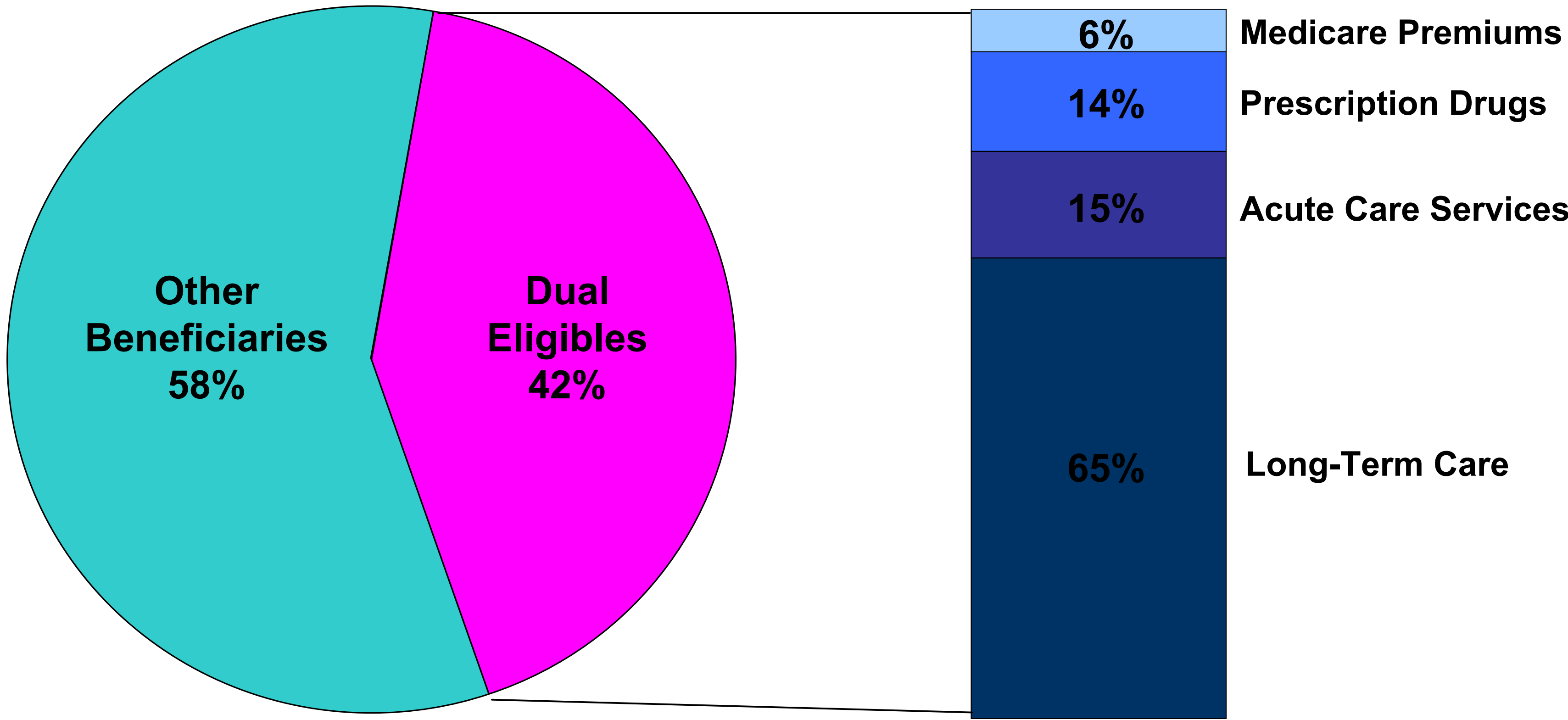
Center on Budget and Policy Priorities

Note: Other services includes prescription drugs, dental, and long-term care facility stays.

SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

THE HENRY J. KAISER FAMILY FOUNDATION

Medicaid Expenditures for Dual Eligibles, FY2002



Center on Budget and Policy Priorities

SOURCE: Urban Institute estimates for KCMU based on an analysis of MSIS and Financial Management reports (CMS Form 64).

