

Q & A: Understanding the New Medicare Prescription Drug Benefit

◆ **When does the program begin?**

The new drug benefit will begin in 2006.

◆ **How much does it cost?**

Costs will vary by the plan you pick. The average plan premium in 2006 will be \$32.20 a month.

◆ **What will I get?**

There is a basic or standard benefit. With that benefit, after you pay the premium and a \$250 annual deductible, the plan will pay 75 percent of your drug costs (you pay 25 percent) until your total drug expenses reach \$2,250. After you reach \$2,250 in drug expenses in a year, your coverage stops and you have to pay for the next \$2,850 in drug expenses entirely by yourself. This is called the “doughnut hole.” Insurance coverage doesn’t start again until your drug expenses reach \$5,100. At that point, you’ve spent \$3,600 of your own money for prescription drugs plus the \$420 premium, and you now qualify for catastrophic coverage. For the rest of the year, you pay either a flat copayment of \$2 for every generic drug prescription and \$5 for every brand-name drug prescription, or 5 percent, whichever is greater. Plans can vary the benefit as long as it is of equal value to this standard benefit.

◆ **What will I have to pay?**

What you’ll have to pay—your out-of-pocket spending—will depend on your drug expenses. Here’s a table summarizing the benefit for different levels of drug expenses—the last column shows your combined total out-of-pocket cost (not including the premium):

In addition to the annual premium . . .			
If your drug costs are . . .	you pay . . .	up to . . .	Cumulative total amount out of your pocket
\$0 – \$250	100%	\$250	\$250
\$251 – \$2,250	25%	\$500	\$750
\$2,251 – \$5,100	100%	\$2,850	\$3,600
Over \$5,100	5%	No limit	\$3,600 plus 5% of costs above \$5,100

◆ **If my income is low, will I get any added help?**

Yes. There is additional help available for people with low incomes. Whether you qualify for this help—and what specific help you may get — will depend on your income and your assets. It will also depend on whether or not you are eligible for Medicaid. For example, your annual income may be less than 135 percent of the federal poverty level (in 2005, that's \$12,919 for a senior living alone or \$17,320 for a couple—the amount will be a little higher in 2006). If so, and if your total assets amount to no more than \$6,000 (for an individual) or \$9,000 (for a couple), you'll be able to get drugs for \$1-2 per prescription for generic drugs and \$3-5 for brand-name drugs. (Note: when determining the value of your "assets" to see if you qualify, the value of your home, your car, and some other non-cash assets [such as a wedding ring] are not counted. You should check with your state Medicaid office or local Social Security Office if you have questions about whether or not your assets are too high.) If you qualify for Medicaid, you're automatically eligible for low-income help. For more information on the help available for those with low incomes, see Families USA's *Extra Help Under Medicare's Drug Benefit: Do You Qualify?*

◆ **How do I get the new benefit?**

The drug benefit will be provided through private prescription drug plans that contract with the Medicare program. Managed care plans, like those currently in Medicare+Choice, can also provide the drug benefit. To receive the benefit, you'll have to sign up with a plan offering the drug benefit in your area.

◆ **Will there be a plan in my area?**

Yes. Medicare is required to contract with at least two plans that provide prescription drug coverage. There may be some areas in the country where no private plan, or only one plan, wants to participate. For those areas, the government will provide a "fall-back" plan, and those plans will offer the standard benefit.

◆ **Will all plans cost the same?**

No. Private plans can charge different premiums. They can also charge different copayments as long as the entire plan is of equal value (as determined by an actuary) to the standard plan described above.

◆ **Are all plans going to offer the same thing?**

No. The drugs covered can vary from plan to plan. Plans don't have to cover all drugs. Medicare has guidelines for what plans must cover, but those guidelines do not guarantee that all plans will offer the same thing. Plans are required to cover some drugs in all "therapeutic" classes. However, plans are not required to cover every drug in a class. For example, a plan may cover several drugs for high blood pressure that are similar to the one you take, but not yours. *You'll need to make sure that the plan you enroll in covers the drugs you need.* This is important because the plan will only pay for the drugs it covers and only those drugs count towards your deductible and out-of-pocket limit.

