

Picking a Medicare Prescription Drug Plan

Basic facts you need to know and questions you should ask

This guide has been provided by the editors of *Pharmacist's Letter* and *Prescriber's Letter* for your pharmacist and doctor's office to give to you. The information in this guide has been jointly prepared by *Pharmacist's Letter*, *Prescriber's Letter* and Consumers Union, the nonprofit publisher of the *Consumer Reports Medical Guide* & *Consumer Reports Best Buy Drugs*.



BASIC FACTS ABOUT THE NEW MEDICARE PRESCRIPTION DRUG PLAN

What Is It?

Insurance coverage for a portion of your prescription drug expenses. The coverage is being partially subsidized by the federal government. This allows private insurance companies across the country to sell you reduced-cost insurance coverage for your prescription drug expenditures. These are called Prescription Drug Plans.

Who Is Eligible?

All Medicare beneficiaries. People who are also enrolled in Medicaid (the government's program for low-income people) will be automatically eligible and enrolled in a drug insurance plan.

What's the Coverage Exactly?

The government has designed a standard plan, but private insurers may offer plans with more generous coverage. They can charge higher premiums for such coverage.

In 2006, for a monthly premium that will vary by plan, the standard coverage includes a \$250 deductible; that's the amount you pay up front before *any* coverage kicks in. Then you will pay 25 percent, or \$500, of the next \$2,000 in drug expenses. After that, there is a gap in coverage (the so-called "donut hole") for expenditures between \$2,251 and \$5,100. In this hole, you *pay for all prescription drugs yourself*. Then, once you reach \$5,100 in total costs in a year and you have paid \$3,600 out of your own pocket for prescription drugs, insurers will pay about 95 percent of all remaining costs. Several private plans have already announced they will "fill in" part of the donut hole gap.

How Much Will the Premiums Be?

Premiums for the standard plans are expected to range from \$2 to about \$40 a month. More generous coverage may cost \$50 to \$80 or more a month.

When Does it Start?

You can enroll starting on November 15 if you are currently in Medicare, or turn 65 in January or February 2006. Actual coverage begins January 1, 2006. You have until May 15, 2006, to sign up before a penalty is imposed for late enrollment. The penalty is a 1 percent higher premium for every month you delay. The penalty does not apply to people who remain in *approved* existing health plans (for example, through a retiree health plan) that offer drug coverage. You can stay in such plans and then quickly switch to one of the new plans later—without penalty—if you want or your circumstances change. Keep in mind that if you have to pay a penalty, you will continue paying the higher rate for as long as you have the Prescription Drug Plan.

How and Where Do I Enroll If I Decide to Do So?

You must fill out an enrollment form. These are available from the insurers and health plans themselves or from your local Social Security office. You can also go online at www.ssa.gov or www.medicare.gov to find out more about enrolling. Your employer may also help. You can also call the Social Security Administration at 1-800-772-1213. Or you can call Medicare at 1-877-486-2048 or 1-800-MEDICARE (1-800-633-4227) to ask questions and have the enrollment form sent to you. Keep in mind that if you are already enrolled in other senior care coverage, you are not automatically enrolled in the Prescription Drug Plan. You must enroll in the Prescription Drug Plan even if it is with your current insurance carrier.

What Does the Term "Part D" Refer to?

In Medicare, Part A refers to hospital coverage, Part B refers to coverage for doctor's services, and Part C refers to coverage and enrollment in Medicare HMOs. Part D is the new prescription drug coverage, and specifically it is drug-only or so-called drug "stand alone" insurance plans.

SHOULD I ENROLL? WHAT FACTORS SHOULD I CONSIDER?

That is going to depend on your individual circumstances. Our advice is an emphatic “yes” if you are living on a low income and have few assets or savings.

Specifically, if your income in 2006 will be below about \$14,600 for an individual and about \$19,600 for a couple, (and you have assets of less than \$10,000 for a single person and \$20,000 for a couple, not counting your house and car and some other exceptions), the government is offering extra help to lower or eliminate your premiums, co-payments, and deductibles. In fact, you may pay a very small amount out-of-pocket for the coverage and for your drugs. This makes the new benefit highly attractive and we urge you to sign up as soon as possible. You can find out about qualifying for this extra help by calling 1-800-772-1213 (TTY 1-800-325-0778) or by going to <http://www.socialsecurity.gov/prescriptionhelp/index.htm>.

