



Start the year right

# What you need to know about Medicare Part D

**Since mid-November, some 260 companies have been wooing the nation's 43 million Medicare participants to sign up for the program's new prescription drug benefit, known as Part D.**

For many seniors who have struggled to pay for their medication, the benefit promises to be a boon. Yet the sheer number of offerings and the complexity of the coverage make finding a good plan a giant pain in the neck. "It's a hostile market for any consumer," says Robert Hayes, president of the Medicare Rights Center, a New York City-based advocacy and service organization.

With pitches coming from TV commercials, brochures at pharmacy counters, mail solicitations, and sales agents trying to cross-sell and upsell everything from memberships in HMOs to hearing aids, misinformation abounds. Some independent sales agents have told seniors that they work for Medicare, while others have offered illegal cash payments as an inducement to sign up.

Sometimes there is no information. When we telephoned First United American Life Insurance Co. about its plan, the sales agent could not say whether or not the company's policy had a deductible, a fact that customers should know before deciding whether to buy.

When Congress authorized the drug benefit two years ago, it let private companies offer the coverage instead of mandating that the government provide it as it does traditional Medicare benefits. The law set forth the basics of the plan but granted great latitude in shaping the benefits to private insurers, HMOs, pharmacy benefit companies, and associations like

AARP. The result is a market free-for-all that makes it difficult for consumers to make apples-to-apples comparisons of the 40 or 50, or even 60 plans that they may be offered in their areas.

## DECISIONS, DECISIONS, DECISIONS

The choice of plan, however, is only the last in a series of considerations that Medicare participants will face. In First Things First, on the facing page, we lay out the factors that should determine whether or not you buy a drug plan.

If you decide to buy a plan, however, you are likely to find yourself bothered and bewildered by the complexities of the new benefit. For example, plans come in three flavors—standard, equivalent (also called basic alternative), and enhanced—but, inconveniently, not all companies use those names consistently, if at all.

Worse, premiums provide no guide to the benefits you will get under any plan. A low-premium plan that falls into the bucket of equivalent plans might be a better deal for you than a standard plan with a similarly low premium. If a company has low premiums in general, its enhanced plan could cost less than a standard plan at some other company.

For help, you can call Medicare at 800-633-4227, but you have to endure a series

of recorded messages before you can get to a human being who will be able to answer all of your questions. You're better off using Medicare's Web site, at [www.medicare.gov](http://www.medicare.gov). If you're not adept with a computer, you should recruit a friend or relative to guide you. But before you go to either the phone or the computer, you'll need to consider the following:

## HMO OR TRADITIONAL MEDICARE?

For seniors who would like to cut insurance costs, this may be the moment to join a Medicare HMO or PPO. Such arrangements, called Medicare Advantage Plans, usually—but not always—charge an extra monthly premium. That's in addition to the \$88.50 monthly premium you'll pay this year for Medicare Part B. But the total will generally cost less than original Medicare plus a Medigap plan.

Medicare Advantage members often have lower out-of-pocket costs and sometimes receive services not covered by Medicare, such as eyeglasses and dental care. And HMOs now may offer the new drug benefit as part of their overall package for little or no extra premium. Members must, however, use the doctors, hospitals, and pharmacies within the plan network.

If you want to change from traditional (also referred to as original) Medicare to an Advantage plan, you can use the search tool on the Medicare Web site to find one. When you switch, you may never again have to think about Medicare's prescription drug benefit unless and until you leave your managed-care plan.

What if you're already in an HMO? You probably have already received a letter from the plan telling about the new

## For more information

### FROM CONSUMER REPORTS

**CR Best Buy Drugs** (free). For lower-priced medicines that might be equally effective alternatives to brand-name drugs for many conditions, go to [www.CRBestBuyDrugs.org](http://www.CRBestBuyDrugs.org).

**More on Medicare Part D** (free). Go to [www.ConsumersUnion.org/issues/medicaredrugs](http://www.ConsumersUnion.org/issues/medicaredrugs).

coverage. You don't have to buy a Medicare drug plan; you get what your HMO offers. If you want to stay with traditional Medicare, however, you'll be shopping for one of the new Prescription Drug Plans, also known as PDPs.

### THE THREE FLAVORS

Congress's blueprint for the standard drug benefit calls for participants to pay monthly premiums and to meet a \$250 deductible. When the deductible is satisfied, the plan pays 75 percent of a person's total drug expenses up to \$2,250. So of the \$2,000 in drug costs that remain after the deductible is paid, the plan pays \$1,500 and you pay \$500.

Enrollees who spend more enter the coverage gap, or so-called doughnut hole, paying all drug costs out of pocket until their total spending on prescription drugs for that year reaches \$3,600, which is known as the "true out-of-pocket cost." At that point, when a total of \$5,100 has been spent by both the enrollee and Medicare, the government pays up to 95 percent of any further expenses. (All amounts apply for 2006 and might

change in future years.)

