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Launching the Medicare Part D Program: Lessons for the New Health Insurance Marketplaces

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Executive Summary

The federal government, partnering with many states, will soon launch one of the largest national health care programs in United States history. Under the Patient Protection and Affordable Care Act (ACA), some 29 million Americans are slated to obtain private coverage through health insurance exchanges by 2019; another 12 million are expected to gain coverage through Medicaid and the Children's Health Insurance Program (CHIP).

The ACA intended for exchanges to be governed and operated by states. But the federal government will be responsible for the design, governance, and operation of individual exchanges in 34 states that have declined to operate one in 2014. Whether state- or federally run, however, the development and launch of exchanges will require an unprecedented amount of coordination among state agencies, federal agencies, and health insurance companies. Designing and building systems that will allow these agencies to communicate with the exchanges, make real-time eligibility assessments, allow insurers to submit health plans for certification, enroll people in appropriate coverage, and ensure premiums are paid correctly are also enormous tasks.

In a short time frame, federal and state officials need to mount nationwide outreach and education campaigns to help people understand their new options. Many individuals without insurance will need extensive in-person assistance to help them navigate the system.

In preparing for implementation, officials and other stakeholders can draw on the federal government's successful launch of Medicare Part D, a major national health coverage program that became law in December 2003 and started enrollment just two years later. The program, which now includes 35 million beneficiaries, represented the first Medicare coverage of outpatient prescription drugs to be implemented and the first Medicare benefit delivered exclusively through private plans.

Like the exchanges, Part D required extensive outreach and education in a short time frame. And, like the exchanges, Part D also required ongoing coordination among federal and state agencies and private plan sponsors. But there are also differences between the two programs. Whereas Part D was a new benefit added to Medicare and

run by the federal government, the success of exchanges depends heavily on continued state involvement and cooperation. And, whereas the target population for Part D was relatively easily identified and reachable through Medicare's existing means of communication, the target population for exchanges – primarily the uninsured – is more diverse, and there is no existing formal mechanism for communicating with them.

Part D's launch also benefited from implementation funding to a degree not available for the exchanges. And although some policy-makers objected to the program's design and costs, many opponents sought to help enroll their constituents. In today's political environment, opponents continue to attack the ACA and seek to block its implementation.

Although the officials implementing Part D encountered significant technical, educational, and coordination difficulties at first, eight years later, many of the initial difficulties have been forgotten. The public generally views the program as a success.

This paper discusses the challenges that led up to the launch of Part D and the real-time improvements officials made to ensure that beneficiaries were able to obtain the benefits they were promised. We then review how state and federal officials working on exchanges may benefit from the lessons their predecessors learned during implementation of Part D.

Wariness in advance of program implementation

Public opinion. Initial polls taken prior to the program's launch showed that more people had an unfavorable opinion of the Part D program than a favorable one, and a majority reported lacking the information they needed to understand how it would affect them personally. After a year's experience with Part D, however, the public's views became more positive. Initial public opinion of the ACA has been similarly low.

Plan participation. Unlike other parts of Medicare, Part D called for private plans to provide drug coverage to beneficiaries. Many observers doubted there would be a sufficient number of plan sponsors participating in the program; however, at the time of open enrollment enrollees had a large number of plan choices. Questions about whether insurers will participate have also plagued

the ACA's insurance exchanges, but many will be attracted by the availability of premium tax credits for potential enrollees.

Program readiness. Prior to the launch of Part D, critics and supporters alike were concerned that the Centers for Medicare & Medicaid Services (CMS) might not succeed in building and testing the necessary information systems and completing plan reviews in time for the start of coverage. But CMS launched the program on schedule. The timeline for reviewing plans and building and testing information systems is similarly compressed for the exchanges. Although the information system demands for the exchanges are much greater than they were for CMS in implementing Part D, the federal government and the states are actively testing the necessary systems.

Costs for consumers. As the start of Part D approached, policy-makers and advocates were concerned that premiums for the new plans would be too expensive for consumers. Program costs actually proved to be lower than projected both in the first year and since then. Insurers eyeing exchanges face cost uncertainties as well, and some have predicted “rate shock” because of new plan standards and the expected risk profile of exchange enrollees. However, because these plans are essentially new products, it is difficult to compare their pricing with products sold in the marketplace today. In addition, for most consumers using the exchanges, any premium increases will likely be mitigated by federal premium and cost-sharing subsidies. Some early rate filings suggest that the fear of rate shock may be overstated.

States' concerns. Although Medicare is a federal program, many states had concerns about the regulatory and cost burdens Part D imposed on them. In particular, the law required the shift of drug coverage for beneficiaries dually eligible for Medicare and Medicaid from Medicaid to Part D. Part D also called for new reporting and information sharing among states and federal agencies. Successful implementation of the ACA is significantly more dependent on states' willingness to cooperate and communicate with their federal partners. Although not all states will run their own exchanges in 2014, a majority will work with the federal government on at least some functions.

Education and outreach

As a new component of Medicare, Part D faced the considerable challenge of educating beneficiaries and their families about the program. The Administration initiated

a nationwide publicity campaign six months prior to Part D's launch, including mass media advertising, public events featuring senior Administration and congressional officials, and a Medicare bus tour. Efforts included a targeted outreach campaign to educate low-income beneficiaries about “extra help” through a Low-Income Subsidy (LIS), eligibility that was automatic for dually eligible Medicare-Medicaid beneficiaries, but required a separate application process for others.

A successful launch of exchanges is similarly a top policy priority for the current Administration, but efforts to educate the public about the law have been, to date, largely unsuccessful. Some of the difficulty stems from widespread misinformation about the law, ongoing legal challenges, a polarized political atmosphere, and congressional rejection of the Administration's requests for additional implementation funds. However, a major educational campaign is expected to start during the summer.

Eligibility and enrollment

Beneficiaries had two initial decisions before acquiring drug coverage in Medicare Part D: whether to enroll and which plan to select. Many had a third choice as well: whether to apply for the LIS. Individuals and families eyeing exchanges must make a more complicated set of assessments about their financial and health situations and the benefits and costs of making a change, due in part to new tax implications of certain decisions under the ACA.

Decisions about whether to enroll. It was initially hard for potential Part D enrollees to understand the value of the new benefit. Many factors, including an unpopular late-enrollment penalty, provided a reason for beneficiaries to enroll. As a result, many initially uncertain about enrollment, including those taking few drugs, did sign up. The ACA also includes incentives for people to enroll in coverage, such as significant premium tax credits and cost-sharing subsidies for those with low and moderate incomes. More controversially, the law requires that individuals who do not maintain coverage pay a tax penalty. It remains unclear whether these incentives will be sufficient to encourage people, particularly healthy people, to enroll.

Financial assistance. Medicare beneficiaries not automatically deemed eligible for LIS had to apply for a determination of eligibility. Not everyone potentially eligible for the LIS was aware of its availability. For many, the process for establishing eligibility was daunting and

deterred some from applying. The application process for premium and cost-sharing assistance under the ACA will likely be even more complicated than that for the LIS, especially for those whose incomes change during the year.

Plan choice. For many Medicare beneficiaries, selecting a plan among a set of alternatives was a new experience. The considerable array of choices made it challenging to compare plans effectively, and many chose plans that were not optimal for their personal circumstances. Although it is not yet known how many plans will be offered in all the exchanges, consumers are likely to face challenges comparing plan premiums, benefits, networks, and cost-sharing arrangements.

Consumer assistance

National, state, and local organizations engaged in a massive effort to provide assistance to beneficiaries considering enrollment in Part D. CMS was the major player at the national level, partnering with more than 10,000 local public and private organizations to provide assistance. In spite of tremendous activity, those assisting Medicare beneficiaries early in the process reported problems getting necessary and accurate information. Beneficiaries reported mixed experiences with the help available by phone and on the web.

The Administration must reach a broader and more diverse audience to educate and engage individuals eligible for exchanges. And, unlike Medicare, there is no one agency with an official line of communication to target all eligible populations.

Written materials. Potential Part D enrollees were exposed to a deluge of written communications from CMS and marketing materials from competing insurers. Many found the material confusing, written in jargon, or just too voluminous. Leading up to the launch of exchanges, consumers are also likely to be barraged with materials from the exchanges and intermediaries such as navigators, as well as marketing from private-sector health insurers.

Online tools. Part D demonstrated that online decision-support tools are critical for providing both basic education about insurance coverage and detailed comparative tools to assess and choose among plans. However, early on there were accuracy problems. Counselors providing in-person assistance reported that they had to confirm information with plan sponsors, adding to the time they had to spend with beneficiaries. Similarly, exchanges are required to operate a website that will allow consumers to compare and select among

participating plans. As with the Part D Plan Finder, these sites are expected to rely on decision-support tools that allow consumers to sort and compare plans based on the level of out-of-pocket cost for the enrollee (as indicated by precious metal tiers, i.e., bronze, silver, gold, or platinum), price, provider network, and other preferences.

Call centers. CMS officials viewed the ability to handle telephone inquiries as a core function of Part D for both the agency and the plans. But it was a challenge to estimate the needed capacity and to ensure that reliable answers could be provided. Beneficiaries initially reported long wait times when they called, and many found that customer service representatives were not knowledgeable or failed to provide accurate information. CMS had to make training and staffing adjustments throughout the initial open enrollment period. The ACA requires that exchanges operate a toll-free telephone hotline to provide consumer assistance. There are questions about the capacity of call centers to meet the demand for consumer assistance.

