



CMA Monthly Column - February, 2005

## **MEDICARE PART D: WHAT EVERY ADVOCATE SHOULD KNOW**

The Medicare prescription drug program, or “Medicare Part D,” which will go into effect on January 1, 2006, will provide limited prescription drug coverage for beneficiaries, but not without significant cost.

Financially, beneficiaries who enroll in a prescription drug plan will be required to pay a monthly premium in addition to the Part B premium. The premium, expected to be approximately \$35 per month, is merely an estimate. Since a standard premium amount is not set in the law, the premium amount may vary regionally and among the different Part D plans.

The Medicare drug law defines a standard drug benefit package. Before Medicare coverage begins, beneficiaries will first need to meet a \$250 deductible. Once the deductible is met, beneficiaries will be responsible for a 25% co-insurance amount on covered medications until they reach an initial coverage limit of \$2250. When beneficiaries reach the initial coverage limit, they will have a gap in coverage, known as the “doughnut hole.” While in the doughnut hole beneficiaries will continue to pay the monthly premium and are responsible for the total cost of their prescription medications until they reach a total yearly out-of-pocket expense of \$3600. Once the required out-of-pocket expense is reached, the beneficiaries will pay \$2 for generics and \$5 for non-preferred drugs or a 5% co-insurance amount, whichever is greater.

Two aspects of the program have not been adequately emphasized. First, only the cost of those medications included on the plan’s formulary (list of covered medications) will count toward meeting the beneficiary’s deductible and out-of-pocket expenses. Therefore, the true out-of-pocket expense for a beneficiary may far exceed the \$3600 out-of-pocket limit established in the law. In addition, the law allows prescription drug plans to offer a different package as long as it is “actuarially equivalent” to the standard benefit package. For example, plans can create tiers for co-payments or co-insurance for different types of drugs, requiring beneficiaries to pay different amounts for generic, brand name and preferred brand name drugs. It is likely that most prescription drug plans will use the tiered co-payment approach, rather than a uniform 25% co-insurance for all prescriptions on their formulary.

The Act provides for full and partial subsidies for low income individuals; full subsidies for individuals with full Medicaid benefits or with incomes at or below 135% of the federal poverty level and partial subsidies for those with incomes at or below 150% of

poverty level. The subsidies include elimination or reduction of the premium and deductible, continued coverage through the doughnut hole and the elimination or reduction of cost-sharing amounts. All low income individuals, other than those on Medicaid who reside in nursing homes, will have to pay small co-payments for their prescriptions. The Social Security Administration will mail letters in May 2005 to low-income Medicare beneficiaries who may be eligible for the subsidies. Certain individuals will be deemed eligible for the subsidies and will not have to apply.

Practically speaking, the Act fails to ensure that beneficiaries will obtain the prescription medications they require, upsetting the very premise of the legislation. The federal government has not provided a standardized list of which medications must be included on the formularies, but has left the decision up to the individual plans. Plans are permitted independently to define the classes and categories of drugs and which drugs within those classes and categories they will include on their formularies. This lack of standardization creates several potential problems for beneficiaries. First, without a standardized plan, comparison and choice of a plan will be more difficult for beneficiaries. Second, those beneficiaries whose drugs are not on the drug plan's formulary, or are removed or moved to another tier for cost-sharing after they enroll in the plan, must apply for an "exception" if they want to get the non-formulary drug covered. The "exception process" is complicated and lengthy. This may leave beneficiaries without the non-formulary medication they require, while they pursue coverage through a lengthy appeals process.

These financial and practical issues are compounded for those individuals who are eligible for Medicare and for full Medicaid benefits, called "full benefit dual eligibles." Beginning January 1, 2006 the Act completely eliminates Medicaid drug coverage for such persons regardless of whether their medications are covered under their plan's formulary. To prevent a gap in coverage, the Act requires that those dually eligible beneficiaries who have not enrolled in Part D by January 1, 2006 be automatically enrolled in a drug plan. The final regulations to implement the Act indicate that the Centers for Medicare and Medicaid Services will automatically enroll dual eligible individuals by January 1, 2006. Questions still remain, however, as to how automatic enrollment will be achieved, what happens to dual eligible individuals who are overlooked and how those who are enrolled in plans will learn how to use their plans.

To prepare for the impending changes to the Medicare system, elderly and disabled individuals and their care givers should become aware of the plans available in their communities, as the information becomes available, so that they can make an informed choice as to which plan that best suits their needs. For further information regarding the Medicare Part D drug benefits, advocates can contact the Center for Medicare Advocacy or visit the Center's web site, [www.medicareadvocacy.org](http://www.medicareadvocacy.org).

---

The Center for Medicare Advocacy, Inc. is a national, non-partisan education and advocacy organization that promotes fair access to Medicare and health care. The Center's national office is in Mansfield with offices in Washington DC and throughout the country. For more information contact Attorney Lara Stauning at (860)456-7790 or visit the Center's website: [www.medicareadvocacy.org](http://www.medicareadvocacy.org). Se habla español.