But Congress allowed insurers to stir benefits into other combinations that might prove attractive to seniors as long as the value of the benefits is at least as great as the standard plan's. The result is a confounding hodgepodge of offerings that fall roughly into three categories.

**Standard plans.** These follow the government blueprint exactly with a deductible of \$250 and 25 percent coinsurance. None offers coverage in the doughnut hole. Premiums are generally low, but standard plans are not very common. In Philadelphia, for instance, no more than 5 of 51 PDPs are standard plans.

**Equivalent or alternative plans.** These may have no deductible or one lower than \$250. Instead of paying a percentage of the expense, you make copayments of specified dollar amounts. An equivalent plan may work well for seniors who take few drugs or lots of inexpensive generics, because they would get coverage right away.

Seniors who join an equivalent plan are likely to find three or four drug tiers, with different copayments for each.

Generic drugs, which usually make up the first tier, have very low copayments, usually under \$10; the second tier includes preferred brand drugs, which require higher copayments, often ranging from \$15 to \$40. So-called nonpreferred brand drugs, which account for the third tier, come with still higher copayments to discourage their use when a cheaper, equally effective alternative is available. In this third tier, copayments can run up to \$60 or \$70 per prescription. Expensive specialty drugs such as Enbrel, an immune-system suppressant, make up the fourth tier. With almost all plans, seniors pay 25 percent of each drug in this tier.

**Enhanced plans.** These are the Cadillacs, offering coverage in the doughnut hole, a low (or no) deductible, and lower copayments in the drug tiers or both. Such plans may appeal to the 39 percent of beneficiaries whose total prescription expenses, including the government's portion, fall between \$2,250 and \$5,100. A few insurers—Aetna, Cigna, and Pacificare—are offering doughnut-hole coverage for generic drugs, while Humana also covers brand-name drugs.

## First things first Should you join a Medicare drug plan?

**If you are a current Medicare participant, you have until May 15 to sign up for a plan. If you delay, you must wait until November 2006 to sign up, and you get no benefits until Jan. 1, 2007. Worse, you are subject to a late-enrollment penalty equal to 1 percent of the average national monthly premium, now \$32.20. If your plan starts in January 2007, the monthly penal-**

**ty would equal 32 cents multiplied by your seven-month delay, or \$2.24. You would have to pay that each month on top of your monthly premium as long as you are in a Medicare drug plan. When CR's actuary examined standard plans, he determined that because of the penalty, only seniors who spend less than \$750 a year should consider waiting to enroll.**

### YES, IF:

**You have a low income.** Individual Medicare participants with monthly incomes below \$1,077 (\$1,444 for couples) and cash assets of less than \$7,500 (\$12,000 for couples) pay no premium, no deductible, and small copayments. Individuals with monthly incomes below \$1,197 (\$1,604 for couples) and assets of \$11,500 (\$23,000 for couples) pay premiums based on a sliding scale, a \$50 deductible, and 15 percent of the cost of each prescription.

**You have coverage under Medigap.** Even if your supplemental insurance policy already covers drugs, Medicare's most basic plan is likely to be superior to almost anything Medigap offers.

**Your annual drug expenses are more than \$750.** Our actuary determined that many of the plans would provide you with savings.

### NO, IF:

**You have a retiree policy that covers medications.** If your former employer, your union, or a membership association notified you that its drug benefit is at least equivalent to Medicare's, you need not enroll in a new plan. If your employer later drops your drug coverage, you pay no late-enrollment penalty if you join Medicare's plan within two months.

### YES, BUT BUY AN 'EQUIVALENT' PLAN:

**If you spend less than \$750 annually** on prescription drugs now and your health is good, you might want to wait. Even if you delay buying a policy for three years, your out-of-pocket expenses with a standard plan would probably stay about the same. If you want to insure yourself against an increase in your prescription drug needs, you should consider a Medicare drug plan. Instead of the standard plan, however, choose a plan with low premiums and a low or zero deductible. That way, you'll get some coverage right away, and if your health deteriorates, you'll have a plan in place.

### YOU'RE AUTOMATICALLY ENROLLED IF:

**You belong to a Medicare HMO.** It may already offer drug benefits that are likely to be even more generous now, reflecting higher government reimbursements—although those may not last forever. Another plus: You don't have to choose a new plan. You get what the HMO provides.

**You're on Medicare and Medicaid.** You should already have been assigned to a plan by the government. If it doesn't cover your drugs, you can switch to another plan every month if you like.

The fact that there are three basic plan types doesn't mean that it's easy to figure out which is which. Sellers can use any name they think will appeal to consumers, and without standardized names or benefits, anything goes. Cigna and Humana call their enhanced plan Complete. WellCare's Complete plan is its basic plan, more generous than its standard plan, which it markets under the

name Signature, but less generous than its Premier plan. You'll have to check with the company to make sure that a plan offers coverage you want.

