



Medicare Prescription Drug Benefit: A Guide Through the Maze

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Introduction

The prescription drug benefit provided under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 takes effect on January 1, 2006. *In the intervening months, Medicare beneficiaries must make a number of decisions and take action. Prescription drug coverage will not be automatic.* Unlike Medicare Part B where beneficiaries must “opt out” of an automatic enrollment for those who receive Social Security, most beneficiaries will have to “opt in” or actively enroll in a drug plan in order to receive the drug benefit. This report is intended to provide basic information individuals will need during the coming months to understand the benefit, the implementation process, the decisions and actions they must take, and the resources available to them. A subsequent brief will examine the assistance that will be available for low-income beneficiaries.

Drug Benefit Basics

The MMA drug benefit will be Part D under Medicare. Those who are eligible to receive the benefit are persons who are either entitled to or enrolled in Medicare Part A (Hospital Insurance) or Part B (Medical Insurance for doctor services and outpatient care).

Most individuals will obtain drug coverage through private plans, either a stand-alone prescription drug plan (PDP) offered by an insurance company or

Medicare Drug Benefit Out-of-Pocket Costs

- Under the standard benefit beneficiaries in 2006 will pay¹:
- A monthly premium estimated at \$37 (\$444/year);
- A deductible of \$250;
- 25 percent of drug costs between \$251 and \$2,250;
- 100 percent of drug costs between \$2,251 and \$5,100 (the \$2,850 coverage “gap” or “doughnut hole”); and
- The greater of \$2 for generics, \$5 for brand drugs, or 5 percent co-insurance after reaching the \$3,600 out-of-pocket limit or \$5,100 catastrophic threshold.

through a Medicare Advantage plan with prescription drug coverage (MA-PD) offered by a health maintenance organization (HMO), preferred provider organization (PPO), or Private Fee-For Service (PFFS) plan (See Glossary, p.6). Beneficiaries with employer/union-provided drug coverage and those already enrolled in Medigap plans (Plans H, I, and J) could have their coverage continue, but there might also be changes for them.

Since the new drug benefit will be offered by private plans, the formulary or covered drugs, premiums, co-payments, and pharmacy network may vary substantially. Some plans may be more generous than the basic benefit for a higher monthly premium. Plans must cover at least two drugs in each therapeutic category and class, but they do not have to cover every drug. ***Beneficiaries will have to decide which available plan best addresses their medication needs. If beneficiaries can't find a plan that includes every one of their drugs, they will have to pay all the costs for the uncovered drugs.*** The costs for these drugs will not count towards the plan's deductible nor towards reaching the end of the gap in coverage. Beneficiaries will also have to pay all the costs of their drugs when they fall into the coverage gap.

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Prescription Drug Benefit Timeline

Since enactment of MMA on December 8, 2003, transitional assistance in the form of drug discount cards with low-income subsidies was provided during 2004 and continues through 2005. The discount cards will phase out on January 1, 2006. Individuals can continue using their discount card until they enroll in a drug plan or until May 15, 2006, when drug plan enrollment ends.

The Centers for Medicare & Medicaid Services (CMS), the agency responsible for implementation, has undertaken a massive effort to launch the benefit on time. In December 2004, CMS announced the establishment of 34 prescription drug plan regions and 26 Medicare Advantage regions and published the final rules for the benefit in January, 2005.² Since then, health plans wishing to offer either a PDP or a MA-PD plan in the regions have completed the application process and submitted formularies for review to CMS. The employer/union application and formulary process for either a subsidy or waiver to offer a Part D plan follows a slightly later schedule than the other plans.

The calendar on the next page shows the approximate timeline for continuing implementation of the benefit from May 2005 through the enrollment deadline of May 2006. At the time of publication, there are a number of unknowns, such as plan sponsors and details, that won't be revealed to beneficiaries until the fall of 2005.

