Michigan League for Human Services

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Medicare Prescription Drug Benefit (Part D) Implementation: Complex Design Ensures Difficult Choices

In the very near future, senior citizens across Michigan and across the country will begin studying materials produced by the federal government and the pharmacy drug plans that were awarded contracts by the federal government to implement the new Medicare Prescription Drug Benefit (Part D of the Social Security Act). Senior citizens (or their representatives) will have to review multiple plans to evaluate their coverages, their costs, and any special conditions for participation to determine whether or not they should enroll in the new Medicare benefit.

Due to the complexity of the federal Medicare Modernization Act, which created Part D of the Social Security Act, it is not surprising that implementation of the Act is both complex and confusing. Information dissemination and coordination will be key with so many governmental agencies involved in the implementation –the Social Security Administration, Department of Health and Human Services, Department of Community Health (State Medicaid Agency), Department of Human Services, Office of Services to the Aging, and the Michigan Medicare/ Medicaid Assistance Program, to name a few.

On August 29, 2005, the Centers for Medicare and Medicaid Services (CMS) announced that nearly every region of the country would have at least one drug plan with a premium at or below $20 per month. For the state of Michigan, which is considered a region, approximately 18 organizations are expected to offer drug plans ranging in cost from about $20 per month to $35 per month, with at least one plan under $20. There are expected to be about 25 plans available to review and choose from, with the majority of plans falling in the $30 - $35 monthly cost range.

Background

The Medicare Modernization Act was passed and signed into law in December 2003. The Act creates a voluntary prescription drug benefit program (Part D) under Medicare for individuals entitled to Medicare Part A or enrolled in Part B. The new benefit is effective January 1, 2006. Beneficiaries will have the option of enrolling in privately administered drug plans that contract with the federal government. There will be two or more drug plans in each region of the country (Michigan is considered a region and is expected to have about 18 organizations offering one or more prescription drug plans) from which beneficiaries will be able to choose. Plans must cover at least two drugs in each therapeutic class, but plans can establish formularies (preferred drugs), tiered cost sharing (some drugs may have higher co-payments than others), and preferred pharmacy networks (costs may be higher in out-of-network pharmacies). For the first time in the history of the Medicare program, the cost and benefit coverage for an individual will be based on his/her income and assets.

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Implementation of the Act will change the underlying continuity of the Medicare program benefit coverage and costs that have been identical across the states, and across all income levels.

Cost and Benefits Under the New Law

As indicated above, the Medicare Program will, for the first time, under Part D establish a Medicare benefit that is determined by the income and assets of the individual. For low-income beneficiaries, there will be subsidies and reduced cost-sharing requirements. In addition to understanding drug plan tiered levels of copays and preferred networks, not to mention drug formularies, individuals will also need to understand the tiered nature of the Part D benefit as well as the tiered nature of the cost.

Of utmost importance to low-income beneficiaries is the requirement that they apply for the low-income subsidy, unless they are automatically eligible because they qualify for Medicaid, or because they are deemed eligible due to their eligibility for the Medicare Savings Programs (Qualified Medicare Beneficiary or Specified Low-Income Medicare Beneficiary programs). The application for the low-income subsidy is separate from, and in addition to, enrollment in a drug plan. Following is a summary of the benefits and costs for the non-subsidized and subsidized components.

4 Basic Benefit (non-subsidized)

The basic benefit is available to beneficiaries with incomes above 150 percent of the federal poverty level ($14,355 for an individual, $19,245 for a couple). For a monthly premium, estimated at $32, which can vary across plans, beneficiaries can enroll in a prescription drug plan. Medicare Part D will then pay 75 percent of the cost of Part D covered drugs for costs between $251 –$2,250. Beneficiaries are responsible for the first $250 in costs, and 25 percent of the costs between $251 - $2,250. Part D provides no coverage for drug costs between $2,251 - $5,100 (the "donut hole"). Beneficiaries must pay 100 percent of that $2,850 cost. When Part D covered drug costs reach $5,100, beneficiaries qualify for the "catastrophic" benefit and must pay only 5 percent (or copays of $2 for generics/$5 brand name drugs, whichever is greater) of any additional drug costs. Total out-of-pocket spending for the beneficiary will be $3,600 in cost sharing for the first $5,100 of drug costs, plus 5 percent of costs (or $2 generic/$5 brand name copays) above $5,100, plus the annual premium estimated to be $384 for the standard plan. Any drug not covered under Part D does not count toward meeting either the $250 deductible or the $2,850 "donut hole." The amount of the deductible, the dollar value where the "donut hole" begins, and the dollar value where catastrophic coverage begins will all increase each year based on the actual increases in Medicare Part D spending. In addition, the premium, set to cover 25 percent of the cost of the standard benefit, will increase each year.