Plans, brokers, and agents. Many Medicare beneficiaries looked to plan representatives, insurance brokers, and agents as sources of assistance. However, some reported instances of marketing abuses, and CMS had the responsibility of ensuring that these intermediaries served the interests of potential enrollees. In rolling out exchanges, the Administration is largely deferring to state laws and regulations regarding health plan marketing.

In-person counseling. Many potential Part D enrollees relied heavily on in-person counselors to help them assess eligibility for subsidies and enroll in the program. Initially, counselors were overwhelmed by the technical details of the program and the demand for services. The ACA provides for a navigator program to provide similar in-person assistance, but funding for this and other counseling programs is likely to vary significantly across states.

Informal counseling. Some Medicare beneficiaries turned to friends, family, and medical professionals for advice about Part D. It was challenging, however, to provide these individuals with the tools they needed to provide assistance. Similar questions exist for exchanges.

Post-enrollment complications

The Part D program's challenges did not end once beneficiaries selected and enrolled in a plan. The program's effectiveness was tested when enrollees attempted to use their coverage. For those purchasing private coverage through exchanges, obtaining benefits

at the point of service will also involve complicated data transactions between the exchange and insurers and between insurers and providers. CMS is likely to need to maintain a steady focus on data transfer issues and be poised to make necessary upgrades or improvements.

Conclusion

Past efforts to design and launch a large national health coverage program suggest that the experience will be far from perfect, at least at the outset. However, the Medicare Part D experience teaches us that, when things went awry, federal and state officials were often able to identify problems and work with stakeholders to develop

policy and operational solutions, so that consumers could obtain the promised benefits. Problems were not always addressed as quickly or as thoroughly as critics would have liked, but fixes were usually found.

Officials, policy-makers, and advocates preparing for the launch of exchanges in October 2013 face considerable challenges, not the least of which are constrained resources to support implementation and a highly polarized political atmosphere. However, there is much to be learned from the mistakes and the overall success of Part D. While flaws remain, a program born amidst partisan controversy and launched with considerable wariness has emerged to become a core part of Medicare.

Introduction: The Launch of Two National Health Programs

The federal government, in partnership with many states, will soon launch one of the largest national health care programs in United States history. Under the Patient Protection and Affordable Care Act (ACA), a projected 29 million Americans under age 65 are slated to obtain private health insurance coverage through health insurance exchanges¹ in their states by 2019. Another 12 million are expected to gain coverage through Medicaid and the Children's Health Insurance Program (CHIP).² In these exchanges, individuals seeking health insurance will be able to determine their eligibility for tax credits, subsidies and public programs, and shop for and enroll in a health plan. The law envisions that most people will be able to go through this process quickly and seamlessly, using web-based applications and decision-support tools.

While the ACA intended for exchanges to be governed and operated at the state level, at least 34 states have declined to operate an individual market exchange for 2014. Instead the federal government will be responsible for the design, governance, and operation of exchanges in those states.^{3,4} Whether federally or state-run, developing and launching these exchanges will require an unprecedented amount of coordination between state and federal officials and health insurance companies, as well as cross-agency cooperation within states and among federal agencies such as the Department of Health and Human Services (HHS), the Internal Revenue Service (IRS), and the Department of Homeland Security (for the verification of an individual's immigration status). Designing and building systems that will allow these agencies to communicate with exchanges, make real-time eligibility assessments, allow insurers to submit health plans for certification, enroll people in appropriate coverage, and ensure premiums are paid to the right plan for the right person are also enormous tasks.

In addition, federal and state officials will need to mount nationwide outreach and education campaigns to ensure people understand their new benefits under the ACA. Many individuals without insurance contemplating exchange coverage will need extensive in-person assistance to help them navigate their options. All of this work needs

to be accomplished in a relatively short time frame. The ACA became law in March 2010, and the first day of open enrollment for exchanges is scheduled for October 1, 2013, with many critical regulations only finalized in the spring of 2013.

While this paper focuses on the development and launch of exchanges, it is important to note that these are not the only responsibilities facing federal and state officials under the ACA. The law also includes expansion of the Medicaid program and sweeping new private health insurance reforms affecting coverage inside and outside the exchanges. Any of these provisions, by themselves, would have presented a daunting implementation challenge. The ACA calls on officials to tackle them all at once.

In facing the complex challenge of launching exchanges, officials can draw on the federal government's recent experience with a successful launch of a major national health coverage program. The Medicare Part D drug benefit became law in December 2003, and enrollment started just two years later in November 2005. The program, which now includes 35 million beneficiaries, represented the first time that Medicare had implemented coverage of outpatient prescription drugs. It was also the first time that a segment of Medicare coverage was available exclusively through enrollment in private plans. Part D was available to all Medicare beneficiaries, including those low-income beneficiaries previously receiving drug benefits through Medicaid. Low-income beneficiaries were eligible for "extra help" through a Low-Income Subsidy (LIS); eligibility was automatic for dually eligible Medicare-Medicaid beneficiaries, but required an application process for others.

Like the exchanges, Part D required an extensive outreach and education campaign in a short time frame. Potential enrollees had an array of print and online tools available to them, while many used in-person assistance to help them with decision-making. The launch of Part D also required coordination among federal and state agencies and private plan sponsors. For a comparison of key elements of the two programs, see Exhibit 1.

Exhibit 1. Comparing Medicare Part D and Health Insurance Exchanges: Key Elements

	Medicare Part D	Health Insurance Exchanges
Program benefits	Insurance coverage for prescription drugs	Insurance coverage for comprehensive health benefits
Target populations	Medicare beneficiaries	<ul style="list-style-type: none"> • Uninsured under age 65 • Low-income consumers • Small businesses
Sources of coverage	<ul style="list-style-type: none"> • Stand-alone private drug plans • Medicare Advantage plans 	<ul style="list-style-type: none"> • Commercial health plans • Medicaid • Children’s Health Insurance Program (CHIP)
Government operation	Federal program (with some state involvement)	Federal-state program
Responsible entity	Centers for Medicare & Medicaid Services (CMS)	<ul style="list-style-type: none"> • CMS • State exchange entity
Timeline	<ul style="list-style-type: none"> • Law enacted: December 2003 • Program launch: November 2005 (coverage effective January 1, 2006) 	<ul style="list-style-type: none"> • Law enacted: March 2010 • Program launch: October 2013 (coverage effective January 1, 2014)
Financial assistance for lower-income individuals	Low-Income Subsidy (LIS)	<ul style="list-style-type: none"> • Premium tax credits and cost-sharing subsidies • Medicaid expansion in some states

While there are many similarities in the experiences of officials working on Part D and those working on exchanges, there are also differences. For example, Part D was a new benefit added to the Medicare program and run by the federal government, although there was a need for coordination with states. In contrast, the success of exchanges – even those run by the federal government – depends heavily on continued state involvement and cooperation.

In addition, the target population for Part D was relatively easily identified and reachable through Medicare’s existing means of communication with beneficiaries. All beneficiaries were eligible for Part D, although eligibility determination was necessary for the LIS. The target population for exchanges – primarily the uninsured – is much more diverse, and there is no existing, formal mechanism for communicating with them. And every individual enrolling through an exchange, even the unsubsidized, must undergo an eligibility determination.

As Part D’s first open enrollment period approached, observers questioned whether the program would work and many called for delaying key elements. Eight years later, many of Part D’s initial difficulties have been forgotten, and the public generally views the program as a success.

Part D’s launch also benefited from funding for the Administration to implement the law. Although some policy-makers objected to the program’s design and costs, many opponents sought to help their constituents benefit from new coverage for prescription drugs. In today’s political environment, opponents of the ACA have subjected the law to court challenges and unrelenting attacks. And Congress has repeatedly denied the Administration’s requests for additional implementation funds.

Nevertheless, as Part D’s first open enrollment period approached, observers questioned whether the program would work and many called for delaying key elements. During initial enrollment, officials encountered significant technical, educational, and coordination difficulties under intense public scrutiny. Eight years later, many of Part D’s initial difficulties have been forgotten, and the public generally views the program as a success.

This paper discusses the challenges federal and state officials faced leading up to the launch of the Part D program and the real-time improvements they made to ensure that beneficiaries were able to obtain the benefits they were promised. It then reviews how state and federal officials working on exchanges may benefit from the lessons their predecessors learned during the development of Part D. We touch on but do not provide an in-depth assessment of the post-enrollment challenges some beneficiaries faced.

Wariness in Advance of Program Implementation

In the months leading up to the initial enrollment of Medicare beneficiaries in Part D, both the public and policy-makers were wary about the program launch. Public opinion was skeptical, and potential enrollees lacked needed information. Observers were uncertain whether plans would be available in the new marketplace, whether the federal government would have all systems ready for the first open enrollment period, and whether the program’s costs would be within the forecast range. States were concerned about whether the transfer of beneficiaries dually eligible for Medicare and Medicaid from receiving drug benefits through Medicaid to Medicare drug coverage would operate smoothly.

Public opinion

Initial polls indicated that many held unfavorable views about the program, and people lacked a good understanding of its components. After a year’s experience, the public’s views became more positive.

Although Medicare Part D is generally viewed favorably today, an April 2005 poll showed that 34 percent of seniors had an unfavorable impression of the program, compared to only 21 percent with a favorable impression.⁵ By October, just before implementation, favorability ratings had risen to 31 percent, but 37 percent then said they had an unfavorable opinion (Exhibit 2).⁶

Understanding of the new drug benefit and how it worked was also lacking. In April 2005, 66 percent said they did not have enough information to understand how it would affect them personally. Although understanding of the new program grew over time, 58 percent still did not feel they had the necessary information on the eve of open enrollment.