Key Dates for MMA Implementation

<p>May 2005</p> <ul style="list-style-type: none"> • Social Security Administration (SSA) begins mail notices to 20 million beneficiaries informing of possible eligibility for low-income subsidy (LIS). Mailing continues through mid-August. • CMS notifies beneficiaries “deemed eligible” they do not have to apply for subsidy; continues through June. • Plan sponsor applications approved/disapproved. 	<p>June</p> <ul style="list-style-type: none"> • Low-income beneficiaries can begin to apply for assistance with drug costs at SSA, state Medicaid agencies, SHIPs, area agencies on aging. • Bids from health plans due at CMS by 6th. 	<p>July</p> <ul style="list-style-type: none"> • SSA and state Medicaid agencies begin eligibility assessments for low-income subsidy on 1st. SSA makes scannable application available on-line. • Employer/unions Part D bids due on the 1st. • Favorable determination of plan bids must be made by CMS by 15th. 	<p>August</p> <ul style="list-style-type: none"> • Employer/union drug subsidy application available.
<p>September</p> <ul style="list-style-type: none"> • CMS enters contracts with approved plans. Fallback plans activated if needed. • Employer/union retiree subsidy application due by 30th. • Rx discount card sponsors notify enrollees of status of cards and what happens with benefit. • Medigap plans send credible coverage notice to enrollees. Continues to November 15. 	<p>October</p> <ul style="list-style-type: none"> • Auto assignment for dual eligibles in PDPs begins if they do not select a plan. • Marketing by PDPs and MA-PDs may begin on 1st. • On 15th, “Medicare and You” 2006 handbook mailed to all beneficiaries. CMS also sends all beneficiaries info describing available Part D plans. • Employers/unions applications accepted/rejected. • MA plans send annual notice of changes to enrollees. 	<p>November</p> <ul style="list-style-type: none"> • Enrollment in drug plans begin on 15th; continues to May 15, 2006. • Employers/unions must notify retirees of coverage status and options by 15th. • Beneficiaries may still apply for low-income subsidy after enrolling in a plan- starts from date application is filed. 	<p>December</p> <ul style="list-style-type: none"> • Dual eligibles may purchase 3 months of Rx prior to losing Medicaid Rx coverage.
<p>January 2006</p> <ul style="list-style-type: none"> • Rx benefit begins for those enrolled on 1st • Medicare Rx discounts cards phased out. • Dual eligibles lose Medicaid coverage for Rx drugs; will be auto enrolled if not in a plan. 	<p>February</p> <ul style="list-style-type: none"> • Enrollment continues. • Subsidy payments to employer/union plans begin. 	<p>March - April</p> <ul style="list-style-type: none"> • Enrollment continues. 	<p>May</p> <ul style="list-style-type: none"> • Enrollment period without penalty ends on 15th. • Late enrollment fee of 1% per month begins. Next open enrollment period November 15-December 31, 2006.

MMA and Other Drug Coverage

Medicare beneficiaries who have supplemental prescription drug coverage from other sources should determine their coverage status as it could change.

Employer/union.³ CMS estimates 11.4 million or 33 percent of the Medicare 65+ population have employer or union coverage and that 9.8 million or 86 percent will continue receiving their employment-based drug coverage.⁴

There are basically two options available for employers and unions with drug coverage plans: apply for the retiree drug subsidy for continuing drug coverage for their retirees, or sponsor a prescription drug plan under Medicare Part D. To qualify for the retiree subsidy, they must meet a “two-pronged” test to show their benefit is at least as generous as the standard Part D benefit.⁵ For employers/unions contributing a certain amount to retiree drug costs, CMS estimates an average tax-free drug subsidy payment of \$668 per participant in 2006.⁶ ***Retirees should contact their benefits administrator to ascertain what their employer/union intends to do.*** If CMS determines that an employer/union plan is eligible for the subsidy, retirees will not have to enroll in the Medicare drug benefit nor face a late enrollment fee in the form of a higher premium if they enroll at a later date.