The following tables provide a pictorial view of the basic benefit.

The Basic Medicare Part D Prescription Drug Benefit

Premium/Coverage	Part D Covered Drug Costs	Part D Pays	Beneficiary Pays	Beneficiary Cumulative Out-Of-Pocket Expenses
Premium, estimated at $32/month	Not Applicable	0%	100%	$384
Deductible	First $250 of cost	0%	100%	$634
Initial Benefit	$251 - $2,250	75%	25%	$1,134
Gap in Coverage "Donut Hole"	$2,251 - $5,100	0%	100%	$3,984
Catastrophic Benefit	Over $5,100	95% of all additional cost	5% of all additional cost, or $2/$5 copays	$3,984 plus 5% (or $2/$5 copays) on all cost above $5,100

Note: The premiums, deductible, dollar value where the gap in coverage begins, and the dollar value where catastrophic coverage begins will all increase in future years based on the increases in Medicare Part D spending.

4 Subsidized Benefit for Low-Income Beneficiaries

For beneficiaries with incomes below 150 percent of the federal poverty level, and who meet the asset requirements, varying degrees of cost and benefit subsidies will be available to those who apply. The application form, while not simple at seven pages and numerous requirements for completion, since it is designed to be scanned, will provide significant benefits to those who apply and are determined eligible. It should be noted that beneficiaries who are also eligible for Medicaid or a Medicare Savings Plan under Medicaid will not be required to file an application for the low-income subsidy; they are automatically eligible. Those who qualify for a low-income subsidy will not be subject to the "donut hole." There are four tiers for the low-income subsidy benefits depending on income and assets.

- Beneficiaries who are enrolled in Medicaid and have incomes of less than 100 percent of the poverty level ($9,570 for an individual and $12,830 for a couple) will pay no premiums, have no deductibles, and have no gap in coverage or co-pays after Part D covered drug costs reach $5,100, the catastrophic cost level. They will have co-pays of $1 for generic drugs and $3 for brand name drugs in 2006 for Part D covered drug costs up to $5,100. The catastrophic cost level and the co-pay amounts will increase each year based on the inflation experienced by the program. Exception: Those in institutions will have no co-pays.

Poverty Levels as of February 14, 2005*

100% of poverty for 1 person = $ 9,570 or $ 798/month
2 people = $12,830 or $1,069/month

135% of poverty for 1 person = $12,920 or $1,077/month
2 people = $17,320 or $1,443/month

150% of poverty for 1 person = $14,355 or $1,196 /month
2 people = $19,245 or $1,604/month

**Values updated annually.*

- Beneficiaries who are enrolled in Medicaid and have incomes of more than 100 percent of the poverty level will pay no premiums, have no deductibles, and have no gap in coverage or

co-pays after Part D covered drug costs reach $5,100, the catastrophic cost level. They will have co-pays of $2 for generic drugs and $5 for brand name drugs in 2006 for Part D covered drug costs up to $5,100. The catastrophic cost level and the co-pay amounts will increase each year based on the inflation experienced by the program. Exception: Those in institutions will have no co-pays.

- Beneficiaries, not enrolled in Medicaid, with incomes below 135 percent of the federal poverty level (currently $12,920 for an individual, $17,320 for a couple) and assets below $6,000 for an individual ($9,000 for a couple), will pay no premiums, have no deductibles, have no gap in coverage and no co-pays after Part D covered drug costs reach $5,100, the catastrophic cost level. They will have co-pays of $2 for generic drugs and $5 for brand name drugs in 2006 for Part D covered drug costs up to $5,100. The catastrophic cost level and co-pay amounts will increase each year based on the inflation experienced by the program.

- Beneficiaries, not enrolled in Medicaid, with incomes between 135 - 150 percent of the federal poverty level and assets below $10,000 for an individual ($20,000 for a couple), will pay sliding-scale premiums, have a $50 deductible, and have no gap in coverage. Their co-payments will be 15 percent of the cost of Part D covered drugs after the deductible is met, for drug costs up to $5,100. They will have co-pays of $2 for generic drugs and $5 for brand name drugs in 2006 after Part D covered drug costs reach $5,100, the catastrophic cost level. The catastrophic cost level and co-pay amounts will increase each year based on the inflation experienced by the program.

