



## THE MEDICARE PRESCRIPTION DRUG BENEFIT: IMPLICATIONS FOR LOW-INCOME BENEFICIARIES AND THEIR PROVIDERS

Emily Aron & D. Brad Wright, MS

### Overview

The Medicare Modernization Act (MMA) introduced legislation that for the first time ever offers senior citizens and those with disabilities relief from high drug costs. January 1<sup>st</sup>, 2006 marks the beginning of the new benefit and the months leading up to this date are important in enrolling beneficiaries into a drug plan that are suited to their needs. The parameters of the new benefit are complicated and difficult to navigate for even the most medically fit individual. Therefore, it is important to approach the transition from current prescription drug entitlements to the new one under Medicare within a transdisciplinary framework so that all low-income patients have meaningful coverage and are well-informed of what their coverage affords them.

### What Clinicians Can Do:

- Understand the basics of the MMA legislation.
- Communicate with Medicaid/Medicare beneficiaries (dual eligibles) that they will no longer be able to use their Medicaid card to pay for MOST of their prescription drugs. It has been indicated that Medicaid most likely will still pay for drugs not covered by Medicare such as benzodiazepines, weight loss or weight gain drugs, etc.
- Help dual eligible patients understand that they will be automatically enrolled in a drug plan that may not cover all of their drugs. However, they will be able to change their drug plan on a monthly basis.
- Explain to dual eligibles that, depending on the drug plan they enroll in, they may need to go to a different pharmacy to pick up their drugs.
- Tell patients that they must fill out applications for TWO separate items. 1) application for a drug plan 2) Application for a subsidy
- Communicate with low-income Medicare patients and let them know that there are subsidies available from Medicare that will help with the cost of their drugs.
- Seek information on additional subsidies, i.e. state pharmacy assistance programs (SPAPs), patient assistance programs (PAPs) that can fill in gaps in coverage (i.e. the donut hole) that may exist for low income beneficiaries and can also help with nominal cost sharing

## Background

On January 1<sup>st</sup> 2006, Medicare will change to include a prescription drug benefit. This new legislation will alter the way many low-income patients pay for and receive prescription drugs as described in the box below.

### Summary of benefits: What is the “donut hole”?

If patients do not meet eligibility requirements for the subsidy they will be subjected to the following payments:

- \$37/month premium (this is a national average and will vary from plan to plan)
- \$250 deductible (also an average)

Cost sharing percentages will vary depending on the amount that a patient has spent. Patients will be charged with:

- 25% of the first \$2,250
- 100% of the drug costs from \$2,251 to \$5,100—this is what is referred to the “**donut hole**” in the benefit.
- After they have spent \$5,100, catastrophic coverage takes effect and the patient will pay 5% of drug costs. Again, these are averages, and cost-sharing may differ from plan to plan

Source: Robert Pear. “Medicare insists on wider choice in drug benefits.” *New York Times*, June 15, 2005, p. A1.

These cost requirements are potentially steep for those who are on the threshold of eligibility requirements and who take multiple prescription drugs. The plan is set up so that Medicare beneficiaries who also receive Medicaid will be automatically enrolled into a plan, beginning in October.<sup>1</sup> Those who are currently enrolled in Medicaid and Medicare are referred to as dual eligibles (DEs). After December 31<sup>st</sup>, 2005, they will no longer receive prescription drug coverage under their state’s Medicaid program. Many of the DEs are among the sickest and poorest of Medicare beneficiaries.<sup>2</sup> Furthermore, there are those among DEs that are younger and receiving Medicare due to a disability (i.e. AIDS, mental illness, Parkinson’s).

The new Medicare prescription drug benefit presents multiple challenges to this group. First and perhaps most importantly, many may not comprehend the fact that they have been automatically enrolled into a prescription drug plan. Furthermore, the prescription drug plan they have been assigned to might not have a formulary that

<sup>1</sup> Medicare: Low-income assistance under the Medicare drug benefit. Fact Sheet. Kaiser Family Foundation. May 2006.

<sup>2</sup> Jocelyn Guyer and Andy Schneider. “Implications of the new Medicare law for dual eligibles: 10 key questions and answers.” Kaiser Commission on Medicaid and the Uninsured. January 9, 2004.

adequately suits their needs.<sup>3</sup> Additionally, the prescription drug plan (PDP) may be set up with a pharmacy that is not the current beneficiary's pharmacy and may not be a practical distance from where they live. For those who are receiving Medicare because of a disability, there is a twenty-four month waiting period before they may start receiving Medicare benefits. With Medicaid drug coverage ending, those who are still in the waiting period might be without any means to pay for their prescription drugs.

Medicaid coverage varies from state to state. As a result of the MMA, states might decide to decrease the number of DEs as a way to relieve the financial burden placed on them through a complicated formula derived by the federal government. Three states have already changed the threshold for Medicaid beneficiaries—Florida, Mississippi, and Missouri—and there may be others to follow.<sup>4</sup> These beneficiaries will join the ranks of others low-income beneficiaries who may be eligible for the prescription drug subsidy afforded to them by Medicare.<sup>5</sup> As a result, patients will need to expeditiously inform themselves about the different drug plans available and enroll in one that best suits their needs. Many may not understand the ramifications of losing Medicaid coverage (i.e. loss of long-term care subsidy, different drug coverage).

