

The New Medicare Prescription Drug Benefit (Part I)

By Bernard A. Krooks, Esq. | 08/01/05

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In recent weeks President Bush, Secretary of Health and Human Services (HHS) Michael Leavitt, Centers for Medicare & Medicaid Services (CMS) Administrator Mark McClellan, former senator and former presidential candidate Bob Dole, and others have begun a publicity campaign around the country to discuss the new Medicare Part D, which adds an optional prescription drug benefit to the Medicare program effective January 1, 2006.

At this time, we really do not know much detail about the practical operation of the Part D program. However, we do know that the prescription drug benefit will be offered through private insurance plans known as Prescription Drug Plans or PDPs. We will not know how many of these plans will be available in each of the prescription drug regions established by CMS until CMS enters into final contracts with the plans sometime in September.

Based on public announcements, we know that 10 companies have applied to CMS to offer national plans that serve all of the regions. CMS has said that beneficiaries in some regions will have many more than 10 plans from which to choose while beneficiaries in other regions may be limited to the 10 national plans. In addition, Medicare HMOs, PPOs, and some private fee-for-service plans (known collectively as Medicare Advantage plans with prescription drug coverage, or MA-PDs)

will also be offering prescription drug benefits, increasing the choices for some beneficiaries.

CMS has recently announced that the monthly premiums for Medicare Part D will average approximately \$32 (about \$5 less than originally estimated). However, it is possible that some plans will have a premium that is much greater.

The amount of the premium may be significant to beneficiaries, especially given the large increase that is anticipated in the Medicare Part B premium for 2006. The premium amounts will be particularly relevant to beneficiaries with low-incomes who seek additional assistance in paying their Part D costs since the assistance with premiums will be capped. In addition, premium amounts are expected to rise each year.

Each plan's benefit structure also is unknown. The statute defines the following standard benefit: There is a \$250 deductible for drugs on a plan's formulary. After the deductible is met, the beneficiary pays 25% of the cost of formulary drugs and the drug plan pays 75% up to \$2,250 in total formulary drug costs.

Then the beneficiary enters the proverbial "doughnut hole" where he is responsible for the full cost of prescriptions while continuing to pay the monthly premium. Once the beneficiary's total out-of-pocket costs for formulary drugs, including the deductible but not the premium, equal \$3,600, the beneficiary is responsible for 5% of drug costs and the drug plan pays the remaining 95% of costs.

Generally, the beneficiary and the drug plan will have expended \$5,100 on formulary drugs before the catastrophic coverage level is reached. The \$3,600, which will be indexed yearly, represents annual out-of-pocket expenditures; a beneficiary begins again at \$0 each January 1.

Drug plans are not required to offer the standard benefit, however, as long as the value of the drug benefit they offer is actuarially equivalent to the value of the standard benefit. In fact, it is anticipated that many drug plans will not offer the standard drug benefit. Instead, plans may follow the model used by private insurance and vary beneficiary cost sharing to promote use of less costly drugs. For example, a plan may have different tiers of cost-sharing; the lowest tier for generic drugs, a higher tier for preferred brand name drugs, and the highest cost-sharing tier for non-preferred brand name drugs.

Plans may also require a very high amount of cost sharing for very expensive and rare drugs. The regulations even allow plans to have a tier under which the beneficiary pays the full cost of the drug. A beneficiary's cost may also depend on the pharmacy used. Plans may charge more if beneficiaries use pharmacies that are not in the drug plan's pharmacy network or charge more for non-preferred network pharmacies.

As you can see, the new Medicare prescription drug benefit is extremely complicated and involves significant co-payments. In next

month's column, we will discuss other requirements of this new benefit; including what drugs will be paid for under Part D.