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MEDICARE PART D MYTHS AND MISINFORMATION

The new Medicare Part D prescription drug plan is confusing to Medicare beneficiaries and their families, to the advocates that advise them, and even to the private insurance companies offering the drug benefit. The following are common myths and misinformation that we have heard from beneficiaries and Part D plans.

MYTH: YOU MUST HAVE A LIMITED INCOME IN ORDER TO ENROLL IN A MEDICARE PART D PRESCRIPTION DRUG PLAN.

All Medicare beneficiaries are eligible to choose and enroll in a Part D prescription drug plan. This includes those who are younger than age 65 and get Medicare because they receive Social Security disability benefits or because they have End Stage Renal Disease. Income and resource limitations apply only to the Medicare Low-Income Subsidy, also known as “Extra Help” that assists with beneficiary cost-sharing for Part D.

MYTH: YOU DON'T NEED TO ENROLL IN A PART D PLAN IF YOU FILED AN APPLICATION FOR EXTRA HELP

Enrolling in Medicare Part D may be a two-step process for some Medicare beneficiaries. The first step involves filing an application for “extra help” with the Social Security Administration (SSA) or with the state Medicaid agency. Once SSA acts on the application, the beneficiary still needs to choose and then enroll in a Part D plan. Beneficiaries who are found eligible for the subsidy in the fall of 2005 will only have drug coverage which is effective January 1, 2006 if they enroll in a Part D plan by December 31, 2005. Note, however, that individuals who are found eligible for the subsidy and who do not choose a plan themselves by May 2006 will be automatically enrolled in a Part D plan in the spring of 2006. Note also that auto-enrollment will occur earlier, in the fall of 2005, for individuals who are dually eligible for Medicare and Medicaid.

MYTH: YOU MUST ENROLL IN A PART D PLAN BY NOVEMBER 15, 2005

The initial enrollment period for Part D starts on November 15, 2005 and extends through May 15, 2006. Medicare beneficiaries may enroll any time during that period. Prescription drug coverage starts on January 1, 2006 for those who enroll by the end of 2005. Otherwise, coverage starts the month after enrollment. Those who do not enroll by May 15, 2006 must wait to enroll until the next annual enrollment period, which will run from November 15-December 31, 2006. They will incur a late penalty on their premium unless they had other prescription drug coverage that is as good as Medicare Part D coverage (known as “creditable coverage”).

MYTH: EVEN IF YOU HAVE OTHER PRESCRIPTION DRUG COVERAGE YOU SHOULD ENROLL IN PART D.

This myth is true in some cases but not in others. Some people who have other drug coverage now will be required to enroll in a Medicare Part D plan. For example, some state pharmacy assistance programs (SPAPs) are requiring Part D enrollment after which the SPAP will "wrap around" and fill in some of the gaps of Part D coverage. Retirees whose employers change their retiree drug coverage to offer only Part D wrap-around coverage will need to enroll in a Part D plan. Payments by an employer-sponsored plan do not count towards the \$3600 out-of-pocket expenses a beneficiary needs in order to reach the catastrophic limits. Payments by a SPAP do count.

For others, enrollment in a Part D plan will result in the loss of their current health coverage. People who are currently enrolled in a Medicare Advantage plan (an HMO or PPO) must get their drug coverage through their health plan. They will be disenrolled from their HMO or PPO if they enroll in a stand-alone prescription drug plan (PDP). People who have retiree drug coverage that is creditable, i.e., considered as good as Medicare, may lose all of their retiree health benefits and not just their drug coverage if they enroll in a PDP. They need to check with their employer to understand the relationship between Part D and their retiree health coverage.

MYTH: THE COST OF ENROLLING IN A MEDICARE HMO OR PPO WITH DRUG COVERAGE IS LESS THAN THE COST OF A MEDICARE SUPPLEMENT (MEDIGAP) POLICY AND A PRESCRIPTION DRUG PLAN (PDP).