For everyone else, the decision to sign up or not will depend primarily on these factors:

- Your income, assets, and financial situation
- Your health status
- Your current drug expenses and needs
- Whether you have drug coverage now from another source (such as retiree health or VA benefits)
- Your tolerance of risk—namely, your comfort level that you will be able to pay for medicines if you delay or forgo buying this insurance
- An assessment of whether the coverage meets your needs and whether you are willing to pay for it given your other insurance and living expenses

If You Have No Drug Coverage Now

If you have no drug coverage now, but do not qualify for low-income assistance, you should start by calculating your current drug expenses. If they exceed about \$630 per year, you may stand to gain by enrolling because your expenses are already greater than the annual premiums (average \$384) plus the annual deductible (\$250). And that’s under the “standard” coverage. Some insurers will be offering lower premiums and perhaps even lower deductibles.

For example, if you have no drug coverage now and your drug expenses are anticipated at \$1,200 in 2006, you would come out ahead by around \$328 under the standard plan (if your premium is \$32 a month).

If you have no drug coverage and your current drug expenses are less than \$600 or so per year, your decision may be based primarily on your ability or willingness to pay the premium and your sense of risk about your potential future drug needs and expenses. You may be willing to take the gamble. Indeed, statistics show that millions of Medicare beneficiaries have drug expenses below this level, and for years. That’s especially true for 65 to 70 year olds. But consider the following before you make this decision:

- If you do begin to need a prescription medicine or medicines, the expense can rise very quickly, easily exceeding \$600 a year. Some commonly-used drugs cost \$100, \$150 or \$200 a month. And for many common ailments (heart disease, diabetes, high blood pressure), taking multiple drugs has become the norm.
- Your premium will be at least 1 percent higher for every month you delay enrolling after you are eligible. Thus, if you put enrollment off for three years, your premium will be at least 36 percent higher. So instead of a premium of, say, \$32 a month, it will be \$43.50 (an extra \$138 a year). Again, you may decide you can wait since you won’t be paying premiums at all for the first three years. On the other hand, if you lived for 20 years after you finally bought the coverage, your additional premium expense would mount up. (The premium may increase over time so we can’t really make a calculation.)

If You Have Drug Coverage Now

If you currently have prescription drug insurance through some other source – a current or former employer, the military or the VA – you will want to determine which coverage is best: what you have now or this new coverage. Your current insurer is required to send you a letter telling you whether your coverage is considered more or less valuable than the standard new Medicare coverage. If the letter says your current coverage is worth *more* than what Medicare has to offer (called creditable coverage), you may want to stick with what you’ve got. You can switch later without any penalty. If the letter says your coverage is worth less, you should strongly consider switching to one of the new plans given other factors.

Your decision may also be based on an assessment and comparison of the more generous plans that insurers will offer—not just the standard one. Several of these may indeed be more comprehensive coverage than you have now. Whether you switch or not will depend in part on what the premium difference would be.

Be sure to check with your current plan’s sponsor (employer, union, etc.) to make sure you won’t lose other health benefits if you join a new Medicare drug plan.

If You Have Medigap Now

Finally, if you have a Medigap policy now that covers drugs, you will want to weigh your options. Insurers will no longer be allowed to sell Medigap policies that include drug coverage. But you will be allowed to keep an existing Medigap policy with drug coverage. Your Medigap insurer is required to evaluate your present drug coverage and compare it to the new Medicare coverage. If you get a letter saying it is *less* valuable than what's being offered under the new benefit, you should drop

the drug portion of your Medigap policy. Most experts believe that the vast majority (if not all) Medigap policyholders with drug coverage will be much better off with the new coverage, since it is subsidized by the government and Medigap policies are not. You can keep the other benefits in your Medigap policy, and your premium should be reduced. You may want to take this opportunity to make sure you have the best Medigap policy for the money and your needs.