The following table summarizes the Part D low-income benefit tiers.

Summary of the Low-Income Part D Benefit

Part D Subsidies for Low Income and Low Asset Beneficiaries	**Enrolled in Medicaid**		**Not Enrolled in Medicaid**	
	Income Below 100% of Poverty	**Income Above 100% of Poverty**	**Income Below 135% of Poverty**	**Income Between 135% - 150% of Poverty**
Asset Limits	Medicaid Policy	Medicaid Policy	$6,000/individual, $9,000/couple	$10,000/individual, $20,000/couple
Premiums	Full subsidy, no premiums	Full subsidy, no premiums	Full subsidy, no premiums	Income-based sliding scale, $0 - $32/month
Deductibles	None	None	None	$50
Copayments/prescription Up to $5,100 in drug costs	$1/generic drugs, $3/brand name	$2/generic drugs, $5/brand name	$2/generic drugs, $5/brand name	15% of drug cost after deductible met
Copayments/prescription Part D drug costs greater than $5,100	None	None	None	$2/generic drugs, $5/brand name drug
Coverage gap (donut hole)	None	None	None	None

It is important to note that those who qualify for a premium subsidy will receive up to the "benchmark premium" amount. The actual amount for 2006 is expected to be announced in the coming weeks. If a beneficiary chooses a plan with a higher premium, the beneficiary will be responsible to pay the difference, irrespective of his/her income level.

Enrollment for Dual Eligibles

Those persons who are enrolled in both Medicaid and Medicare are called dual eligibles. Dual eligibles are a particularly critical population because their drug coverage under Medicaid for drugs covered under Part D ends on December 31, 2005. Effective January 1, 2006, state Medicaid programs cannot receive federal match for providing Part D covered drugs to Medicaid recipients. Federal match will remain available for drugs covered by Medicaid that are not covered by the new Medicare benefit. It is imperative that Medicaid recipients be enrolled in a drug plan by December 31, 2005 in order to avoid the loss of drug coverage. The enrollment period is effectively only six weeks (November 15 - December 31, 2005) for those enrolled in Medicaid, since comprehensive drug coverage under Medicaid ends on December 31.

Due to the short timeframe, the federal government is preparing to automatically enroll those who have not enrolled on their own. During October 2005, the federal government will automatically assign, on a random basis, every Medicaid/Medicare recipient to a drug plan, and will then notify Medicaid recipients of the plans in which they will be enrolled if they do not choose different plans by December 31, 2005. The assigned plans will not be guaranteed to meet the recipients' needs. While Medicaid recipients will have the opportunity to change drug plans at any time, there is no guarantee that, in the end, they will find a plan that meets all of their needs and provides the same comprehensive coverage, available to them under Medicaid. In addition, the copayments under the Part D benefit may be higher than the copayments under Medicaid. Medicaid recipients must also be aware that the federal premium subsidy covers the cost of the "benchmark premium" only, and that if they choose a plan with a higher cost premium, they will be responsible to pay the additional cost.

Enrollment for Beneficiaries Who are Not Medicaid Recipients, and Not Covered by Another Plan

For non-Medicaid beneficiaries, the enrollment period will be much longer, spanning a period of six months, rather than six weeks. These beneficiaries will have until May 15, 2006 to study, select and enroll in a drug plan. While participation in the Medicare Part D benefit is voluntary, those who are eligible and do not have other equivalent prescription drug coverage, and do not enroll in the program during their initial eligibility period (six months), will be assessed a one percent (of the base premium) per month lifetime penalty.

Impacts for Beneficiaries with Other Private Coverage

Medicare beneficiaries with "equivalent" prescription drug coverage through an employer-sponsored plan or other private plan can retain that coverage. Employers are required to notify their retirees if the prescription drug coverage they offer is equivalent to the benefit available under Part D. If coverage is equivalent, beneficiaries can maintain the private coverage and not enroll in Part D. If the coverage is not "equivalent," and the retiree maintains the private coverage and later decides to enroll in Part D, he/she will be assessed the one percent per month penalty for the period that he/she was eligible for but did not enroll in Part D.