Supporters of the ACA may be able to take heart from the fact that, in spite of early unfavorable reviews, Part D gained in popularity after it was fully implemented.

Public opinion of the ACA has been similarly low (Exhibit 2). Six months prior to the launch of exchanges, 40 percent of Americans reported an unfavorable opinion of the law, compared to 35 percent reporting a favorable view. And 58 percent of the uninsured and about half (49 percent) of Americans overall reported that they had too little information to assess how the ACA will affect them.⁷ While this is a high proportion of respondents, it demonstrates a higher level of reported understanding than for seniors as they neared the start of Part D.

Supporters of the ACA may be able to take heart from the fact that, in spite of early unfavorable reviews, Part D gained in popularity after it was fully implemented. A year into the program, beneficiaries began to report more positive views. In November 2006, half of the seniors polled said the program was working well or that just minor changes were needed, although most supporters chose the latter characterization. About one-third (38 percent) thought the program was not working well and required either major changes or complete repeal. But most of the latter group would opt for major changes over repeal.⁸ As time moved forward, enrollees still had concerns about various plan features, but the level of satisfaction grew, particularly over the idea of having better drug coverage.⁹

Exhibit 2. Polling in Advance of Program Implementation

Polling Prior to Start	Medicare Part D	ACA
Public Opinion		
Favorable	21%	35%
Unfavorable	34%	40%
Don’t Know or Volunteered Response of Neutral or Neither	45%	24%
Public Understanding		
Yes, Have Enough Information to Understand Personal Impact	27%	49%
No, Do Not Have Enough Information to Understand Personal Impact	66%	49%

Sources: The Kaiser Family Foundation/Harvard School of Public Health, *March/April 2005 Kaiser Health Poll Report – Toplines*, April 2005 and The Kaiser Family Foundation, *Kaiser Health Tracking Poll: April 2013*, April 2013.

Plan participation

Many observers doubted there would be a sufficient number of plan sponsors participating in the program. However, at the time of open enrollment enrollees had a large number of plan choices.

The design of Part D called for private health insurers to provide a drug benefit to Medicare beneficiaries, thus creating a new marketplace and a new type of health plan. Ahead of the Part D program's launch, there were substantial concerns about the program's preparedness and viability – including whether drug plan sponsors would actually enter this new market. Even the program's architects were not certain that private plan sponsors would enter a market to offer stand-alone drug plans for beneficiaries enrolled in traditional Medicare. To address that concern, the law provided for a fallback option offered directly through the federal government in any region without at least two plans available. Many experts anticipated that fallback plans would be needed in some parts of the country.¹⁰

The deadline for plan sponsors to submit to the Centers for Medicare & Medicaid Services (CMS) notices of their intent to bid was March 23, 2005, about seven months before the start of enrollment on November 15. By that time, it was clear to CMS that fallback drug plans likely would not be needed anywhere in the country.¹¹ When enrollment began on November 15, 2005, Part D had a robust marketplace nationwide. Every Medicare beneficiary had at least 27 plan options available, and most had 40 or more stand-alone drug plans – even more in areas where many beneficiaries used the option to get their traditional Medicare benefits (Parts A and B) from private Medicare Advantage plans (managed care plans that offer an optional means of receiving Medicare benefits).¹²

Questions about whether insurers would participate have also plagued exchanges. To be sure, developing a full benefit plan and provider network is a more complicated task for a health insurer than developing a benefit design, formulary, and pharmacy network for a stand-alone drug benefit. Insurers have a different business calculus as they consider participating on the exchanges than they did regarding participation in Medicare Part D.

The ACA offers exchanges some mechanisms to encourage plan participation. The primary incentive is that premium tax credits are only available through exchanges.¹³ The ACA also attempts to increase competition on exchanges by providing start-up loans to 24 new non-profit Consumer Oriented and Operated

Plans (CO-OPs) in 24 states.¹⁴ States operating their own exchanges may establish additional incentives for insurers to participate, such as waiting periods for insurers who do not join in the first year, or requirements that insurers who meet certain standards participate in the exchange.¹⁵

Even with these provisions, there were concerns whether enrollees would have a choice of more than one insurer in all markets in all states in 2014. CMS now reports that about 90 percent of potential enrollees will be able to select among at least five different insurers and will have multiple options across the different tiers of coverage.¹⁶ Furthermore, the insurers that do participate in exchanges are expected to offer multiple plans. For example, while only 6 insurers are expected to participate in the Illinois exchange, they submitted 165 different individual and small-group plans for sale through the exchange.¹⁷

Program readiness

Critics and supporters alike were concerned that CMS would not build and test the necessary information technology (IT) systems and complete plan reviews in time to have the program ready for open enrollment and the start of coverage. But CMS launched the program on schedule.

In Medicare Part D, concerns about adequate plan participation were coupled with questions of whether the program itself would be ready in time for the open enrollment period starting on November 15, 2005. Potential plan sponsors that chose to enter the market needed to make decisions about drug formularies and premium bids and submit detailed bid proposals to CMS by the first week of June. Formularies and bids had to be compliant with program rules, but also had to position plans for success by drawing enrollment and building market share. CMS had responsibility for reviewing the bid proposals to determine, for example, whether the proposed premiums and benefit designs were actuarially sound and whether formularies and pharmacy networks were in compliance with program rules. During and after the agency's review, there were opportunities for plan sponsors to negotiate with the agency or submit revisions to their bids.¹⁸

The interval from the early June submissions by plan sponsors to the mid-October release of the full list of participating plans, premiums, and benefits left CMS about four months for the entire review and negotiation process. This schedule created significant challenges for both the agency and the plan sponsors, and throughout this period critics raised questions about the thoroughness

Exhibit 3. Plan Certification Timeline, Part D and Federally Run Exchanges

Activities	Part D Dates (2005)	Exchange Dates (2013)
Issuers submit plan applications, bids	Applications, by March 23 Bids, by June 6	April 1 – May 3
CMS reviews plan applications, bids	Applications: March 23-June 1 Bids: June 6 – September 14	May 4 – September 3
CMS notifies plans of decisions	Applications: June 1 Bids: September 14	September 4
Plans sign agreements with CMS	September 15	September 5-9
Plan marketing begins	October 1	
Open enrollment begins	November 15	October 1

Sources: Kaiser Family Foundation, *Medicare Prescription Drug Improvement and Modernization Act Implementation Timeline: June 2004 – December 2006 Key Dates*, May 30, 2005, <http://kff.org/medicaid/report/medicare-prescription-drug-improvement-and-modernization-act/>; Center for Consumer Information and Insurance Oversight, “*Letter to Issuers on Federally Facilitated and State Partnership Exchanges*,” April 5, 2013, http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf; and *FAQ and Timeline on QHP Application Extension and Data Correction Window*, April 29, 2013, <http://www.healthreformgps.org/wp-content/uploads/deadline-extension-4-29.pdf>.

of the reviews. But CMS completed the review process and launched the open enrollment period on schedule.¹⁹

The timeline for the development and review of plans under the ACA has been similarly compressed (Exhibit 3). Federal rules establishing minimum standards for benefits and premium rates were not finalized until March 2013, and extensive substantive guidance on participation in the federally run exchange was only published on April 5, 2013. Yet, in most states, insurers were required to submit applications by May 3, 2013.²⁰ As with Part D, CMS will take approximately four months to review and approve applications, with the goal of notifying issuers of final certification decisions by September 4, 2013, less than one month away from the first day of open enrollment.²¹ With approximately 120 insurers applying to offer plans²² and no limit on the number of plans each insurer may file,²³ CMS faces many of the same capacity challenges they faced in 2005.

State-run exchanges could establish their own timelines and standards for plan certification.²⁴ Some states began their certification process in late 2012 or early 2013, while others only began it in the spring of 2013 and will accept plan applications through the end of May, if not later.²⁵ However, even some of the early certifying states, such as Oregon, expect to continue finalizing contracts and ensuring plan data are uploaded to the exchange web portals accurately through September.²⁶ To help manage the number of plan submissions, some states, such as New York,²⁷ have chosen to limit the number of plans that each issuer can offer on the exchange.

In addition to plan readiness, program roll-out requires that the necessary IT infrastructures be in place. For Part D, all Medicare beneficiaries were eligible to participate, so system needs during open enrollment were mostly limited to being able to receive and process applications and ensure that appropriate information would be available to enrollees and clinicians at the point of service.