SHOULD I ENROLL IN A STAND-ALONE DRUG PLAN OR A MEDICARE HMO OR PPO?

If you are already in a Medicare HMO that will be offering a drug benefit, you must use that plan's drug benefit or drop out of the HMO. You will learn about your HMO's offerings in the weeks ahead.

If you are not currently in a Medicare HMO, you have a choice. You can remain in traditional Medicare and enroll in a stand-alone drug plan or you can choose among a range of new Medicare HMOs and PPOs (Preferred Provider Organizations), now also being called "Medicare Advantage" plans. Almost all cities and heavily populated areas will have such plans. Rural areas may not. All of them will include drug coverage and integrate it with their coverage of other medical services, such as hospital care and doctor's visits. For example, you'll pay one premium.

Your choice is totally dependent on your comfort level in joining such a plan, if one is available in your area. Weigh the pros and cons. As is now well known, such plans restrict your choice of hospitals and doctors, and you will have to pay extra (sometimes a lot more) to see a doctor not in the plan's network. In contrast, under traditional Medicare you can see any doctor you want. However, on the plus side, some Medicare managed care plans are trying much harder these days to

coordinate your care better, especially for people with chronic diseases. Such coordination is notably lacking when you see multiple doctors on your own.

The new Medicare Advantage plans will be seeking to increase enrollment of Medicare beneficiaries using the drug benefit as inducement. They may advertise widely. We advise caution and careful consideration. Many of these managed care plans will be able to offer very attractive benefit packages, and lower premiums and co-pays, in part because of generous subsidies from the federal government. But future Medicare budget cuts could cause these plans to cut their benefits, as happened in the late 1990s. You should not join such a plan just for the drug benefit, but consider its other features and compare the various plans in your area carefully. You will especially want to assess whether your doctor or doctors are in the plan's network, and which hospitals are as well. The plans themselves and your doctor's office should be able to tell you this information. If they cannot, be cautious.

HOW DO I EVALUATE IF A PLAN WILL COVER THE DRUGS I TAKE?

All the insurers who offer the new drug coverage – whether a Medicare Advantage plan or a stand-alone plan – will have a list of covered and preferred drugs, called a formulary. You can use the plan finder at www.medicare.gov to see if the prescription drugs you are taking are covered by any individual plan. You can also contact the plans to ask whether your drug or drugs are on the list and what level of co-pay will be required for them.

For example, you may be taking a cholesterol-lowering drug that is not on a plan's preferred drug list. Thus, you may have to pay more out-of-pocket for that drug, or switch to the preferred drug after consulting your doctor.

If you take multiple drugs for a chronic condition, the task of comparing the new drug plans based on their formularies could be complex. But since the government is essentially requiring that a great many drugs be covered, many formularies and

preferred drug lists will be pretty much the same. But they can differ, and they change over time.

Under the law that set up the new drug benefit, all plans have to have an appeals process that will allow you and your doctor to request that a non-formulary or non-preferred drug be covered or have a lower co-pay. There is no good way to predict how receptive a plan will be to adding a drug upon your doctor's or your request.

See the Consumer Reports free Web site www.CRBESTBUYDRUGS.org for more information about lower cost, safe, effective drug choices that can save you money.

WILL MY PRESCRIPTIONS BE “MANAGED” IN OTHER WAYS? IS THIS A GOOD THING?

Besides setting co-pays based on a drug’s status on a formulary, insurers will be able to use an array of other methods to control drug use and cost. These include putting limits on the length of some prescriptions, requiring you to try the least expensive drug in a category first, and requiring your

doctor to get permission to prescribe certain drugs. Some of these ideas make sense: for example, substituting a low-cost generic drug for an expensive brand drug that doesn’t provide any extra benefit can save money for everyone, including you.

WILL MY LOCAL PHARMACIES BE PARTICIPATING?

Virtually all pharmacies, including independent and chain pharmacies, will be participating, but not necessarily with all plans. Insurers will be selectively contracting with different pharmacies in your area. That means that you should also consider which pharmacies will be participating in the plans that you are interested in. Be sure to select a plan that allows you to use the pharmacy of your choice.