THE HENRY J. KAISER FAMILY FOUNDATION

Medicare Prescription Drug Benefit Subsidies for Low-Income Beneficiaries, 2006

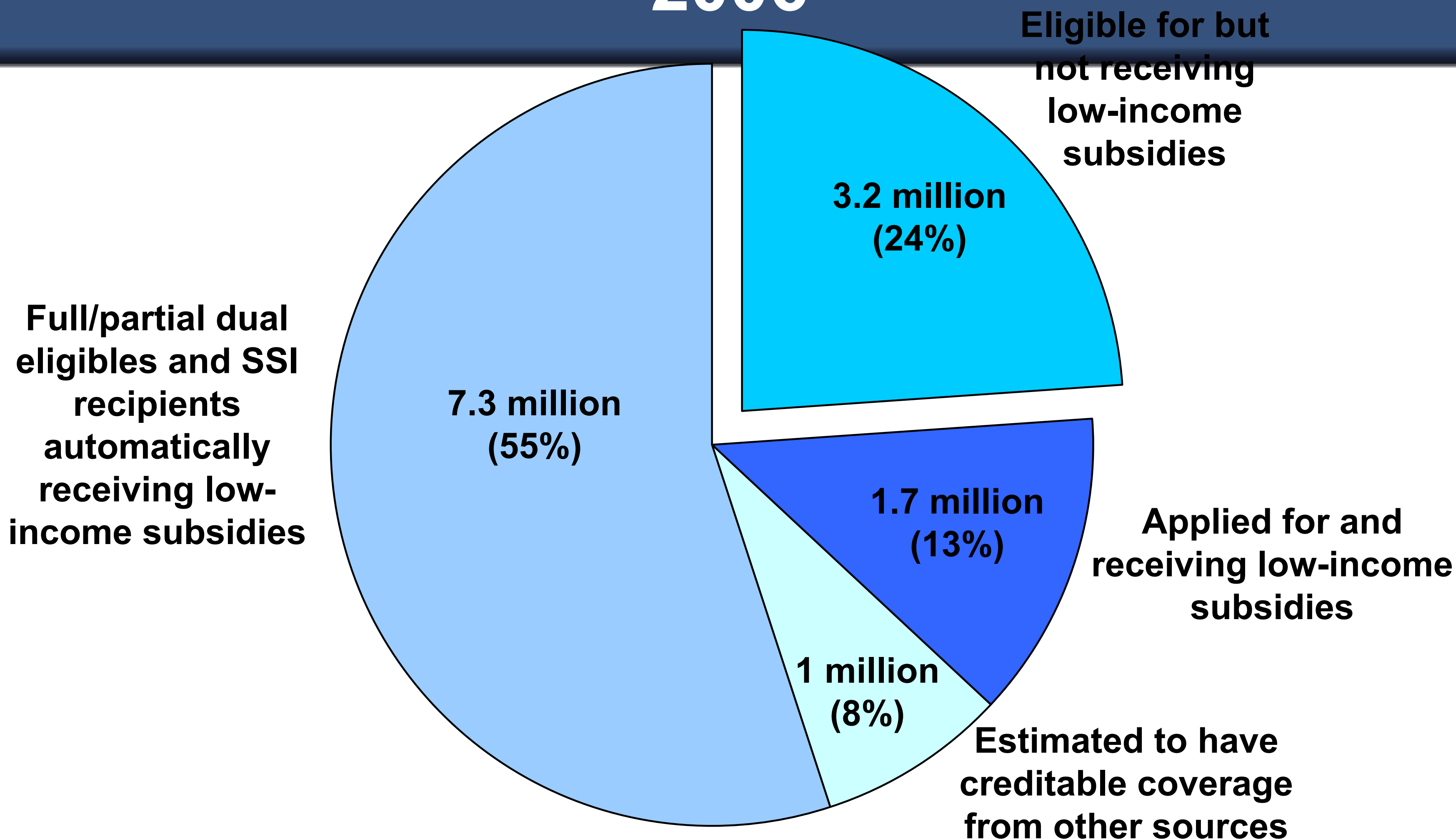
Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Individuals with Medicare & Medicaid (Full benefit "dual eligibles")	$0	$0	$1-$2/generic $3-$5/brand-name; no copays after total drug spending reaches $5,100
Individuals with Medicare and Medicaid benefits in nursing homes	$0	$0	No copays
Individuals with income <135% of poverty and resources <$7,500/individual; $12,000/couple (Includes Medicare Savings Program participants other than "dual eligibles")	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Individuals with income 135%-150% of poverty and resources <$11,500/individual; $23,000/couple	sliding scale up to $32.20*	$50	15% of total costs up to $5,100; $2/generic $5/brand-name thereafter