If CMS determines a plan is not as good as the Part D benefit and hence not eligible for the subsidy, retirees have three options:

- Retain coverage under the current employer/union plan AND enroll in Part D by May 15, 2006 in order to get the prescription drug benefit as well as avoid a late enrollment fee. CMS estimates 1.7 million retirees will enroll in a PDP and receive either additional coverage or financial help from their employer/union;
- Keep current coverage and not enroll in Part D. However, retirees will be subject to the increase in premiums for late enrollment if they join later;
- Drop current coverage and enroll in a PDP. If a retiree does this, the ability to revert to employer/union coverage later is unlikely.

Before making any of the above decisions, retirees should contact their benefits administrator and make sure they understand their current drug coverage.

Medigap plans are private insurance plans that supplement Medicare. Only three of the ten standardized plans offer prescription drug coverage. Those currently enrolled will be able to continue with their Medigap plan for drug coverage but the plans are not available for new enrollees after January 1, 2006. Most Medigap coverage is not as good as the Medicare basic benefit. ***Persons enrolled in a Medigap plan with drug coverage will be notified by their insurance company in the fall of 2005 whether their Medigap plan meets Medicare standards.*** If not, the individual can enroll in a PDP and still have Medigap without drug coverage. Individuals who keep their Medigap plan with drug coverage that is not as good as Medicare will be subject to the increase in premiums for late enrollment if they join a Part D plan later.

Medicare Advantage is the new name for Medicare+Choice, the managed care Part C program in Medicare. It allows private companies, primarily HMOs and PPOs, to offer a managed care health plan to Medicare eligible beneficiaries. MA plans that include prescription drug coverage

are Medicare Advantage Prescription Drug (MA-PD) plans. Participating MA-PD plans will automatically enroll their current plan participants. New and expanded MA-PDs will begin marketing their plans to other Medicare beneficiaries in October, 2005. **Persons enrolled in a MA-PD should review materials from their plan carefully as coverage may change; they can select another plan.**

State Pharmaceutical Assistance Programs (SPAPs) are programs that many states operate to provide drug coverage to residents with limited income. SPAPs may supplement the new Medicare prescription drug coverage for certain individuals. **Those currently receiving assistance with their drug costs from their SPAP should inquire whether or how their state program intends to continue assistance.**

Veterans Administration (VA) and TRICARE. Veterans and military retirees who get their health care benefits from the VA or TRICARE already have coverage that is at least as good as the Medicare prescription drug plan and they should keep that coverage.

Choosing A Plan

Beneficiaries who are not automatically assigned and enrolled, nor covered by an existing plan that will continue, will have to make three basic decisions in order to obtain prescription drug coverage.

First, individuals must choose whether to apply for the benefit at all. Those who have low drug costs may find that it is more costly to join a plan. However, they will take a chance on a higher premium of at least 1 percent per month for every month they wait to enroll after the initial enrollment period ends on May 15, 2006.

Second, there is the choice of type of plan-whether to apply for the benefit either through a stand-alone drug plan or a Medicare Advantage managed care plan with prescription drug coverage.

Third, those who want drug coverage will have to choose from among plans available where they live. In some regions, there will be just two plans and the choice may be relatively easy. Others, however, may have to compare and select from a number of plans that could vary substantially on generic and brand name drugs covered, premiums and co-payments. Plans will also have their own pharmacy networks, which means that not all pharmacies will be able to fill prescriptions. Comparing several plans and their features will likely be very difficult. Most important, it is possible that none of the plans offered will cover all the drugs an individual needs.

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For Information and Help With Plan Choice and Enrollment:

Beneficiaries should compare plans based on their prescription needs. Information and applications from approved plans and also from CMS will be available in October 2005. The following agencies will be available to assist with applications. To find the nearest office, beneficiaries should consult their local telephone book or go to the web sites listed below:

- Phone enrollment through 1-800-Medicare (800-633-4227; TTY 877-486-2048) beginning in October.
- Internet enrollment at www.medicare.gov beginning mid-October.
- Counseling and enrollment at on-site locations such as community-based organizations and area agencies on aging. www.shiptalk.org, click “Find a Counselor” for one in your area.
- State Health Insurance Counseling Programs (SHIPS). www.shiptalk.org

Endnotes

¹ In addition to the expenditures for the prescription drug benefit, beneficiaries will also see an increase in the Medicare Part B premium from \$78.20 in 2005 to \$89.20 in 2006 and a continued increase in the Part B deductible, which is \$110 in 2005.