Such selective contracting will be saving the insurers money but may also yield savings for you because of negotiated discounts on drugs. For example, if you fall in the coverage “donut hole” (after around \$2,250 in expenses) where you

have to pay all your drug costs, you will still be able to buy medicines at the discounted prices. (Those discounts may range from minor to pretty significant.) A few patients with very high prescription expenditures and certain conditions will be enrolled in Medication Therapy Management programs to help make sure their medications are working well. If you may qualify for this, select a pharmacy that you would want to provide these clinical services for you.

You will be able to go to “non-participating” pharmacies, but the co-pays for drugs will be higher at those.

TO AVOID TELEMARKETING, SIGN UP FOR THE GOVERNMENT’S DO NOT CALL REGISTRY

The choice of drug plan is too important and too complicated to be decided over the phone. You can avoid these calls by signing up for the Do Not Call Registry by going to www.DoNotCall.gov or call toll-free, 1-888-382-1222 (TTY 1-866-290-4236), from the phone number you wish to register. Consider also registering any cell phone number because it is possible that in the future telemarketers may be able to get cell phone numbers, however it is still against the law to telemarket to cell phone numbers. Registration is free.

Fraud alert:

- Remember not to give any telemarketer—or anyone who comes to your door—any financial information, your Medicare or Social Security number, or a check or cash.

WHO CAN I TRUST TO HELP SORT OUT MY DRUG PLAN CHOICES?

One place to start is with your State’s Health Insurance Assistance Program (SHIP). Trained local volunteers can help you determine which plan will leave you with the lowest out-of-pocket costs. You can find your state’s SHIP by calling Medicare at 1-800-MEDICARE (1-800-633-4227) or at this Web site: www.medicare.gov/contacts/static/allStateContacts.asp

The 2006 edition of *Medicare and You*, a government publication, has just been mailed and contains information on the new benefit. Be aware that there is an error in this book. If

you are eligible for no cost prescription drug coverage, the booklet provides a list of plans. The book erroneously says that all of those plans are free, when in fact only about 40% of the listed plans are actually free. In addition, the government’s Medicare Web site, www.medicare.gov, and another site, www.carxe.org, will soon have online tools that will let you compare drugs plans and estimate your out-of-pocket costs under each.

OTHER HELPFUL SITES

www.medicarerights.org/101.html

Overview of the new benefit and other guidance from the Medicare Rights Center.

www.ssa.gov/prescriptionhelp

The Social Security Administration's site to learn about the new benefit and enroll.

www.medicareadvocacy.org

Guidance and online tutorials on the new benefit from the Center for Medicare Advocacy.

www.kff.org/medicare/rxdrugbenefit.cfm

Guidance and useful information from The Kaiser Family Foundation, a health research organization.

www.medicare.gov/contacts/static/allStateContacts.asp

The Center for Medicare and Medicaid Services' link to state health insurance assistance programs.



HOW CAN CONSUMER REPORTS BEST BUY DRUGS HELP MEDICARE BENEFICIARIES?

Consumer Reports Best Buy Drugs provides free information about the comparative effectiveness, safety, and price of drugs in various therapeutic categories such as statins (for cholesterol) and NSAIDs (for arthritis pain). Medicare beneficiaries can make use of the free information available at www.CRBestBuyDrugs.org in order to:

- Determine whether Medicare prescription drug plans provide coverage for the most effective, safe and affordable drugs.
- Identify “best buy drugs” alternatives that will be equally effective to medicines currently taken in case the latter are not covered by their Medicare drug plan.
- Switch to “best buy drugs” in order to reduce their out-of-pocket costs, since many drug plans will have deductibles, co-payments, and gaps in coverage.



ConsumerReportsMedicalGuide.org, a subscription-based online service with rich, continuously updated content for non-subscribers as well, provides information on approximately 60 common and chronic conditions, with sections explaining how each condition is diagnosed, what symptoms manifest, what to expect, what treatments are available, and specific questions to ask physicians. ConsumerReportsMedicalGuide.org offers consumers independent, trustworthy information on best treatments and prescription drugs with no advertising influence.



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