Look at costs very carefully. In 2006 the premium for an HMO or PPO with drug coverage may be less than or the same as the cost of a Medigap policy and a PDP, but individuals must look at other costs in addition to premiums. Many Medigap policies pay most or all of a beneficiary's out-of-pocket costs in traditional Medicare. Beneficiaries will still have to contribute out of their own pockets for Medicare services received through an HMO and PPO. Though some of these costs may be minimal, costs for some services in an HMO and PPO may be more expensive than out-of-pocket costs in traditional Medicare. And, new regional PPOs have a combined Part A and Part B deductible. That means that people who use only doctor's services and not hospital services in a given year will have to pay more out-of-pocket for doctors' services than in traditional Medicare before their PPO starts paying.

MYTH: ALL DRUGS WILL BE COVERED UNDER ALL PLANS

Each plan has its own list of the drugs that it covers (called a formulary), and most will tell beneficiaries that they cover a very high percentage of drugs that "seniors" take. Be aware that the percentage of the top 100 drugs listed as covered by each plan in the "Landscape of Local Plans" on the Medicare website refers to a percentage of the top 100 drugs used by beneficiaries enrolled in the Medicare discount drug card program. Thus, this list may not be the 100 top drugs used by all Medicare beneficiaries.

Instead, look carefully at the drug lists for each plan. Not all drugs are included. Some are excluded because Medicare simply will not cover them (ex., Valium, nutritional supplements

like Ensure, prescription vitamins like folic acid). Others may be on the plan's formulary but the plan may require the enrollee to try less expensive drugs first or to get the plan's approval before the doctor prescribes them, or the plan may limit the quantities that can be dispensed. Still other drugs may not be included on the plan's formulary because the plan covers similar drugs.

MYTH: ALL PHARMACIES PARTICIPATE IN ALL DRUG PLANS

Each plan has its own list of network pharmacies and will only pay for drugs obtained at non-network pharmacies in limited circumstances. If a plan is a regional plan, then the network of pharmacies may be limited to pharmacies within the plan's region. The cost of a plan may have no relationship to the number of pharmacies in the plan's network. For example, a more costly plan in a Washington, D.C. suburban community had fewer pharmacies than some of its less costly competitors. In addition, plans have not been forthcoming about the long-term care pharmacies in their networks that will serve nursing home residents, and advocates are having difficulty gathering this information.

MYTH: ENROLLEES CAN SAVE MONEY BY ENROLLING IN A PLAN WITH SET TIERED CO-PAYMENTS RATHER THAN BY ENROLLING IN A PLAN WITH THE STANDARD 25% CO-INSURANCE.

Beneficiaries need to look at the cost-sharing structure of each plan very closely. In some cases the flat set co-payment for a drug may actually be higher than the cost of the drug itself, so that the beneficiary will still pay the full cost of the drug. For example, if a plan charges \$30 for preferred brand name drugs and the cost of a preferred brand name drug is \$27, then the beneficiary pays \$27. If the beneficiary had enrolled in a standard benefit plan with a 25% co-insurance amount, the beneficiary would pay \$6.75 for the same drug. Thus, beneficiaries will have to know the cost of each of their drugs in order to truly calculate which plan may provide them the greatest savings.

MYTH: PART D WILL REDUCE THE COST OF PRESCRIPTIONS.

We just do not know the answer. Information about drug pricing for each plan is not yet available. But even when more information becomes available, we will still be unable to say that Part D will reduce the cost of prescription drugs. There are two basic reasons. First, plans can change their drug pricing and their formulary lists throughout the year. Second, even if beneficiaries choose plans that meet their existing prescription drug needs, they may unexpectedly develop new medical conditions that require new and unanticipated prescription drugs. Only at the end of a calendar year will beneficiaries be able to determine whether their Part D plan actually saved them money.

For further discussion of Medicare myths and misinformation please contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028, or attorney Judith Stein (jstein@medicareadvocacy.org) in the Center's Connecticut office at (860) 456-7790.