

Navigating Medicare Part D: A personal experience with the new Medicare prescription drug benefit

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The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created the largest expansion of benefits in the 40-year history of Medicare. It is also the first time in the history of the program that a Medicare benefit will not be available through the basic Medicare program but only through enrollment either in a stand-alone private drug plan or through a Medicare Advantage managed care plan. The MMA does not allow Medicare to negotiate volume discounts as is done by the Department of Veterans Affairs. The idea behind the law is that choice among seniors and competition among the private insurers will lead to lower drug prices.

A few days ago, I received a dreaded phone call from my mother. No, she wasn't ill. She was calling to ask me to help her enroll in the new Medicare prescription drug plan.


Coincidentally, I was giving a lecture on Medicare to the JMC first year medical students the next morning. I even had a few slides to explain the new Medicare drug plan. I know people have said it is complicated, but it shouldn't be too hard for me. I'm computer literate; I teach health policy; I've been doing health services research for 25 years. I assumed I could just go on-line, help my mother, and get some material for my class at the same time.

I signed on to Medicare.gov. Right there on the home page I saw what I needed. Just click here, it said, and we'll help you select the correct plan. Easy. I entered my mother's zip code and up came this message:

47 Medicare Prescription Drug plans are available in your area

Under this message there was a table summarizing the 47 plans.¹ For each of them, it told me the monthly premium, annual deductible, cost sharing, coverage in the gap, and formulary (percent of drugs covered).

The monthly premiums varied from \$4.10 to \$85.02. Both the \$4 plan and the \$85 plan have a \$250 annual deductible, no gap coverage, and 25% cost sharing. Both plans offer a choice of convenient local pharmacies in their preferred network. According to the summary table, the formulary for the \$4 plan covers 95% of the 200 most commonly used drugs by people with Medicare while the \$85 plan covers 85%. I guess that I need to dig a little deeper.

The monthly premium seems clear as does the annual deductible, but what do they mean by “cost sharing”? No problem, if I just click on the information icon , a pop-up window will explain all. Here’s the definition of cost sharing:

The copayment and/or coinsurance amount range you will pay for each prescription. Plans can make changes in the list of prescription drugs they cover and their costs during the year. Call the plan to get all the details of prescription drug coverage, including the list of drugs the plan covers, so you understand any conditions or limits.

When I clicked on a few of the plan names, I was able to get a bit more information. The copayment and coinsurance seem to differ by “tier.” Now what does that mean? I found a glossary:

Drug tiers are definable by the plan. The option “tier” was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the “tier” option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Searching through a few of the plans, I found that some have fixed dollar copayments that differ by tier and some have coinsurance, shown as a percentage, although I’m not quite sure what the percentage is based on. And, if I understand correctly, each plan can define its own list of drugs that goes into each tier. Oops, maybe this isn’t going to be so simple. I love my mother, but I’m not sure I really want to call 47 different plans.

Medicare.gov also has a place to enter what drugs you’re taking. Ah, I thought, maybe that will help to narrow things down. I called my mom and asked her to gather all her prescriptions and give me a list. Her answer was: “I’m not taking any prescription drugs.” That’s great for her, but not much help in picking a drug plan.

Now what? I work at a medical school so maybe I could call an epidemiologist and ask what are the diseases that an 80 year-old woman is most likely to develop, then call a pharmacist to ask what are the most appropriate prescription drugs for these diseases, and then I would have what I needed to compare the coverage of the different plans. But that wouldn’t work anyway. Since the plans can change their formulary, their prices, and their copayments, I wouldn’t know whether a particular drug would be included by the time she needed it and what it would cost.

Apparently, I’m not alone in my confusion. In a national survey, when asked how well they understand the drug benefit, 61% of seniors said “not at all” or “not well”.² When told that most Medicare beneficiaries will have more than 40 plans to choose from 73% say that having so many plans “makes it confusing and difficult to pick the best plan.” Readers of the Health Policy Newsletter should take note that 75% of seniors expect their

pharmacists to be very or somewhat knowledgeable about drug plan choices and 65% expect the same of their physicians.

So after all of this, what was my advice to my mother? Don't do anything – yet. The 1% per month penalty for not enrolling does not start until May 2006. Maybe some of the plans will close before you have to decide.

Notes:

1. I would have included the table with this article, but at 12 pages it would have taken most of this issue of the Health Policy Newsletter.
2. Source: Kaiser Family Foundation/Harvard School of Public Health Survey. *The Medicare Drug Benefit: Beneficiary Perspectives Just Before Implementation* (conducted October 13-31, 2005)