However, many policy experts, state officials, and beneficiary advocates were concerned about the data infrastructure necessary for smooth operation of the LIS program. Medicare beneficiaries who are dually eligible for full Medicaid benefits, those enrolled in Medicare Savings Programs,²⁸ and those receiving Supplemental Security Income are “deemed” eligible for the LIS; they automatically qualify and do not have to apply separately. Transitioning these individuals from Medicaid drug coverage to Part D coverage involved data exchanges among states, CMS, and private drug plan sponsors. Beneficiaries had to be identified as eligible for the LIS, assigned to appropriate plans, ensured uninterrupted access to prescribed drugs, and charged the right amount at the pharmacy. Prior to the launch of Part D, it was unclear whether the necessary data transfers would work as required. Low-income beneficiaries who did not qualify for Medicaid might still be eligible for the LIS but needed to submit a separate application through the Social Security Administration (SSA) or the state Medicaid program. Initially, it was also unclear whether timely and accurate data transfers would occur for these beneficiaries.²⁹

IT system demands are much greater for exchanges. Enrollment through exchanges hinges on the readiness of an IT infrastructure to support both eligibility determinations and enrollment in plans. At the heart of this infrastructure is a federal data services “hub” designed to verify the citizenship, immigration status, and tax information provided by individuals and families applying for financial assistance, drawing upon data from federal agencies including the IRS, SSA, and the Department of Homeland Security. States running their own exchanges are expected to be able to “plug and play” into the federal hub to streamline eligibility determinations.³⁰ Although the readiness of the federal data hub has been the subject of significant concern, federal officials have been actively testing the systems and have offered assurances that the system will be fully operational and interoperable by open enrollment.³¹

Costs for consumers

Prior to the launch of the program, there was considerable concern that premiums for the new plans would be too expensive for consumers. Program costs, however, proved to be lower than projected both in the first year and since then.

Before Part D enrollment began in November 2005, there were questions about the cost of the program for potential enrollees. Would premium costs be a deterrent to participation and acceptance?³² In advance of the program’s start, the Congressional Budget Office (CBO) had projected that average premiums would be about \$35 per month.³³ But since this market for drug plans was new, there was uncertainty about the accuracy of this estimate. Actual premiums in the first year would be driven primarily by plan sponsors’ estimates of the cost of offering the benefit and strategies about how to approach a new market. Plan sponsors set bids by looking at projected enrollment, estimates of drug utilization by prospective enrollees, their ability to negotiate discounts and manage utilization, as well as strategic decisions about a price point in the marketplace. Government subsidies were set by a formula related to the average plan premium bids. Plan sponsors had limited ability to forecast other plans’ premium bids or the average bid, which made it hard for them to position themselves in the market or to know the final premium amounts to be paid by enrollees.

Insurers eyeing exchanges face uncertainty for similar reasons – anticipating other insurers’ bids, but also forecasting the risk profile of the consumers likely to enroll in exchanges. Many potential new enrollees have never been insured before and may have a pent-up demand for health care services. In addition, because

the Affordable Care Act’s insurance market reforms now require insurers to “guarantee issue” coverage to any applicant, no matter what their health condition, and meet minimum benefit and rating standards that could encourage older, less healthy people to sign up for coverage, some have projected that these higher risks could cause a dramatic increase in premiums, often called rate shock.³⁴ However, because plans on the market in 2014 will be essentially new products with a new set of benefit and cost-sharing standards, it is difficult to compare their pricing with products sold in the marketplace today. In addition, for most consumers getting coverage through the exchanges, any premium increases will likely be mitigated by the availability of federal premium and cost-sharing subsidies.³⁵ It remains to be seen whether insurers will attempt to keep initial plan prices low in order to compete for market share, but some early rate filings suggest that the fear of rate shock may be overstated.³⁶

Ultimately, Medicare Part D costs were lower than the advance projections, although there was considerable variation across the market. Actual bids for stand-alone drug plans were close to the estimated average of \$35 per month, but lower bids by Medicare Advantage drug plans brought down the overall average (not weighted by enrollment) to \$29. There was considerable variation across the market: 5 percent of stand-alone plans had monthly premiums of \$60 or higher, but 6 percent had premiums under \$20 per month. Because people were more likely to pick plans with lower premiums, the final enrollment-weighted average for enrollees in stand-alone drug plans was \$26 (\$23 for all drug plans, combined).³⁷

The pattern of lower costs has persisted to the present, with net Part D spending about 30 percent below CBO projections. Both lower-than-expected premiums for 2006 and the longer-term cost trend are explained largely by drug cost trends that were lower than expected. Much of the lower trend can be attributed to substitution of generic drugs as patents for many common drugs expired and relatively few new drugs entered the market. Plan competition may have played some role in encouraging generic substitution, but competition seems not to be the main factor.³⁸

States’ concerns

Many states had significant concerns about the regulatory and cost burdens of the new program.

Although Medicare is fundamentally a federal program, Part D involved a substantial role for states in several respects. The program created a big shift by moving drug

coverage for 6 million dually eligible beneficiaries from Medicaid to Medicare. The shift was designed to occur on January 1, 2006, simultaneous with the start of new coverage for other eligible beneficiaries. While states would no longer have the responsibility to provide drug coverage, they were still responsible for some other health services used by dually eligible beneficiaries. Some were concerned that there could be adverse consequences for beneficiaries if the transition did not go smoothly. Some also noted that the split in coverage responsibility could diminish their capacity to coordinate and manage care for Medicaid beneficiaries.³⁹

When the Part D program was introduced, states generally viewed LIS outreach and application assistance as unfunded mandates, and most states had a policy of simply referring beneficiaries to SSA. Still, there were new reporting and information-sharing requirements involving states, CMS, and SSA.⁴⁰ This joint responsibility raised numerous communication and coordination challenges. States typically had no existing relationships with SSA, and SSA had little or no experience screening for Medicaid eligibility. Since Medicaid requirements are different in every state, it was no small task to ensure that the right beneficiary was connected to the right program.⁴¹

About 30 states also operated state pharmacy assistance programs (SPAPs) that provided some type of drug coverage to certain low-income state residents who do not participate in Medicaid and not all of whom would be eligible for the federal LIS program. States had to determine whether these popular programs would continue to add value, and if they were to be maintained, how they would interact with the new coverage.⁴²

Successful implementation of the ACA is considerably more dependent on states' willingness to cooperate – and communicate – with their federal partners. The law is grounded in the assumption that states will maintain their

historic role as the primary regulators of health insurance and health insurance markets. Congress assumed most states would operate their own exchange and enforce the market reforms.⁴³

In 2014, 16 states and the District of Columbia are planning to run their own individual market exchanges, while 34 will be run by the federal government. Of the states relying on a federally run exchange, 14 will work with HHS to conduct one or more functions of the exchanges.⁴⁴ States are also expected to implement the ACA's insurance market reforms and ensure that insurers comply. If they do not, the federal government is required to enforce the reforms. Because few states have enacted the laws necessary to implement the insurance reforms fully, HHS will attempt to “collaboratively enforce” the reforms in states willing to share information about consumer complaints and insurer conduct with the federal government.⁴⁵ In states unwilling or unable to share information with federal regulators, HHS will need to provide direct enforcement, but it is not yet clear how HHS will effectively monitor insurers' market conduct and respond to consumer complaints.

Furthermore, in the wake of the Supreme Court's decision giving states discretion over whether to implement the ACA's Medicaid expansion, some states have chosen not to expand their Medicaid program in 2014.⁴⁶ As a result, in these states the federally run exchange will be responsible for making an assessment of whether an individual or family seeking coverage through an exchange is eligible for Medicaid under the state's existing eligibility standards. In both expansion and non-expansion states with federally run exchanges, the state Medicaid agency can then either accept the exchange's determination or make its own. In either case, the state and the federal government will need to work together on an ongoing basis to ensure that applicants have appropriate coverage.

Education and Outreach

The Administration designed an extensive education and outreach effort, with the goal of ensuring that a top policy priority would have a smooth launch.

Medicare Part D represented the first outpatient drug benefit to be implemented as part of the Medicare program, and it was the first part of Medicare to be delivered exclusively through private plans. It was also the first time that beneficiaries were offered income-

based subsidies from Medicare to defray the cost of a benefit. These facts contributed to the educational challenge in introducing a new program to the Medicare population. Some beneficiaries had no drug coverage, so the program was an opportunity to obtain a new benefit. Others had drug benefits through various private sources and faced decisions on whether to retain their existing coverage or switch to Part D. Many with dual

eligibility in Medicare and Medicaid were obtaining drug coverage from Medicaid, but would be required to switch their source of coverage to a Part D plan. The Administration's first challenge was to introduce Part D with some basic information.

Six months before the start of open enrollment, HHS initiated a publicity campaign. Agency officials thought that an early publicity campaign would help to build general awareness and provide a starting point for the later, more targeted campaign. This early effort included both mass media advertising (print, radio, and television) and event appearances that featured the HHS leadership. A Medicare bus tour visited more than 80 cities and 40 states during the spring and summer and covered 600,000 miles by the time enrollment closed on May 15, 2006. The Part D program was considered one of President Bush's top domestic accomplishments of his first term, and he had considerable political capital invested in its success with the approach of midterm elections in 2006. As a result, he was featured in public events leading up to the launch and deployed resources across his Administration to conduct education and outreach.⁴⁷

These efforts extended beyond HHS. CMS identified 21 federal programs with resources available to educate Medicare beneficiaries about the drug benefit.⁴⁸ One key example was the national network of state-based community aging services providers (including Area Agencies on Aging), funded by the Administration on Aging. Other examples included service coordinators working on programs of the Department of Housing and Urban Development, the Department of Agriculture's Rural Housing Service, and the Department of Energy's Weatherization Assistance Program. These programs had components aimed at seniors and offered additional publicity opportunities.⁴⁹

In addition to the public events, the Administration worked to involve elected officials. CMS briefed congressional delegations from all states. Many members of Congress held events to publicize the benefit and provide help with signing up. Although the political environment of 2005 was less polarized than that of 2013, there was clearly an element of partisanship in the education process. To the President and many Republican officials, it was important that a signature policy initiative have a successful launch. Democrats were more cautious, torn between their opposition to the design of Part D and their support for the idea of Medicare drug coverage. They were often critical of various implementation decisions, but legislators also wanted to make sure that their constituents were able to