² Maps of the MA and PD regions can be found at: www.cms.hhs.gov/medicarereform/mmaregions. Final rules may also be obtained at the CMS website. Note that the documents are very long.

³ Many retirees have prescription drug coverage from an employer or their union. The options and process for both employers and unions are the same and are combined here for ease of explanation.

⁴ Employers include non-profit organizations as well as commercial businesses.

⁵ “Creditable” is the term used by the Centers for Medicare & Medicaid Services in its determination of whether employer/union/Medigap plans are as good as the standard Part D drug benefit.

⁶ This is equivalent to \$891 for plan sponsors with a 25 percent marginal tax rate, and \$1,028 for plan sponsors with a 35 percent marginal tax rate.

Glossary of Key Terms

Centers for Medicare & Medicaid Services (CMS). The federal agency that administers the Medicare and Medicaid programs and responsible for implementation of MMA.

Creditable. Determination by CMS of employer/union status as qualified to receive the retiree drug subsidy. Also, CMS determination of Medigap plans that provide prescription drug coverage as good as the Part D benefit.

Deemed Eligible. Determination by CMS of those who already qualify for the low-income subsidy and do not need to apply for it.

Dual Eligibles. Individuals who are beneficiaries of both the Medicare and Medicaid programs.

Formulary. List of drugs approved for use or payment-in other words, covered or reimbursable drugs.

Health Maintenance Organization (HMO). Managed care plan primarily owned and operated by insurers that acts as both the insurer and the provider of health care services to an enrolled population.

Managed Care Plan/Organization. A plan/organization that provides a range of services in exchange for a per capita payment.

Medicare Savings Program. A part of state Medicaid programs that pays Medicare premiums, and in some cases, Medicare deductibles and coinsurance for three categories of low-income Medicare beneficiaries: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).

Medicare Advantage (MA, formerly Medicare+Choice). Part C in the Medicare program allows private companies to offer a managed care health plan to Medicare eligible beneficiaries. MA plans may offer prescription drug coverage through a Medicare Advantage Prescription Drug Plan (MA-PD).

Medigap Plans. Private supplemental insurance plans designed to cover gaps in the Medicare program. There are 10 standardized policies labeled Plan A through Plan J. Only Plans H through J offer a prescription drug benefit; but the drug coverage offered through these plans will not be available after January 1, 2006.

Preferred Provider Organization (PPO). Network of doctors and hospitals that contract with an insurer to provide health care on a fee-for-service basis at lower rates for those enrolled.

Private Fee-For-Service (PFFS). Plan that covers enrollees through a private indemnity health insurance policy.

Stand Alone Prescription Drug Plan (PDP). Private plans that offer just a drug benefit.

Alliance for Retired Americans Position on MMA

The Alliance opposed passage of the 2003 Medicare prescription drug law for four major reasons:

- The benefit is not comprehensive—beneficiaries will have to pay high-out-of-pocket costs for the benefit which will increase nearly 80 percent over the first 8 years alone;
- The law does too much to dismantle traditional Medicare in favor of private health plans, which stand to gain billions in government subsidies;
- The law does nothing to control the escalating increases in drug prices and expressly prohibits Medicare from using its buying power to negotiate lower drug costs; and
- There is a possibility that employer-sponsored health benefits more generous than the Medicare drug benefit may end coverage.

This is the third in a series of issue briefs from the Alliance for Retired Americans Educational Fund on issues and programs that should be considered at the White House Conference on Aging scheduled for October 23-26, 2005 in Washington, D.C.

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