Note: The 2006 poverty level is $9,800/individual and $13,200/couple. Resources include $1,500/individual and $3,000/couple for funeral or burial expenses. *$32.20 is the national monthly Part D base beneficiary premium for 2006.

Center on Budget and Policy Priorities

The Henry J. Kaiser Family Foundation

Eligibility and Participation in the Medicare Drug Benefit Low-Income Subsidy Program, 2006

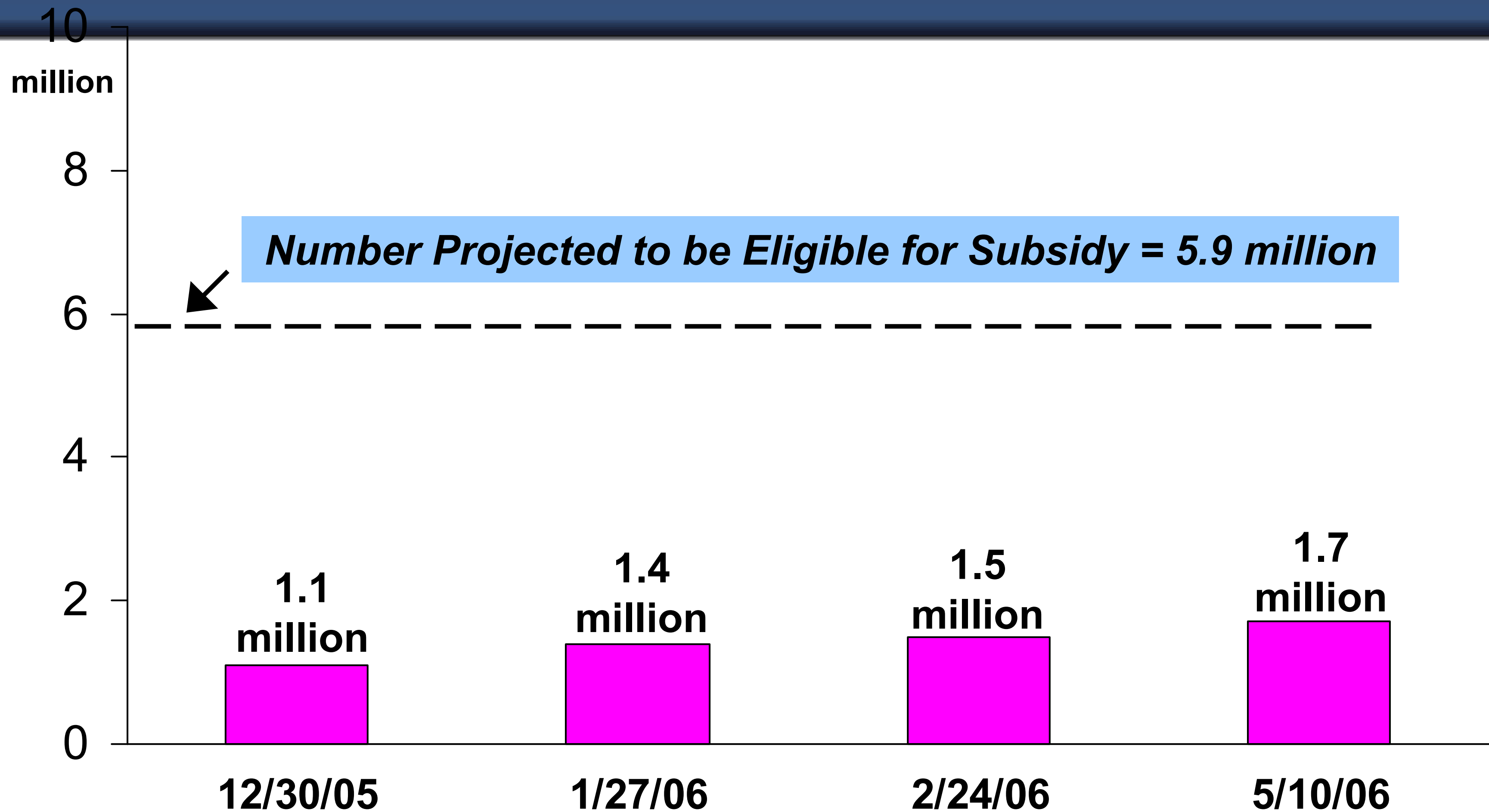


Beneficiaries Eligible for Low-Income Subsidies = 13.2 million