Just as Medicare Part D was widely seen as one of President Bush's most significant domestic accomplishments, the Affordable Care Act is viewed as one of President Obama's.

take advantage of the new drug coverage. CMS reported that members of Congress participated in many events as honorary chairs or as in-person participants.⁵⁰

The outreach efforts evolved from broad educational initiatives to more targeted enrollment efforts. In particular, federal efforts targeted low-income beneficiaries to educate them about the availability of the LIS. Some beneficiaries are "deemed" eligible because of their dual eligibility for Medicaid, the Medicare Savings Program, or Supplemental Security Income. But others must submit an application for the program and are assessed for eligibility based on specified income and asset levels. These individuals must apply for the LIS either through SSA or through their state Medicaid programs. Many observers were concerned that these beneficiaries would not be aware a subsidy was available to them, know where to apply, or how to get help. SSA conducted an extensive outreach campaign from May 2005 to August 2006. The agency identified almost 19 million Medicare beneficiaries who might qualify for the subsidy and mailed LIS information and applications to them. SSA reported working with 7,000 community organizations and participating in 50,000 events where over 1.5 million LIS applications were distributed.⁵¹

In spite of these significant efforts, enrollment in the LIS program for beneficiaries not automatically deemed eligible was low. And low enrollment rates persist. In 2006, an estimated 35 percent of those required to apply separately for the LIS received it.⁵² Beneficiaries reported that they were not aware that a subsidy was available; this was particularly true among low-income seniors of color.⁵³ In addition, after the first year's open enrollment period, outreach to low-income beneficiaries declined, in part because of staffing constraints in SSA field offices.⁵⁴

Just as Medicare Part D was widely seen as one of President Bush's most significant domestic accomplishments, the Affordable Care Act is viewed as one of President Obama's. The Obama Administration thus has considerable political capital invested in a successful launch of exchanges and smooth implementation of the market reforms. However, as evidenced by the results of the tracking polls cited above, efforts to educate the public about the law have been, to date, largely unsuccessful.⁵⁵ Some of the difficulty in

gaining widespread public understanding and acceptance of the law is attributable to legal challenges, as well as a polarized political atmosphere in which opponents of the law have deployed more communications resources than supporters.⁵⁶ Furthermore, due to political opposition to the law, Congress has to date denied the Administration's requests for additional resources to support federal ACA implementation and outreach efforts.⁵⁷ However, a major educational campaign is expected to start during the summer.⁵⁸

In part because of a lack of resources,⁵⁹ the Administration is relying on the private sector to act as messengers. Officials have asked the health care

industry to provide support for ACA outreach and enrollment efforts.⁶⁰ Enroll America, a newly created nonprofit organization, has raised funds from the health insurance and provider industries to support an outreach campaign.⁶¹ The Administration is also increasingly relying on states to supplement federal efforts. While state participation in education and outreach activities was originally limited to states running or partnering with the federal government to implement exchanges, CMS announced that all states, including states with federally run exchanges, could use federal funds to support statewide marketing campaigns.⁶² This decision opens the door for significantly more money to be put toward outreach and education if states take advantage of it.

Eligibility and Enrollment

In Part D, each beneficiary had at least two initial decisions before acquiring drug coverage: whether to enroll in Part D and which plan to select. Many had a third choice as well: whether to apply for the LIS.

For most people, enrollment in Medicare Parts A and B occurs automatically, either after turning 65 or 24 months after qualifying for Social Security Disability Insurance. But this was not the case in Part D. Beneficiaries who made no decision were not included in the program. A decision about whether to enroll meant determining whether the benefit brought value to the beneficiary and whether he or she preferred to keep an existing source of coverage. Although enrollment is voluntary, a penalty in the form of higher premiums is applied for those who do not enroll at their first opportunity and lack creditable coverage.

Many individuals and families eyeing the opening of exchanges must make an even more complicated set of assessments about their financial and health situations and the benefits and costs of making a change. Those currently without coverage must decide whether obtaining coverage is worth the cost or whether to pay a tax penalty for not maintaining insurance. They must decide whether to obtain a determination of their eligibility for public coverage or tax subsidies for an exchange plan. Then, assuming they are eligible to enroll in exchange coverage, they must choose a health plan that is, ideally, optimal for their financial and health status. For those with an offer of employer-based coverage, but unsatisfied with its affordability or adequacy, or with family members

that may be eligible for different types of coverage, the questions are even more thorny.

Decisions about whether to enroll

It was initially hard for potential enrollees to understand the value of the new benefit, especially for those who did not anticipate needing to use it. Many factors, including a late-enrollment penalty, provided an incentive for people to enroll.

Two provisions in the law creating Part D were designed to help encourage enrollment. One was a penalty for late enrollment. To avoid adverse selection, anyone enrolling after their first period of eligibility would in perpetuity be charged a higher monthly premium based on the number of months that enrollment was delayed.⁶³ Second, the program's initial enrollment period was extended through May 15, 2006 – four and a half months after the official program start – thus extending the initial chance to enroll without a penalty.

Just before the start of enrollment (October 2005), only one in five seniors (20 percent) expected to enroll in Part D, one-third of seniors (37 percent) indicated that they thought they would not enroll in a drug plan (often because they had other coverage), and a similar number (43 percent) was uncertain. By the end of open enrollment, about 53 percent of Medicare beneficiaries had enrolled in Part D plans and another 16 percent participated through subsidized coverage from former employers. About 21 percent stayed with some other type of equivalent coverage, but about 10 percent of all beneficiaries remained without

coverage.⁶⁴ Evidently, many who were initially uncertain made decisions to enroll.

Various studies found that Medicare beneficiaries were confused about different aspects of Part D, especially in the early months around the program's implementation.⁶⁵ Some studies also took note of limits to how well they understood the program's benefit structure, including nature of cost sharing, the working of plan formularies (if they even knew what a formulary was), and the existence of the coverage gap (doughnut hole).⁶⁶

Many not enrolling in Part D had other coverage, such as from a former employer. For those without other coverage, the most cited reasons for not enrolling related to their assessment of the value of the benefit, especially if they thought they had too few prescriptions to need coverage, that the benefit would not save them money, or that the program was confusing.⁶⁷ Those who enrolled typically cited the ability to save money in the short term, the desire to reduce high drug costs or fill prescriptions they could not previously afford, or to protect themselves against future costs.⁶⁸ Although many disliked the idea of a late enrollment penalty and did not understand how it worked, it helped convey the message that they should sign up. One survey found that a majority of enrollees (69 percent) felt very confident or somewhat confident about having made the right decision to enroll and an even larger share planned to sign up again the following year.⁶⁹

The ACA also includes incentives for people to enroll in coverage. First, the law provides significant premium tax credits and cost-sharing subsidies to low-income individuals and families. This assistance will help make the cost of health insurance coverage more affordable to millions of Americans. Second, and most controversially, individuals who do not maintain public or private coverage or qualify for an exemption⁷⁰ must pay a tax penalty, starting at \$95 per person (or 1 percent of family income, if greater) in 2014, and rising to \$695 per adult (or 2 percent of family income, if greater) in 2016.⁷¹ Third, individuals are only able to enroll in exchange coverage during open enrollment periods, unless they qualify for a special enrollment period. The initial open enrollment period is an extended one, from October 1, 2013 to March 31, 2014,⁷² to help ensure there is sufficient time to conduct outreach and educational efforts, and provide the kind of hands-on consumer assistance that many people will need.

There is, however, no late enrollment penalty, and it is unclear whether the tax penalty for failure to maintain insurance coverage provides sufficient incentive for people,

particularly healthy people, to enroll. The Congressional Budget Office has projected that 6 million people will pay the penalty rather than purchase insurance.⁷³

Financial assistance

Not everyone potentially eligible for financial assistance was aware that subsidies were available. For many, the process involved in establishing eligibility was daunting and deterred some from applying.

As discussed above, Medicare beneficiaries not automatically deemed eligible for LIS were required to apply for a determination of eligibility. These beneficiaries faced a complicated, two-step application process, which likely affected enrollment levels. In surveys conducted from 2005 to 2007, beneficiaries lacked awareness about the LIS and had misperceptions about their eligibility and how to apply.⁷⁴

In deciding whether to apply for the LIS, beneficiaries had to consider the value of the subsidy and their own income and resources. Some felt they did not have the information they needed to make good decisions. Some assumed that they were ineligible for financial reasons.⁷⁵ Asset tests made the eligibility rules more difficult to understand and the application process more complex than if eligibility were based just on income. As is true with other benefit programs, certain Medicare beneficiaries were reluctant to ask for help or to share personal financial information. Others did not apply because of concerns that the LIS could count as income and they could then become ineligible for other benefits.⁷⁶

Medicare beneficiaries with limited English proficiency faced additional challenges. For example, SSA made sample LIS applications available in 15 languages for information purposes, but only had the capacity to accept scannable English and Spanish versions for processing.⁷⁷

The application and enrollment process for low-income beneficiaries also required information sharing among a number of entities – CMS, SSA, states, and drug plans. Difficulties arose when the information was not shared or transmitted on a timely basis. For example, states and SSA made separate LIS eligibility determinations and generally did not share data even though a beneficiary who is determined not eligible through SSA could qualify for Medicaid and the LIS in states with more liberal Medicaid eligibility rules. There was also variation in the frequency with which states and CMS shared data. In addition, plan sponsors did not always have up-to-date information about beneficiaries' subsidy status.⁷⁸

