



CMA Weekly Alert – August 17, 2006

## CMS “TIP SHEET” ON THE PART D COVERAGE GAP IS NOT HELPFUL

The new Tip Sheet that the Centers for Medicare & Medicaid Services (CMS) has distributed to its Partners on “How the Coverage Gap works for People with Medicare Prescription Drug Plans” (Aug. 2006) is not helpful. It contains misleading and inaccurate slanting of information which will cause confusion for advocates who are trying to help Medicare beneficiaries navigate the complexities of Medicare Part D’s coverage gap.

<b>What the Tip Sheet says</b>	<b>In reality</b>
<p>“Many health insurance plans have limits on how much they will cover for prescription drugs, and Medicare drug plans are no different.” This sentence is the first sentence in the Tip Sheet.</p>	<p>No other health insurance plan has ever been structured like Part D plans, with first-day coverage, an enormous gap, and catastrophic coverage. Rather, Part D is more like two entirely separate plans, with a large hole in the middle.</p>
<p>“The good news is that Medicare drug plans provide catastrophic coverage if a person with Medicare has an unexpected illness or injury that results in extremely high drug costs.” This is the second sentence.</p>	<p>Catastrophic coverage is available to plan enrollees <i>only if</i> their prescription drug costs (for formulary drugs) are high enough to push them through the donut hole. Catastrophic coverage is not automatically available to all plan enrollees with high drug costs. Moreover, many beneficiaries need catastrophic coverage not because of an unexpected illness or injury but because of a chronic condition and high (and increasingly higher) prescription drug prices.</p>
<p>“This catastrophic coverage assures that almost all of their costs are covered after they have paid \$3,600 out-of-pocket.” This is the third sentence.</p>	<p>Beneficiary out-of-pocket costs are actually higher, since the premiums that beneficiaries pay are not included in the calculation. Additionally, only costs associated with formulary drugs count toward the \$3,600 figure, or true out-of-pocket costs (TrOOP), and only if the enrollee, a family member, or certain charities pay the costs. Payments made by ADAPs, employer plans, and pharmacy assistance programs are not included, even if the drugs are on the</p>

	<p>formulary. Plan enrollees who take non-formulary drugs pay the full costs of those drugs and these costs also are not counted towards satisfying the TrOOP. \$3600 is the minimum amount of out-of-pocket costs that an enrollee must pay before becoming eligible for catastrophic coverage (coverage beyond the donut hole); the real out-of-pocket cost may be considerably higher.</p>
<p>“After the person with Medicare has met their plan’s standard level of coverage and before they meet the catastrophic coverage, they will pay all of the costs for their drugs. This period is called the coverage gap (sometimes called the ‘donut hole’). Sentences four and five.</p>	<p>True. Beneficiaries must also continue to pay their monthly Part D premium, even though they receive no insurance benefit during this coverage gap.</p>
<p>“Only about 28% of people with Medicare who have drug coverage are in a plan that has a coverage gap.”</p>	<p>This statement is misleading because it suggests that most beneficiaries are in plans that do not have a donut hole. In fact, only thirteen percent (13%) of PDPs offer coverage for generic drugs in the coverage gap and only two percent (2%) offer coverage for generic and brand name drugs. Plans that offer the standard drug benefit do not offer gap coverage. The Humana plans with the lowest premiums, for example, are standard benefit plans. Moreover, many beneficiaries without a coverage gap are, as the Tip Sheet acknowledges, those who get their drug coverage from former employers or other insurance plans, not from Part D plans at all. And, even if a beneficiary is in a Part D plan that provides some assistance in the coverage gap, there is no assurance that the plan provides gap coverage for drugs taken by the particular beneficiary.</p>
<p>“People who have limited income and resources and qualify for full extra help will not be affected by the gap in coverage. However they will have to pay a small copayment or coinsurance amount for each prescription they get.”</p>	<p>“Small copayment” is in the eye of the payer. For many beneficiaries, these “small copayments” are new and completely unaffordable. Full benefit dual eligible beneficiaries who, until January 2006, got their prescription drug coverage from Medicaid now have higher costs and many are less able to get their prescription drugs.</p>

<p>“The person with Medicare should <b>always use their Medicare drug plan card</b>, even during the coverage gap.”</p>	<p>CMS’s case example, following this statement, belies this dubious advice.. CMS gives an example of a beneficiary using a pharmacy discount card to purchase a drug at a lower price than the plan’s negotiated price. CMS reminds beneficiaries buying a drug at a lower price to “send their receipt to their Medicare drug plan” in order to have the amount count towards the TrOOP. This example is a clear acknowledgement that Part D plan prices may not be the lowest drug prices.</p>
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Possible solutions for beneficiaries who are in the coverage gap:

- Beneficiaries in some states may be eligible for assistance through a State Pharmaceutical Assistance Program (SPAP) if their state has an SPAP and if they meet the eligibility criteria.
- Some current Part D enrollees may be eligible for the low-income subsidy, or extra help, which will provide assistance with costs through the donut hole.
- A few pharmacy assistance programs (PAPs) may provide some drugs at no or a reduced cost for people with Medicare; most do not. However, even if they do offer this service, payments made by a PAP do not count towards the \$3600, meaning that people who receive assistance from these programs may never reach the catastrophic coverage.

For most beneficiaries, unfortunately, there is no solution for the coverage gap. They must continue to pay the full cost of their drugs AND their Part D premiums until they either reach the out-of-pocket limit or until January 1, when the calculations begin all over again. A beneficiary who finally reaches the \$3600 on December 31 must start to accrue out-of-pocket costs all over again on January 1, in order to get out of the gap and get catastrophic coverage in the following year.

CMS’ failure to understand the adverse effect of the donut hole on older people and people with disabilities was apparent in this week’s announcement of the average Part D premium for 2007. Coming only a week after the donut hole tip sheet, the premium announcement fails to acknowledge that the lowest cost plans for 2007, like those in 2006, do not provide the donut hole coverage that CMS touts in its tip sheets. Once again, many Medicare beneficiaries may have to choose between low premiums and adequate prescription drug coverage.

The donut hole as a health care policy experiment has not been successful. Older people and people with disabilities need a prescription drug benefit that provides continuous coverage as long as their premium is paid, so that they are not faced with large, sudden drug care costs.

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