◆ **Will the amounts that I pay change over time?**

Yes. The deductible, and the size of the "doughnut hole" will grow each year based on increases in drug spending for the Medicare benefit. Thus, if Medicare drug costs skyrocket, so will your deductible and the "doughnut hole." Because drug spending increases much faster than regular inflation—and is projected to continue to do so—most people in Medicare will see the amounts they have to pay go up faster than their income.

Not only will the amounts you have to pay in deductibles and in the “doughnut hole” go up with drug spending in Medicare, but your premiums will increase as well. Premiums will be set based on plans’ bids. Plans will base their bids on drug costs. So, as drug spending goes up, you can expect to see your premiums increase, too.

◆ **Does the legislation prevent drug costs from skyrocketing?**

No. Drug companies, which spend more money lobbying Congress than any other health care group, succeeded in getting a bill that does virtually nothing to moderate drug costs. The legislation actually *prohibits* Medicare from using its purchasing power to negotiate lower drug prices for beneficiaries. While private health plans will seek discounts for those enrolled in their plans, they won’t have Medicare’s purchasing power, so they will have much less leverage to get lower prices.

◆ **Will I be allowed to buy cheaper drugs from Canada or other countries?**

No. Under the legislation, drugs can only be reimported from Canada, *and then only if the Secretary of Health and Human Services certifies both that reimportation is safe and that it would significantly reduce costs*. The Secretary has already issued a report finding that the cost of making individual reimportation safe is too high.

◆ **Who are the big winners in this legislation?**

The biggest winners are the drug companies and the managed care industry. They will reap much larger profits from this legislation.

The drug companies will gain a lot from the legislation. Not only are there no mechanisms to contain skyrocketing drug costs, but a new drug benefit will mean a much larger volume of sales. One Wall Street analyst estimated that drug sales could increase by as much as \$13 billion a year.

Private insurance companies that participate in the Medicare program also will gain a huge and unjustifiable windfall. Private plans “cherry pick,” enrolling the healthiest and youngest seniors, and, therefore, have considerably lower costs. Study after study has shown that they are overpaid because, despite their lower costs, they’re paid roughly the same per person as the traditional Medicare program, which serves older and sicker seniors. Despite such overpayments, the new legislation will provide these private plans with billions of dollars in increased payments. The legislation also includes a big opportunity for private plans to eventually gain even more by setting up demonstration programs that lay the groundwork for privatizing Medicare.

◆ **Will this change how Medicare operates?**

In 2010, Medicare will begin a “demonstration project” in six metropolitan areas. These demonstrations could radically alter Medicare. The communities where these demonstrations will be implemented have not yet been selected.

Traditional fee-for-service Medicare will competitively bid against private plans. Since traditional Medicare serves a much more expensive (older and sicker) population, its costs will be greater—and the legislation requires that most of those extra costs be passed on to Medicare’s enrollees. Over time, those costs will skyrocket, and fewer seniors will stay in traditional Medicare. As a result, the program will increasingly be privatized.

◆ **Does the bill provide any assistance before the new drug program begins in 2006?**

Starting in the spring of 2004 and ending by 2006, seniors will be able to purchase drug discount cards for about \$30 per year. Seniors with incomes below 135 percent of the federal poverty level (\$12,123 in annual income for a senior living alone or \$16,362 for a couple) will be able to get these discount cards for free and will also receive a credit worth \$600 embedded in the card (like a prepaid telephone card) to be used for the purchase of drugs—although you will also owe a copay of 5 to 10 percent on each purchase. This credit is pro-rated so if you apply in 2005, the amount you receive will be reduced. If you do not use all of the \$600, you *do not* get cash back.

These drug discount cards are similar to discount cards that many seniors have today. The legislation that creates these new discount cards does not set any rules about the base prices from which these discounts will occur. Thus, the value of any discount will be significantly eroded as base prices rise.

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