Beneficiaries must re-qualify for the LIS each year. In the fall of 2006, however, few beneficiaries were aware of this requirement or knew how to fulfill it.⁷⁹ Some 630,000 enrollees (about 10 percent of those with subsidies) were not automatically determined eligible for the LIS again in 2007 because of a change in their Medicaid status.⁸⁰

The application process for premium tax credits and cost-sharing assistance under the ACA will likely be considerably more complicated than that for the LIS. Yet consumers may be motivated to undertake the application process because the full cost of health insurance is out of reach for most low- and moderate-income families, and, depending on their income level, the tax credits can dramatically reduce – or in some cases eliminate – premium payments.⁸¹

The ACA requires exchanges to use a single streamlined application for multiple health coverage programs, and eligibility is based on modified adjusted gross income (MAGI) and does not require an asset test. But those making eligibility determinations must also examine citizenship and immigration status, access to job-based coverage, and the affordability of other current coverage, potentially for multiple applicants within one family.⁸² Many families will have mixed eligibility for public and private coverage, such as when a child is eligible for CHIP and the parent is eligible for premium tax credits. In addition, the single streamlined application will only be available in English and Spanish,⁸³ with a limited selection of educational materials translated into additional languages.⁸⁴ Exchanges are required to provide oral interpretation services at no cost to consumers with limited English proficiency.⁸⁵

A consumer's eligibility also may change during the year due to changes in income, family size, and other criteria. If this change means that a consumer no longer qualifies for a premium tax credit, or qualifies for a less generous tax credit, they may owe any excess credit they received back to the IRS when they file their tax return.⁸⁶ Thus, it will be critical that consumers learn about both the need to update their income information as soon as it changes and the potential tax liability they may face. This threat may deter some consumers from applying for subsidies

The application process for premium tax credits and cost-sharing assistance under the ACA will likely be considerably more complicated than that for the Part D Low-Income Subsidy.

in the first instance, particularly if they have a volatile income. By contrast, Medicare Part D LIS enrollees are not at risk for refunding their subsidies in the event of a change in financial circumstances.

Periodically, some Medicare beneficiaries are informed by letter that they will lose their LIS status for the next year unless they reapply and demonstrate again that they meet the LIS eligibility criteria.⁸⁷ Exchanges, however, are required to automatically re-determine the eligibility of enrollees on an annual basis and provide notice to enrollees.⁸⁸

Plan choice

For many participants, selecting a plan among a set of alternatives was a new experience. The considerable array of choices made it challenging to compare plans effectively, and many chose plans that were not optimal for their personal circumstances.

A decision to enroll in Part D must be followed by selection of a plan in order to obtain the drug benefit. As noted above, not everyone initially understood that this was how the program worked. In selecting a plan, potential Part D enrollees considered such factors as estimated costs under the different plans, the attractiveness of deductibles, plan reputation, and other plan features. Plan selection involved a relatively modest set of variables and relatively predictable year-to-year costs, but even so most Medicare beneficiaries found the decision process difficult. Plan choice was somewhat more complicated for beneficiaries who qualified for the LIS because they could only choose certain plans if they wanted the subsidy to cover the full cost of the premium.

Furthermore, many potential enrollees thought that the large number of plan choices made the decision process “overwhelming.”⁸⁹ There is other evidence that when respondents were asked to choose from a larger set of plans, they found the decision process difficult but were more likely to be happy with the actual plan they chose.⁹⁰

According to one study, only 41 percent of those making enrollment decisions compared the costs and features of different plans, often taking a close look at only a small subset of available plans.⁹¹ Many simply opted to select plans offered by companies with which they had an existing relationship, such as the company from which they had purchased supplementary (Medigap) coverage. Others responded to marketing representatives or advertisements or picked based on endorsements such as those bearing the AARP label.

The outcome of beneficiaries' confusion, reluctance to do extensive research, and use of short-cut decision approaches may be perfectly rational from the perspective of the individual's ability to move forward with a selection. But one consequence is that many enrollees failed to make optimal choices from the perspective of finding a plan that would minimize their overall projected costs.⁹² Rather than pick a plan that lowered their overall drug costs, including plan premiums, some enrollees gave more importance to plan premiums or attributed more value to plan features, such as gap coverage, than the feature was worth.⁹³ There is also evidence that older beneficiaries made poorer decisions.⁹⁴

Although it is not yet known how many plans will be offered on exchanges, consumers are likely to face a similar set of challenges comparing plan premiums, benefits, networks, and cost-sharing arrangements. Moreover, research has found that most consumers have little

understanding of critical health insurance concepts, do not fully assess their health needs or the services that plans cover, and tend to fall back on brand and word of mouth.⁹⁵

While the ACA attempts to impose some standardization on plans, through a required set of essential health benefits and organization of plans into tiers based on four levels of out-of-pocket expenses for an enrollee (indicated by precious metals, i.e., bronze, silver, gold, and platinum), consumers could still face hundreds of different plan options. Some state-run exchanges are attempting to further standardize plan benefits and cost-sharing in order to streamline consumers' shopping experience and encourage true "apples-to-apples" comparisons.⁹⁶ In addition, federally run exchanges will weed out plans that are not meaningfully different from other plans offered by the same insurer.⁹⁷ However, consumers are still likely to need considerable assistance comparing and understanding their plan options.

Consumer Assistance

National, state, and local organizations, both public and private, provided a tremendous amount of assistance to beneficiaries when the Part D program was introduced. CMS was the major player on the national level, with SSA playing an important role in publicizing and assisting with the LIS program. State Health Insurance Assistance Programs (SHIPs), state-based organizations that receive federal funds to assist Medicare beneficiaries with insurance issues, were instrumental in counseling beneficiaries about Part D. In addition, some state pharmacy assistance programs (SPAPs) were active in educating and assisting beneficiaries.

CMS reported that it worked with more than 10,000 local partners, including senior organizations and centers; youth groups; churches; civic and social organizations; and federal, state, and local government agencies.⁹⁸ The agency also reported that during the initial open enrollment period, grassroots partners sponsored more than 50,000 Medicare events and opportunities for people to receive personalized assistance. Several thousand of those events were held during the last weeks of the enrollment period.⁹⁹

New non-governmental organizations were established to provide enrollment assistance. The Access to Benefits Coalition (ABC) comprising national and community-based organizations was formed to help low-income

Medicare beneficiaries become aware of and enroll in prescription drug programs. The Health Assistance Partnership (HAP) worked with SHIPs to build their capacity to educate, counsel, and assist Medicare beneficiaries on Part D. State-level coalitions supplied information, training, and support to community organizations engaged in outreach, education, and enrollment activities. Pharmacists and physicians also played a prominent role in counseling beneficiaries and many people received help from family and friends.¹⁰⁰

Helping with enrollment was complicated because of the need to understand, educate, and provide assistance on several topics: whether to enroll in Part D - which involved ensuring that beneficiaries knew about the program; whether and how to apply for financial assistance; and how to choose a Part D plan. A variety of approaches was used, including written materials, websites, online tools, call centers, and in-person counseling. Counselors also had to be careful not to steer potential enrollees into certain plans.

Despite all this activity, individuals assisting Medicare beneficiaries early in the process expressed a need for clearer information about the program, reporting that beneficiaries and counselors often could not get information when they asked for it from plan sponsors, pharmacists, or CMS, or at times had received inaccurate

information.¹⁰¹ Observers noted that the participation of so many groups was generally positive, but that sometimes information and activities were not well coordinated.¹⁰² Focus groups with beneficiaries in 2006 and 2007 (reflecting two years of experience) indicated that awareness of and satisfaction with the help available by phone and on the web was mixed and that only a small share of beneficiaries actually used counseling services. The primary reason for this appeared to be that there was little awareness of the community resources that are available for counseling.¹⁰³

The online Part D Plan Finder tool was identified as particularly helpful for beneficiaries and their counselors. Over the years, CMS has made improvements.

Written materials

Potential participants were exposed to a deluge of written communications from CMS and marketing materials from competing insurers. Many found the material confusing, written in jargon, or just too voluminous.

Beneficiaries received written materials about the Part D program from many sources including government and non-governmental organizations and Part D plans. Much of the early communication was sent by mail. There were reports that beneficiaries did not receive official notices or that they received, but did not understand them. Other beneficiaries said they got too much mail. Counselors reported that it was not uncommon for beneficiaries to ignore mail from government agencies or if they opened it, to be confused by the contents. Some had difficulty distinguishing between the Part D program and materials sent by insurance companies. Beneficiaries said they appreciated the material they received from Part D plan sponsors, but noted that it was difficult to make “apples-to-apples” comparisons across plans because marketing materials did not present information in a consistent manner.¹⁰⁴

An independent review of CMS documents describing Part D concluded that the information was largely complete and accurate, but that the documents contained too much technical jargon and often did not define difficult terms, such as “formulary.”¹⁰⁵ The “Medicare and You” handbook was cited as an important source of information about Part D, but some beneficiaries said they found the information confusing and “too legalistic.”¹⁰⁶

The Administration must reach a broader and more diverse audience to educate and engage individuals eligible about exchanges. And, unlike in Medicare, there is no one agency that has an official line of communication to all target populations. In addition, many consumers have come to rely on newer forms of communication to obtain information, such as through online formats and social media. That said, consumers are likely to be barraged with written materials from the state- and federally run exchanges and official intermediaries such as exchange-appointed navigators, as well as marketing from private health insurers.