### GETTING THE RIGHT DRUGS

Each plan has its own distinct formulary, or list of covered drugs. After you enter the names of the drugs you take in the Medicare Web site's search tool, it will

produce a list of plans that include them in their formularies.

Drugs can go on and off the formularies at any time, and it's possible that a plan will not cover every drug you take, forcing you to pay for the medications out of pocket (an expense that doesn't count toward meeting the deductible or filling the doughnut hole). Your plan must notify you when a drug goes off its formulary and provide a transition plan that will allow your doctor 60 days to file for an exception or to change your treatment plan.

There's yet another wrinkle. The insurer may impose restrictions on certain medications. Many insurers require you or your doctor to get their approval—or preauthorization—before they will pay for certain drugs, ones that are likely to be taken incorrectly or prescribed inappropriately. If the plan covers the drug, copayments for the appropriate tier will apply. If it doesn't, you pay.

Companies also target certain medications, such as pain relievers, for "step therapy." Before it will cover a drug, the plan asks you to try a therapeutically equivalent and less expensive drug. If it doesn't work, the plan steps you up to the next least expensive drug in the class. The plan keeps stepping you up until you and your doctor find a drug that works.

Companies use such restrictions to manage the cost of the drug benefit and encourage patients to use generics, not an unreasonable strategy. But you'll have to be persistent to get this information. Pacificare, for example, uses more of those management tools for patients who choose its lowest-cost plans, but its information brochure simply points out that the company may offer "medication therapy management." Unless you take only the least expensive, generic drugs, you'll have to ask plans you're considering whether your medications are subject to preauthorization or step planning.

That's just one more hurdle in what's likely to be a rather arduous shopping effort for most seniors. Many are likely to throw up their hands in exasperation and avoid enrolling altogether. That would be a shame, since the new drug benefit offers many consumers true savings. At this point, however, they come with too much confusion.

## dollars&sense

### THE HUNT FOR A GOOD PLAN

To see what it takes to find the right drug plan, a CR reporter shopped with Marie (who asked us not to disclose her last name), an 88-year-old in southern Connecticut. She is not computer-proficient, so our reporter guided her through the process. Here's what they did.

**1 Calculated current drug costs.** Marie takes only three drugs: Fosamax for bone health, Lipitor to lower cholesterol, and Norvasc for high blood pressure. She has been buying them in Canada and paying about \$400 in U.S. currency every three months. At a typical U.S. pharmacy, they'd cost \$160 a month or \$1,920 a year.

**2 Used Medicare's online tools.** Marie and the CR reporter went to [www.medicare.gov](http://www.medicare.gov) and clicked on Compare Medicare Prescription Drug Plans. Marie entered her Medicare number and her birth date (which the Web site tells you it will discard) and her ZIP code, and found that she had 55 plans to choose from in her county, including 11 Medicare Advantage Plans or HMOs. "How would I know which one I want?" she asked. "None of these plans mean anything to me."

Her first decision was easy. She didn't want to belong to an HMO. That left 44 plans. She narrowed the list to eight, mainly on name recognition: a plan from Anthem Blue Cross Blue Shield, \$28.64 a month; two Aetna plans, one with a monthly premium of \$37.61, the other, \$65.58. She wanted more details about the plan AARP is marketing to its 35 million members. Its monthly premium of \$23.69 sounded about right. Besides, she said, "I have a lot of faith in them." Humana offered the lowest premium on her list, \$7.32, but she was wary. "For that, they are not going to give you anything," she said, so she asked to see the two higher-priced Humana plans as well—the company's

Complete plan with a monthly premium of \$55.08 and its Enhanced plan, \$13.92 a month. She also selected a plan from Uni-care for \$18.85 a month.

**3 Compared plan costs.** Marie then entered all her drugs into another Web tool at the site. It combined copayments, drug prices, deductibles, and premiums for the eight plans and then told her how much she would end up spending.

It turns out you can't judge a plan by its premium or its name. Marie would pay the most for her drugs—\$4,488 a year—with Aetna's Rx Premier plan, which has a \$65.58 premium. Aetna's Essentials and AARP's plan would cost a few hundred dollars less. Humana's low \$7.32-monthly plan turned out to be much more costly than its Complete plan, which cost \$55.08. Because the latter provided some coverage in the doughnut hole (where there is normally no coverage), it reduced her annual out-of-pocket spending to \$1,740.

**4 Inquired about the companies.** To link to plan Web sites, you have to return to the first Web tool, but Marie decided to phone for more information. She didn't get much. The Humana representative said she was too busy to answer questions and told Marie to call back. Aetna's rep estimated that her copayments would be \$20 to \$40 but said he couldn't say for sure because he didn't have the sales kit. Others rattled off information about copayments and drug tiers, and 30- and 90-day supplies. None mentioned step therapy or other tools that plans use to control drug costs. The coverage gap (or doughnut hole) still confused Marie. "Gap," she said. "I only know the store."

In the end, Marie decided to continue buying drugs in Canada. What she's spending there is still less than the least expensive plan she investigated.