SOURCE: HHS press release, May 10, 2006.

Center on Budget and Policy Priorities
THE HENRY J. KAISER FAMILY FOUNDATION

Less than three in 10 eligible for low-income subsidy are receiving “extra help”

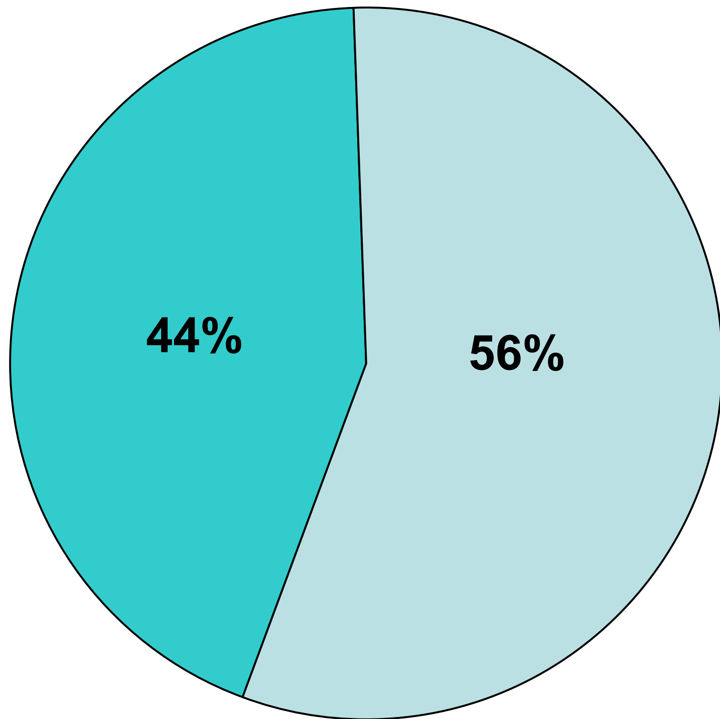


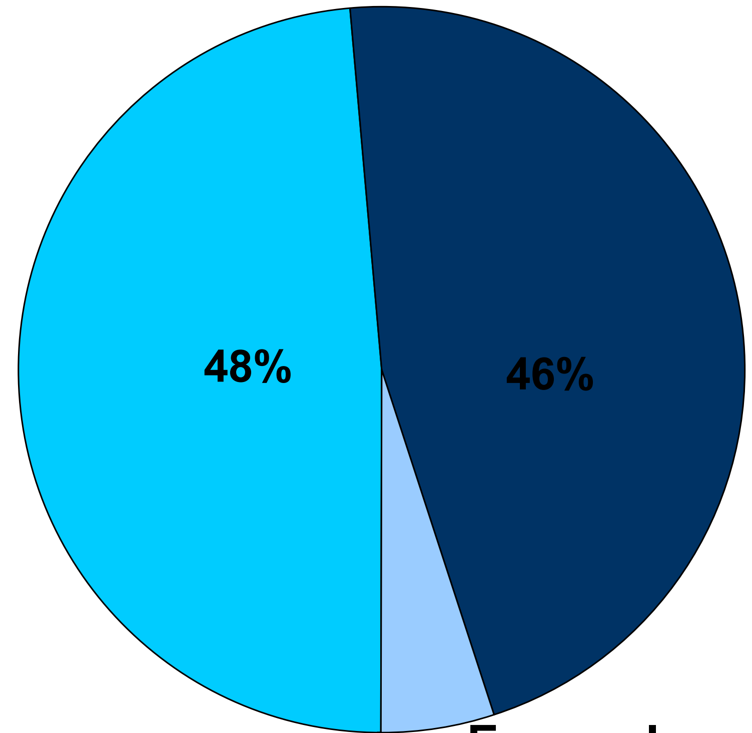
Center on Budget and Policy Priorities

SOURCE: Projected: HHS, Medicare Prescription Drug Benefit Final Rule, January 28, 2005; Actual: SSA, December 2005, January-April 2006, HHS press release, May 10, 2006.