To help people independently evaluate their plan options, the ACA requires that insurers provide a standardized summary of benefits and coverage that describes, in plain language, the benefits and limitations of each health plan.¹⁰⁷ The availability of these simplified plan summaries has become one of the most popular provisions of the law.¹⁰⁸

Online tools

The program demonstrated that online decision-support tools are critical for providing both basic education about insurance coverage and detailed comparative tools to assess and choose among plans.

In Part D, the online Plan Finder tool, developed by CMS and available at the website www.medicare.gov, was identified as particularly helpful for beneficiaries and their counselors.¹⁰⁹ CMS reported that, in 2006, about 3.6 million people – more than one-third of all individuals who voluntarily selected and enrolled in a plan – enrolled through the Plan Finder, although this count includes those signed up by counselors and brokers.¹¹⁰ Surveys suggested that only about one in ten beneficiaries used the Plan Finder on their own, although more used it indirectly through family members and other helpers.¹¹¹

Initially, there were accuracy problems with some of the information in the Plan Finder. Counselors used the tool extensively to identify the best choices for beneficiaries, but before they had complete confidence in the Plan Finder, counselors reported that they tried to confirm information with plan sponsors when they were advising beneficiaries and that this added to the amount of time they spent assisting individuals.¹¹² Early reports indicated that beneficiaries were concerned about discrepancies between plan-specific information in the Plan Finder, the “Medicare and You” handbook, and other information sources. Over the years, the quality of the Plan Finder has improved, as well as users’ familiarity and comfort with

it. CMS made improvements to the Plan Finder based on feedback from users.¹¹³

One of the key responsibilities of exchanges is the operation of a website that will allow consumers to compare and select among available plans.¹¹⁴ While these websites have not yet launched, they are expected to rely heavily on interactive decision-support tools that allow consumers to sort and compare plans based on out-of-pocket expenses for the enrollee (indicated by bronze, silver, gold, and platinum designations), price, provider network, and other preferences.¹¹⁵

Call centers

Officials viewed the ability to handle telephone inquiries as a core function of the program, but it was a challenge to estimate the capacity that would be needed and to ensure that reliable answers could be provided about a complex program. CMS had to make adjustments throughout the initial open enrollment period.

The national toll-free Medicare number (1-800-Medicare) was another important source of information and assistance regarding Part D. CMS reported that the call line handled more than 27.5 million calls during the initial open enrollment period. On the last day of the enrollment period, call volume and use of the online enrollment center reached record levels and was 58 percent higher than any other period of operation.¹¹⁶ In surveys, however, only about 20 percent of beneficiaries said they used the call center.¹¹⁷

Initially, beneficiaries and counselors reported long wait times when they called. The volume and length of the calls was greater than had been anticipated. Users also reported that customer service representatives (CSRs) were not knowledgeable and did not always provide accurate information.¹¹⁸ In an early survey, about three-fifths of beneficiaries who had called 1-800-Medicare or used the website said they found the information helpful. The others did not.¹¹⁹ Another evaluation found that the CSRs at 1-800-Medicare responded to calls accurately and completely only about two-thirds of the time.¹²⁰

CMS made a number of changes to improve the call center. The agency hired and trained additional staff exclusively devoted to calls about choosing plans. All CSRs received one week of classroom training followed by two or three additional days of practice calls, simulation, quality monitoring, and follow-up coaching. CSR certification with a written examination and test calls were required prior to taking live calls. The agency also revised the scripts used by CSRs and continued to update scripts based on

feedback from the representatives. With these changes, CMS reported a decrease in wait times for callers.¹²¹

Part D plan sponsors also operate call centers. An early examination found that call center service was generally prompt and courteous, but that call centers did not consistently provide accurate and complete responses.¹²² A 2007 survey in California indicated that plan sponsor call centers were only able to serve beneficiaries with limited English proficiency in their primary language 55 percent of the time and non-English or Spanish speakers 37 percent of the time. A similar survey the next year showed some improvement with 67 and 57 percent of callers, respectively, receiving assistance in their preferred languages.¹²³

The ACA requires exchanges to operate a toll-free telephone hotline to provide consumer assistance.¹²⁴ State-run exchanges will operate their own hotlines, and the federal government will operate the call center for the remaining states. Generally, exchange call centers can be expected to provide consumers with limited English proficiency access to a language line if bilingual staff is not available. The federal call center is expected to provide 24-hour service and employ at least 300 representatives.¹²⁵ One challenge for the federal call center, however, is that staff will likely need to be trained on some of the state-to-state differences in Medicaid and commercial insurance rules and coverage programs, so that they can serve consumers regardless of the state from which they are calling. CMS has said that all customer service representatives at the federal call center will be able to “address requests for general information, consumer eligibility, plan comparisons, and enrollment.” However, CMS also reports that customer service representatives will make referrals to insurers or assistance programs, such as navigators, where possible, raising questions regarding the capacity of the call center to provide assistance directly to consumers.¹²⁶

Plans, brokers, and agents

Many consumers looked to plan representatives, insurance brokers, and agents as sources of assistance. Instances of marketing abuses were reported, and CMS had the responsibility of ensuring that these individuals served the interests of potential enrollees.

The private plan sponsors that offered Medicare drug plans actively marketed their plans. In addition to mailing fliers and plan brochures to potential enrollees, they participated in general educational and outreach events within the limits imposed by marketing rules. They also offered plan-specific presentations to interested consumers.

Some beneficiaries were victims of marketing abuses. For example, some insurance company agents and brokers inappropriately steered people into Medicare Advantage plans or into certain Part D plans, regardless of whether they were in the beneficiaries' best interests. Some deployed aggressive tactics, including unsolicited sales calls, and targeted particularly vulnerable individuals (i.e., residents of nursing homes). Some committed outright fraud.¹²⁷ At the least, aggressive marketing tended to add to beneficiary confusion.¹²⁸

For exchanges, the federal government is largely deferring to state laws and regulations regarding health plan marketing, although brokers participating in federally run exchanges must sign an agreement stating that they will comply with federal rules and requirements. The final exchange rules broadly prohibit insurers from employing marketing practices that would discourage enrollment by individuals with significant health needs and require insurers to comply with all applicable state marketing laws.¹²⁹ For insurers participating in the federally run exchanges, CMS has said that it does not intend to monitor plan compliance with state laws.¹³⁰

States also have significant flexibility to set the rules for agent and broker participation (including web-based brokers) in exchanges.¹³¹ If a state allows, federally run exchanges will enable agents and brokers that are licensed by the state to assist with applications for insurance affordability programs and enroll consumers in exchange plans. The federal government will require agents and brokers to complete federal training and certification, but insurers, rather than the exchange, are then expected to ensure that agent and broker marketing activities comply with applicable state and federal rules.¹³²

In-person counseling

Many potential enrollees relied heavily on in-person counselors to help them assess eligibility for subsidies and enroll in the program. Initially, these counselors were overwhelmed by the technical details of the program and the demand for services.

The availability of in-person counseling provided at SHIPs and community-based organizations were viewed as particularly helpful for those Part D beneficiaries who used it.¹³³ Counselors described beneficiaries as overwhelmed at the start of the program because there was so much information for them to absorb. They had questions on the number of plan choices, the variation in benefit structure, the requirements related to the LIS, the coverage gap, and the penalty for late enrollment. The

counseling process was time-consuming because each beneficiary had a particular drug regimen and each plan had different formularies. Counselors noted that often a series of encounters occurred with a single beneficiary: to provide general information, to help identify potential plans, and to then help with the actual enrollment for plans and application for the LIS if appropriate.¹³⁴ Federal funding for the SHIP program increased from \$12.5 million in 2003 to about \$30 million for each year from 2005 to 2007. This represented about \$0.70 per Medicare beneficiary.¹³⁵ With only limited funds, one-on-one counseling was not always available.¹³⁶

During the Part D enrollment period, organizations that assisted beneficiaries reported that they could not respond adequately to all of the requests for assistance.

During the Part D enrollment period, organizations that assisted beneficiaries reported that they could not respond adequately to all of the requests for assistance. They described voice mailboxes that were full and waiting lists for appointments.¹³⁷ SHIP counselors consistently reported that they did not have the capacity to respond to the high volume of requests for assistance that they received.¹³⁸

Policy experts and advocates recommended providing educational materials, applications, and correspondence at a literacy level appropriate to beneficiaries as well as materials for those with limited English proficiency. Trusted local organizations were important sources for the in-person counseling for members of culturally and linguistically diverse populations, but counselors who could communicate effectively with beneficiaries and who also had a thorough understanding of the Part D program were in short supply.¹³⁹ In addition, these counselors needed training to fully meet the needs of populations they had not traditionally served. For example, SHIPs reported serving more beneficiaries under 65 with disabilities than they served previously.¹⁴⁰ However, accommodations and support for people with disabilities were not common.¹⁴¹

Congress recognized the need for in-person assistance in drafting the ACA and created a navigator program to provide eligibility and enrollment assistance as well as education and outreach services. Under the law, exchanges are required to award grants to at least two navigator

entities, one of which must be a community or consumer-focused non-profit, to provide fair and impartial information and assistance to consumers.¹⁴² HHS also provided that states operating their own exchanges or partnering with the federal government on exchange implementation can use federal funds to establish in-person assistance programs, to supplement their navigator program in early years.¹⁴³

HHS is requiring recipients of navigator and in-person assistance grants to provide culturally and linguistically appropriate services and ensure they are accessible to people with disabilities. Assisters are expected to provide information in the consumer’s preferred language and must “develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area.”¹⁴⁴ HHS has also proposed to create a volunteer role (certified application counselors) for health care providers and staff and volunteers affiliated with community-based organizations and other organizations with expertise in social services to assist vulnerable populations with eligibility and enrollment in exchanges.¹⁴⁵

Despite these provisions, funding for consumer assistance programs – and, thus, the capacity and quality of these programs – is likely to vary significantly across states. State-run exchanges have been able to draw down millions in federal grants to support in-person consumer assistance. For example, Maryland has been awarded \$16 million for its program, and plans to supplement this

amount with \$8.6 million in state dollars.¹⁴⁶ Conversely, states with federally run exchanges could have far fewer resources. Virginia will likely have less than \$1.5 million for its navigator program.¹⁴⁷

Informal counseling

Some potential enrollees turned to friends, family, and medical professionals for advice. It was challenging, however, to provide these individuals with the tools they need to provide assistance.

