

MEDICARE DRUG COVERAGE COMING IN 2006

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On December 8, 2003, the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Known as the "MMA," the law includes some the most significant changes in Medicare since it was created in 1965. Among other things, the MMA creates a Medicare "Part D" plan to provide outpatient prescription drug coverage, and makes changes to the traditional Medicare program and to private Medicare supplement insurance plans.

Outpatient Prescription Drug Coverage

People with Medicare Part A hospital coverage or Part B medical coverage, or both, may purchase Part D drug coverage beginning in 2006. This drug coverage is available through a Prescription Drug Plan ("PDP") or a Medicare Advantage (formerly Medicare+Choice) plan that offers drug coverage. Also, plans that provide actuarially equivalent drug coverage to Medicare beneficiaries – such as employer-sponsored plans covering retirees – may receive a federal subsidy. These prescription drug coverages replace the interim prescription drug discount cards created by the MMA beginning in June 2004.

PDP enrollments began in November 2005, and those enrolling by December 31, 2005 will have Medicare prescription drug coverage effective on January 1, 2006. Coverage for people who enroll after December 31, 2005 will be effective the first day of the month after enrollment. To avoid adverse selection, people with Medicare who enroll in a PDP after May 15, 2006 will pay a higher monthly premium unless they had a drug plan that covers at least as much as Medicare Part D. This penalty is 1% of the premium per month for every month a person waits to enroll (though this percentage may increase once there is sufficient data to evaluate the costs arising from these late enrollees). This higher premium remains in effect as long as the person is in a PDP.

People with Medicare should have received notices regarding the Medicare prescription drug program and the options available from one or more of the Social Security Administration ("SSA"), the Centers for Medicare and Medicaid Services ("CMS"), their Medicare supplement insurance carrier, and their employer or union. The SSA provided information to Medicare beneficiaries who qualify for a low-income subsidy that would provide assistance with paying some of the costs associated with Medicare prescription drug coverage. CMS provided beneficiaries with information on the Medicare prescription drug program in various mailings, including the Medicare & You 2006 handbook. CMS also provided information to people covered by both Medicaid and Medicare (known as dual eligibles), who automatically qualify for drug coverage. CMS will assign dual eligibles to a PDP if they do not enroll in one of their choice. Medicare supplement insurers provided information to their insureds regarding the status of any existing prescription drug coverage and the availability of coverage through a PDP. Finally, employers and unions provided retirees and members, respectively, with information regarding their current drug coverage and whether it would continue.

Each PDP covers some core prescription drugs, but is allowed to implement a formulary of other covered drugs that may vary among the PDPs (and that a PDP may revise in the future). The plans have a \$250 deductible and a 25% coinsurance for allowable drug expenses up to \$2,250. After the first \$2,250, PDP enrollees pay 100% of their allowable drug expenses up to \$5,100. At this point, the enrollee's out-of-pocket costs total \$3,600 (coverage by PDPs above the standard plan and third-party payments – except those from state or federal programs – do not count toward this out-of-pocket limit). Allowable drug costs in excess of \$5,100 are covered with a 5% coinsurance. The 2006 premium for a PDP will be around \$37 per month, but the cost will vary depending on the PDP. This premium can increase over time as the cost of the coverage increases.

Direct and indirect subsidies by governments will cover about 74.5% of the cost of providing Medicare Part D. There is a sliding scale of subsidies to cover premiums, the deductible, and all but a minimal copayment for enrollees with incomes up to 150% of the federal poverty level. The cost of coverage for Medicare and Medicaid "dual eligibles" that is shifted to Medicare will be paid by the states. These state contributions are reduced to 75% of the cost for dual eligibles over 10 years. Employer sponsored retiree plans providing "actuarially equivalent" coverage are eligible to receive a 28% limited subsidy.

According to CMS, Medicare beneficiaries who qualify for low income subsidies, and those who currently have no outpatient prescription drug coverage, will generally want to enroll in a PDP. On the other hand, Medicare beneficiaries who currently have outpatient prescription drug coverage through SeniorCare, Medicare supplement policies, or employer or union benefit plans, may find it makes sense to keep the coverage they have.

Regulation of PDPs and Medicare Advantage

PDPs and Medicare Advantage plans must be approved by CMS, and PDPs must be licensed as risk-bearing entities in the states in which they operate unless they receive a waiver from CMS. PDPs are eligible for such a waiver if (1) the state fails to act on a license application in a timely manner or does not have a licensing process for PDPs; (2) the state denied a license on a basis that discriminates against PDPs; or (3) the state denied a license based on solvency standards that differ from the federal standards (which were developed in consultation with the NAIC). PDPs that receive a waiver still must be approved by CMS. Grievance, internal review, and external appeal procedures for PDPs are based on Medicaid rules.

More than 2,000 different plans offered by PDPs have been approved by CMS. The number of plans available in each region of the country varies. In Wisconsin, for example, there are 13 approved PDPs that offer 37 different plans.

Medicare Supplement Changes

The MMA requires that the states amend their laws on Medicare supplement insurance, including addition of a ban on coverage for any outpatient prescription drugs in such policies issued after December 31, 2005. Medicare supplement insurance policies with drug coverage may not be issued to or renewed for a person enrolled in a Medicare Part D program. However, these policies may be renewed if the drug coverage is eliminated (e.g., by rider or a different plan) when the insured enrolls in Medicare Part D. In short, an insured with drug coverage under a Medicare supplement insurance policy may choose to (1) enroll in Medicare Part D and (a) remain in his or her current plan with the drug coverage eliminated or (b) switch to a Medicare supplement insurance policy, such as plans A, B, C or F, or (2) forego Medicare Part D and keep the Medicare supplement insurance policy drug coverage. As indicated above, Medicare supplement insurance carriers were to notify their insureds of these options by November 15, 2005.

CMS relied on the NAIC to revise Medicare supplement insurance laws to implement these changes and for assistance in other areas. The NAIC revised its model laws in record time to remove drug coverage from Medicare supplement insurance plans H, I, and J; to add two new plans with cost-sharing and out-of-pocket limits; and to make other changes required by the MMA. The NAIC has also advised CMS on drafting the notice materials Medicare supplement insurers are required to file.

Medicare Advantage

In addition to creating Medicare Part D, the MMA also modified Medicare Part C (Medicare+Choice) and re-named it Medicare Advantage. One of the main goals of these modifications was to conform the Medicare Advantage program more closely to the Federal Employees Health Benefits (FEHB) Program with respect to the coverage choices available. CMS hopes that these reforms will bring additional health plans into the Medicare Advantage program.

Some of the MMA modifications to Part C, such as higher payments, are already in effect, while others will take effect beginning with the 2006 contract year. These modifications include authority for new Medicare Advantage regional plans that will be organized as preferred provider organizations, and a new process for setting enrollee premiums and benefits. For 2006 and beyond, each Medicare Advantage plan will submit a bid for covering the benefits it plans to offer. The plans will bid against the weighted average, with enrollees keeping the savings for choosing lower-cost plans. In a pilot program slated for 2010, Medicare Advantage plans in six metropolitan areas will compete directly with Medicare fee-for-service. As was the case before the MMA, all state laws except those governing licensing and solvency are specifically superseded for Medicare Advantage plans.