Concern has been raised that employers may drop coverage for their retirees once Part D is implemented. To discourage this practice, the federal government will provide tax-free subsidies of 28 percent, of the retiree drug costs between $250 - $5,000 (up to $1,330 per retiree), to employers who maintain drug coverage comparable to the Part D benefit. The statute precludes Medigap plans from providing prescription drug coverage in policies issued in or after 2006. State pharmacy assistance programs, however, can continue to provide supplemental coverage or wrap-around benefits. In Michigan, however, the state ś pharmacy assistance program, the Elder Prescription Insurance Coverage Program (EPIC) will be eliminated effective January 1, 2006.

What to Expect from the Federal Government -- Communication/Education Strategies

The Social Security Administration and the Centers for Medicare and Medicaid Services are committed to communication and advocacy strategies to educate and assist Medicare beneficiaries in understanding and enrolling in Medicare Part D. They are partnering with state agencies and other organizations that have contact with Medicare beneficiaries to educate recipients and advocates about this complex program. The Centers for Medicare and Medicaid Services have produced volumes of materials to educate partners and beneficiaries about the program. Information is available on the Medicare website, www.Medicare.gov and from their toll-free number 1-800-MEDICARE. There is concern, however, based on experience with the drug discount cards, that seniors will not understand the materials that they receive in the mail and will simply discard them. Federal officials will be carefully monitoring the return rate of the 20 million Low Income Subsidy Program applications that were mailed to potentially eligible beneficiaries. As mentioned above, the application is seven pages and may be intimidating to some elderly beneficiaries. The Congressional Budget Office estimates that up to 14 million people may be eligible for a low income subsidy. However, advocates fear that fewer than five percent will actually complete and submit the application.

What to Expect from the State -- Communication/Education Strategies

The state Medicaid program sent letters to dual eligible recipients and those enrolled in the Elder Prescription Insurance Coverage Program in June 2005 alerting them to the change in drug coverage effective January 1, 2006. The Michigan Medicare/Medicaid Assistance Program (MMAP) has trained volunteer counselors to work with beneficiaries in reviewing their prescription drug needs and in assisting with the selection of prescription drug plans (PDP). MMAP volunteers can be reached by calling 1-800-803-7174. The Medicaid Beneficiary Help Line will also have trained staff available to answer questions. The Help Line can be reached by dialing 1-800-642-3195. Numerous other agencies are partnering with the state/federal governments to educate senior citizens and others about the program.

It is important to note that the State, in addition to the Social Security Administration, is also responsible for accepting applications and determining eligibility for the low-income subsidy. For those beneficiaries who apply at a Department of Human Services local office (rather than the Social Security office) and request that the State determine their eligibility for the Low Income Subsidy Program, the local office will forward DHS Assistance Applications to the beneficiaries to enable a determination of eligibility for Medicaid or the Medicare Savings Programs. There is also great advantage to qualifying for and being determined eligible for the Medicare Savings Program because it not only pays for certain Medicare Part A and Part B costs, including part or all of the Medicare Part B premium, coinsurance, and deductibles, but it also entitles the Medicare beneficiary to the low-income subsidy for Part D without completion of the application. Medicare Savings Program participants are deemed eligible for a low-income subsidy. For beneficiaries who are not found eligible for Medicaid or a Medicare Savings Program, or who do not return the completed

Assistance Application, their Low Income Subsidy Program applications will be forwarded to the State Medicaid Agency contractor to determine eligibility for the Low Income Subsidy Program.

Future Cost Increases

The out-of-pocket costs for beneficiaries to participate in Medicare Part D will increase each year by the amount of growth in per capita Part D spending. Since there is no meaningful cost restraint included in the law, and in fact, there is a prohibition against Medicare negotiating for the best price, significant increases are anticipated in the premium, the amount of the deductible, the co-pays, the point where the "donut hole" begins, and the size of the "donut hole." The 2005 Annual Report to the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds included estimates for 2010 of the following amounts for cost sharing:

- Monthly premiums –$49 (from $32 in 2006)
- Annual deductible –$331 (from $250 in 2006)
- Beginning of "donut hole" –$2,980 (from $2,250 in 2006)
- Amount of coverage gap –$3,774 (from $2,850 in 2006).

Conclusion

With competition among prospective drug plans described by CMS as "aggressive," it is likely the marketing for the various approved plans will be equally aggressive when it begins in October. Senior citizens and others who qualify for Medicare can expect boatloads of materials to begin arriving in their mailboxes in the very near future. It will be a daunting task for senior citizens to sort through and understand the materials, and then evaluate the potential medical and financial benefits of the various drug plans.

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