There are approximately 8.1 million low-income non-dual eligible beneficiaries who are expected to qualify for the subsidy based on income and assets.<sup>6</sup> These beneficiaries will not be automatically enrolled and have the greatest potential to both benefit from the MMA, but also to fail to realize its full advantage. Low-income beneficiaries will need to both apply for the subsidy (a four page document) as well as simultaneously enroll in a PDP.<sup>7</sup> Low income beneficiaries can and should apply now for the subsidy, in advance of the announcement of the PDPs in the fall. Then they can concentrate on choosing a plan come November. These administrative tasks will undoubtedly be difficult to many of these low-income beneficiaries and will require the assistance of their families, community members, in addition to ACU members. Without receiving this subsidy, these beneficiaries will face extraordinary costs that will put them at risk of nonadherence and consequently medical jeopardy.

The Social Security Administration (SSA) and Center for Medicaid and Medicare Services (CMS) are responsible for mailing out enrollment forms and information to dual eligibles and low-income beneficiaries in addition to forms available on the Internet. Beneficiaries may also apply to state Medicaid programs to receive benefits. If they meet the criteria for receiving the drug benefit subsidy, they will be required to enroll in a drug plan that has an average cost premium for that region. If they choose one that is above the average cost, they will be required to pay the difference. ACU members can provide education and assistance to beneficiaries directly, to family members of patients, or

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<sup>3</sup> The new Medicare prescription drug law: Issues for dual eligibles with disabilities and serious conditions. Kaiser Family Foundation. June 2004.

<sup>4</sup> Andy Schneider. "The Clawback: State financing of Medicare drug coverage." Kaiser Family Foundation. June 2004.

<sup>5</sup> Medicare: Low-income assistance under the Medicare drug benefit. Fact Sheet. Kaiser Family Foundation. May 2006.

<sup>6</sup> *Ibid.*

<sup>7</sup> *Ibid.*

coordinate with other providers to both educate and provide practical assistance to these patients. **Without prescription drug coverage, these low-income patients will potentially face exorbitant drug costs that will put them at risk for nonadherence and noncompliance that will place them in medical jeopardy.** Therefore, it is crucial for providers to work together to ensure that these patients do not fall through the cracks of the Medicare program.

Patients will also need assistance in finding a drug plan that best suits their needs. DEs need to evaluate the one they are automatically enrolled in and assess if it is adequate and if it is not, change to one that suits their needs. Low-income beneficiaries need to find a plan that best suits their needs and that is at or close to average cost so as not to incur any additional premium payments. CMS has stated that PDP formularies will be comprehensive and will exceed the minimum two drug options per drug class.<sup>8</sup> It is also important for ACU members to understand and communicate with patients that there are certain drugs that Medicare will not cover such as benzodiazepines, over-the-counter drugs, weight gain or weight loss drugs. These drugs are currently covered by state Medicaid programs. Therefore it is important for those who are eligible for Medicaid to remain enrolled in it.

## **Recommendations**

### **Providers Need to Assist Medicare Enrollees with Enrolling in Part D**

Providers should assist beneficiaries in finding alternative resources that may alleviate the financial burden of their drug costs. The cost-sharing imposed on DEs may be higher than what they previously experienced with their state Medicaid program. They will be required to pay \$1 for generics and \$3 for brand name drugs.<sup>9</sup> Although this is a small amount, many of these patients have six or more prescription drugs which can become a financial constraint based on their income level. Low-income beneficiaries will face even higher nominal co-payments of \$2 and \$5 for generic and brand name drugs, respectively.<sup>10</sup>

### **Providers Need to Help their Patients Utilize State Pharmacy Assistance Programs**

State pharmacy assistance programs (SPAPs) are a valuable resource in providing assistance to beneficiaries who have difficulty finding money to pay for cost-sharing, premiums, and deductibles. These programs vary from state to state. Some ways that SPAPs can “wrap around” the PDPs and provide additional coverage can be in the form of paying premiums, deductibles, and cost-sharing for drugs. While these programs are helpful for those who are financially burdened by drug costs, they are at risk of ending in states who are more fiscally strapped.

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<sup>8</sup> Robert Pear. “Medicare insists on wider choice in drug benefits.” *New York Times*, June 15, 2005, p. A1.

<sup>9</sup> Medicare: Low-income assistance under the Medicare drug benefit. Fact Sheet. Kaiser Family Foundation. May 2006.

<sup>10</sup> *Ibid.*

### **Providers Need to Help their Patients Utilize Patient Assistance Programs**

Patient assistance programs (PAPs) provided by pharmaceutical companies are an additional resource in dispensing free drugs to patients. While these programs are reducing the financial burden on patients and can also contribute to out-of-pocket drug costs, it is unclear whether they will be able to continue once MMA takes effect.<sup>11</sup>

As of now, ensuring that low-income beneficiaries reap the benefits of what Medicare has to offer coupled with alternative resources is of utmost importance. It will require the attention of all providers—pharmacists, physicians, nurse practitioners, social workers and others—to make Medicare effective for those who so desperately require recourse from high drug costs.

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<sup>11</sup> Rx for Access. “The future of PAPs under Medicare?” MedPin. Vol. 2, No. 5