In Part D, beneficiaries relied heavily on informal counseling from friends, family, and professionals, and it is likely people signing up for exchange coverage will also rely on such networks. Among beneficiaries who had help making a decision about signing up for a drug plan in 2006, almost half (49 percent) said they had help from a family member or friend. The next largest group (17 percent) received help from an insurance agent.¹⁴⁸ Pharmacists also played an important role in helping beneficiaries at the start of Part D and physicians were consulted.¹⁴⁹ When Part D was introduced and pharmacists and doctors were approached for information or assistance they often did not know how to give advice about the program or did not have the time to do so.¹⁵⁰ Observers noted that given the complexity of the program, more extensive training was needed so that anyone who was approached for help could be responsive to questions about complicated program issues.¹⁵¹ It is likely exchanges will face similar challenges.

Post-Enrollment Complications

The challenges for Part D were not over once beneficiaries had selected and enrolled in a plan. The next test came when they visited the point of service (the pharmacy) to fill prescriptions. At this point, some beneficiaries discovered that their plan enrollment or their LIS status was not recognized. Others learned at the pharmacy that their prescribed drug was not covered on the plan’s formulary. In addition, by the end of the year, Part D enrollees would face a new open enrollment period. All beneficiaries were advised to reexamine their choice of plans in the light of new plan offerings. They also needed to consider modifications to their current plan that might include changes in premiums, benefit offerings, or formularies. Some low-income beneficiaries would learn that their current plan was no longer available without an extra premium charge, necessitating a switch to maintain the

full value of their subsidy. This paper briefly addresses just one of these issues – the failure to recognize the correct enrollment status, especially for low-income beneficiaries.

The systems that CMS established to convey information electronically about beneficiaries’ plan affiliation and subsidy status and to anticipate and address problems at the point of service (pharmacy) were in place when the Part D program was implemented, but beneficiaries, pharmacists, physicians, and advocates all reported early problems when beneficiaries, especially low-income beneficiaries, went to pick up prescription drugs.¹⁵²

The Part D program involves data transfers among many organizations. CMS and plan sponsors must communicate about beneficiaries’ plan choices, and pharmacies need access to information about enrollees’

enrollment status and plan choice. For low-income beneficiaries, states must transfer Medicaid eligibility data to CMS. CMS and SSA also communicate regarding LIS eligibility. CMS must send enrollment and subsidy eligibility data to Part D plans, and that information must be available to pharmacies as well. Early reports highlighted problems related to data exchanges at the start of the program:

- CMS and state eligibility data did not always match so that some dually eligible individuals were not correctly identified as LIS enrollees;
- Pharmacies did not know that beneficiaries had LIS status and therefore should not be subject to deductibles and high co-payments;
- Beneficiaries who were auto-enrolled in a plan, but changed their enrollment did not appear in the system as enrolled or appeared as enrolled in two plans; and
- When LIS beneficiaries changed plans after an initial auto-enrollment by CMS, the record of their LIS status was not conveyed to the new plan.¹⁵³

As a result of these administrative glitches, there were reports of LIS beneficiaries leaving pharmacies without needed medications because their eligibility could not be verified, they could not afford to pay, and they were not offered temporary supplies of medicine.¹⁵⁴ Initially CMS established a 30-day transition period and required that plans ensure that new enrollees could obtain coverage for a one-time supply even if the prescribed medications were not included on the plan formulary. In response to reports that some prescriptions were inappropriately denied and that plan service representatives were not aware of transition policies, CMS issued additional guidance to plans regarding transitions and extended the transition period.¹⁵⁵

States stepped in to fill gaps in coverage during the early transition when Medicaid beneficiaries were deemed eligible for the LIS and obtained Medicare Part D coverage. Thirty-seven states implemented temporary coverage programs to provide access to drugs for these beneficiaries – initially without assurance that they would be repaid by the federal government.¹⁵⁶ There were also reports of pharmacists who provided temporary supplies of medicines for beneficiaries without assurances that they would be reimbursed.

CMS provided special Part D resources for pharmacists, but initially pharmacists had difficulty using these tools. They had long waits on phone lines when trying to verify information and they were unable to get information

from the *E! Eligibility Verification System*, which CMS established to give them a means of retrieving real-time enrollment and eligibility information. Initially, the system provided incomplete or inaccurate information about plan enrollment and required cost sharing.¹⁵⁷ CMS worked to resolve early technical problems and expanded its call handling capacity at the toll-free pharmacist help line by increasing the number of customer service representatives from 150 to about 4,500. Hours were expanded so that the line was available 24 hours a day. After pharmacists reported on problems obtaining timely and accurate information from plans, CMS issued guidance to plans instructing them to increase the number of customer service representatives in their call centers and to provide dedicated lines for technical support to pharmacists.¹⁵⁸

In anticipation of problems with transitioning drug coverage to Medicare for dually eligible beneficiaries, CMS created a Point of Sale Facilitated Enrollment process (POS) at the start of the Part D program to assist dually eligible beneficiaries in filling prescriptions at the pharmacy if they had not yet been assigned to a Part D plan or there was no record of the assignment. In cases where beneficiaries could show or pharmacists could confirm proof of participation in Medicaid and Medicare, and there was no record of plan assignment for beneficiaries, pharmacists could provide a 14-day supply of a medication and bill the POS contractor. Early in 2006, the process did not work smoothly. One problem was that it relied on the *E! Eligibility* system, which was not always accurate. Also, the POS system pertained only to full-benefit dually eligible beneficiaries; it was later modified to cover other low-income beneficiaries. Another limitation was that pharmacists were not required to use the system. A review of the system found that initially, pharmacists received reimbursement for millions of claims that were later found ineligible. As a result, the pharmacies were forced to make repayments and then to seek reimbursement from plans or beneficiaries. Administrative fixes made the program more efficient over time. As time passed and other aspects of the program improved, utilization of the POS system decreased.¹⁵⁹

With so many entities involved, beneficiaries were unsure about who to contact when they had questions or problems. They reported being told by one entity to contact another to solve problems.¹⁶⁰ CMS trained hundreds of its own staff as temporary caseworkers who could intervene in special cases to make sure that enrollees get needed medications. The need for their services lessened somewhat with time, but in August 2006, CMS

reported that that staff in its regional offices continued to spend significant time on individual casework to help beneficiaries obtain their prescription drugs.¹⁶¹

A group of stakeholders convened in August 2006 to discuss Part D indicated that data issues were the most serious unresolved problems related to the program. They noted that adding tasks associated with Part D implementation to CMS data systems that were already in need of updating was problematic and observed that, until a new “real-time” system could be established and more standardization of data formats could be achieved, state

and federal staff resources would have to continue to be diverted to short-term fixes.¹⁶²

For those purchasing private coverage through exchanges, obtaining benefits at the point of service will also involve numerous “back office” data transactions – between the exchange and the insurers, and between insurers and providers. It is unclear at this time whether HHS will offer a provider help line to answer questions on a real-time basis. At a minimum, CMS is likely to need to maintain a steady focus on data transfer issues and be poised to make any necessary upgrades or improvements.

Conclusion

Past efforts to design and launch a large national health coverage program suggest that the experience will be far from perfect, at least at the outset. Government officials, policy-makers, advocates, and the public are often wary of a new program’s effectiveness and viability. Technology and data transfer glitches will typically cause problems when consumers seek eligibility determinations, enroll in coverage, and obtain services. And inadequate investments in consumer education and assistance have the potential to cause confusion, suppress enrollment, and have a negative impact on consumers.

However, the Medicare Part D experience teaches us that, when things went awry, federal and state officials were often able to identify problems and work with stakeholders to develop policy and operational solutions, so that consumers could obtain the benefits they had been promised. Problems were not always addressed as quickly or as thoroughly as critics would have liked, but fixes were usually found.

Those officials, policy-makers, and advocates preparing for the launch of exchanges in October 2013 face considerable challenges, not the least of which are limited resources to support implementation and a highly polarized political atmosphere. However, there is much to be learned from both the mistakes and the overall success of Part D. Eight years after being launched, Part D is popular with both enrollees and policy-makers. As part of the ACA, Congress addressed one of the benefit’s largest flaws by phasing out the coverage gap (doughnut hole) by 2020. Program enrollees today spend less money out of pocket and are more likely to get the drugs they need than before Part D.¹⁶³ Aided by the recent overall slowdown in drug spending, the cost of Part D has been well below the levels projected at the time of its passage.¹⁶⁴ Although flaws remain, a program born amidst partisan controversy and launched with considerable wariness has emerged to become a core part of Medicare.

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