THE HENRY J. KAISER FAMILY FOUNDATION

Low-Income Subsidy Determinations





Low-Income Subsidy Applications Processed = 3.9 Million (as of April 28, 2006)

Center on Budget and Policy Priorities

SOURCE: Personal Correspondence from SSA, May 2006.

THE HENRY J. KAISER FAMILY FOUNDATION

Why is this a Public Health issue?

- "The scope, abruptness, and complexity of the switch to Part D are unprecedented. Problems with this transition could lead to interruption in medication regimens, emergency medical conditions, and premature nursing home placement."
- Populations in Baltimore City affected:
  - 15,000 people with disabilities dually enrolled
  - 5,000 elderly dually enrolled
  - 8,000 elderly enrolled in both Medicare and Maryland's SPAP
- Baltimore City Health Department, Baltimore City Commission on Aging and Retirement Education, *Medicare Part D Surveillance and Response Plan* (December 2005), pp. 3, 7 www.baltimorecitymedicare.org

Center on Budget and Policy Priorities

Part D Surveillance and Response Program

- Surveillance: Pharmacists report (24/7) to Health Department when Medicare patient cannot obtain needed medication under Part D
- Immediate Support: Health Department staff assist pharmacists (24/7) in negotiating Part D procedures, pay copayments or purchase prescriptions for low-income patients when necessary
- Response: Commission on Aging caseworkers follow up with patients identified through pharmacy surveillance program to resolve any enrollment or coverage issues
- Outcome Assessment: Measure changes in number and percentage of senior Baltimore City residents presenting with high blood sugar to area Emergency Departments

Surveillance and Response Results (May 2006)

- Over 150 cases reported to Health Department by over 50 pharmacies in 19 zip codes
- Most common problems: Dual eligibles not enrolled in Part D Plans, or Part D Plan charges dual eligible patients copayment amounts well in excess of $2/$5
- Approximately $15,000 committed by Health Department to pay copayment or prescription costs for low-income patients
- No statistically significant increase in seniors with high blood sugar presenting to the ER

Challenges Ahead:
The "Perpetual Transition"

- LIS-qualifying plans likely to change in 2007
- CMS May 30, 2006 e-mail: "We are currently considering an option that will allow benchmarks to be calculated in a manner that will further limit any facilitated changes in LIS beneficiary enrollment. Plans should be preparing bids that can be uploaded quickly should this option regarding LIS benchmarks be adopted. CMS appreciates the efforts of Part D Sponsors to remain flexible in their bid preparation to assure the best possible coverage for our LIS-enrolled beneficiaries."

Challenges Ahead: Improving Participation in LIS

- Rice and Desmond estimates for KFF (2005): 2.37 million Medicare beneficiaries with incomes < 150% FPL will be ineligible due to asset test
  - disproportionately (46 %) widows and widowers, 93% female
- Nearly half of all LIS applicants determined ineligible to date are not eligible due solely to excess assets (SSA, May 2006)
  - Average excess amounts: $18,000 for individuals, $25,000 for couples
- An individual at 150% FPL has income of $14,700 in 2006
- A couple at 150% FPL has income of $19,800 in 2006
- Estimated average value of LIS subsidy: $3,051 (CMS, Jan . 2005)

Center on Budget and Policy Priorities

Challenges Ahead: Measuring the Health Impact of Part D

- Estimated cost of Part D program in FY 07: $57.8 billion, including $14.6 billion in LIS (CBO 2006)
- What difference, if any, is this investment making with respect to;
  - access to needed medications for 6.4 million full-benefit duals?
  - the health status of 7.3 million full and partial duals?
  - the health status of other LIS participants?
  - the health disparities experienced by low-income Medicare beneficiaries?