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The Medicare Drug Benefit: A Prescription for Confusion

Richard L. Kaplan*

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^{*}University of Illinois College of Law, rkaplan@law.uiuc.edu

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Abstract

This article examines the Medicare Part D prescription drug benefit that became effective on January 1, 2006. The article begins by setting forth the political development of this benefit and explaining the constraints that were imposed by the ill-fated attempt in 1988 to add prescription medications to Medicare's coverage. The article then examines the key components of the Medicare drug benefit, including its unique coverage gap known popularly as the "doughnut hole," and illustrates how beneficiaries will fare depending upon their level of annual drug expenditures. After considering the program's penalty for delayed enrollment, the article analyzes the perplexing decisions that Medicare Part D presents for Medicare beneficiaries who have drug coverage from former employers, medigap insurance policies, or managed care plans. The article concludes with some perspective about the uncertainties faced by older Americans as they contemplate what their drug regimens might entail in the future.



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THE MEDICARE DRUG BENEFIT: A PRESCRIPTION FOR CONFUSION

Richard L. Kaplan*

*Peer and Sarah Pedersen Professor, University of Illinois College of Law

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Richard L. Kaplan, Esq.*

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^{*} Richard L. Kaplan, Esq., is the Peer and Sarah Pedersen Professor of Law at the University of Illinois. He is the faculty advisor to *The Elder Law Journal* and a vice-chair of the Elder Law Committee of the American Bar Association's Senior Lawyers Division. He has been a member of NAELA since 1992. Portions of this article have been adapted from "Consumer Choice on Drugs: Medicare and Medications" (co-authored with Richard W. Olson), which appears as chapter 8 in "Consumer Choice: Social Welfare & Health Policy" (edited by Robert F. Rich & Christopher T. Erb), published by Transaction Publishers in 2005.

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I. Introduction

Near the end of 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act (hereinafter referred to as "the Act"), which represented the largest expansion of Medicare's scope since that program was created in 1965. Though the Act has many features affecting Medicare beneficiaries and the health care providers who care for them, its most salient part is the creation of a broadly available program to cover the cost of outpatient prescription medications.³ That part takes effect in 2006, more than two years after it was enacted. This delayed effective date recognizes the wide-ranging significance of this program, which is denominated Medicare Part D and is the focus of this article.

The article begins by setting forth some basic background to better understand the constraints under which Congress was legislating. It then considers the convoluted structure of the Medicare Part D benefit itself. The article then analyzes the options that Medicare enrollees and their advisors face in terms of Medicare Part D versus other arrangements for financing their prescription drug costs. The article concludes with some observations about the dilemmas that Medicare Part D presents for clients of elder law attorneys.

II. BACKGROUND TO THE 2003 ENACTMENT

A. Role of Drugs in Medical Care

In the nearly four decades since Medicare was enacted, the role of prescription drugs in medicine has changed radically. ⁵ Medications have been developed to control the debilitating effects of a wide range of maladies, especially chronic medical conditions such as diabetes, hypertension, asthma, and heart disease. Existing drug regimens, moreover, have been refined to more precisely target appropriate pharmaceutical interventions to patients with ever more individualized medical profiles. As a result, drug efficacy has increased while side effects have been minimized. The prospects for even greater pharmacological progress seem brighter than ever. The bottom line is that prescription drugs have become a major component of medical care for all Americans, but especially for those Americans who are aged 65 years and older. Consequently, many Medicare beneficiaries now take several different

- 1. Pub. L. No. 108-173, 117 Stat. 2066 (2003) [hereinafter "Act"].
- 2. See John K. Iglehart, The New Medicare Prescription Drug Benefit—A Pure Power Play, 350 New Eng. J. Med. 826, 826 (2004).
- 3. Act § 101(a) (2), 117 Stat. 2071-2075, adding Social Security Act § 1860D-1 (codified at 42 U.S.C. § 1395w-101).
- 4. Act § 101(a) (2), 117 Stat. 2072, adding Social Security Act § 1860D-1(a)(2).
- 5. See Jennifer Rak, Note, An Rx for Reform: A Medicare Prescription Drug Benefit, 12 Health Matrix 449, 451-56 (2002).
- 6. See Earl P. Steinberg et al., Beyond Survey Data: A Claims-Based Analysis of Drug Use and Spending by the Elderly, Health Aff. (Mar.-Apr. 2000), at 198, 199.

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pills as part of their regular routine, rather than for specific episodes of some medical incident.

Related to this development is the significant increase in the cost of drug regimens. Drugs tailored for specific populations are usually more expensive than drugs for common conditions, and as the range of available medications has grown, their cost has become a major expense for clients who need to take these medications on a more-or-less permanent basis. According to recent estimates, prescription drugs constitute the second largest component of seniors' out-of-pocket medical expenses.⁸

B. Medicare's Noncoverage of Drugs

Yet Medicare, the health care system for older and disabled Americans, does not cover the cost of prescription drugs outside the hospital context. That was the situation in 1965, and Medicare's coverage had not responded to the greatly increased prominence of drug therapy in modern medicine. Indeed, Medicare in 2003 was one of the few general health care plans available to Americans that did not provide some coverage of outpatient medications, and certainly the most prominent.

In many cases, this situation leads to medically bad and economically perverse Because Medicare does not cover the cost of needed medications, some Medicare patients forego taking these pills to avoid the associated expense. If the underlying medical condition subsequently gets out of control, the patient often requires hospitalization to stabilize his or her situation. The cost of such hospitalization exceeds the cost of the drugs that were not taken by many degrees of magnitude, but Medicare covers the costs of hospital care, largely in full. Thus, Medicare's lack of drug coverage often ends up costing the program many times more than the cost of maintenance drugs that could have prevented these hospitalizations.¹⁰ Indeed, it is precisely for this reason that some companies offer their employees prescription drugs at little or no financial cost: the expense of these drug regimens is dwarfed by the cost savings from prevented hospitalizations. 11 Medicare's lack of drug coverage, in other words, is both medically outdated as well as economically counterproductive.

^{7.} See Nat'l Inst. Health Care Mgmt. Found., Prescription Drug Expenditures in 2000: The Upward Trend Continues 2-3, 9-10 (2001), available at www.nihcm.org/spending2001.pdf.

^{8.} Craig Caplan & Normandy Brangan, Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older in 2003, AARP Pub. Pol'y Inst. Data Digest (Sept. 2004), at 1.

^{9. 42} U.S.C. § 1395x(b)(2000); see generally Lawrence A. Frolik & Richard L. Kaplan, Elder Law in *a Nutshell* 67-68 (3d ed. West Group 2003).

^{10.} See Robert Pear, Clinton Will Seek a Medicare Change on Drug Coverage, N.Y. Times A1 (June 8, 1999) (reporting that every \$1 spent on prescription drugs saves \$3.65 on hospital costs).

^{11.} See Vanessa Fuhrmans, A Radical Prescription, Wall St. J. R3 (May 10, 2004).

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C. Prior Attempt to Add Drug Coverage to Medicare

To be sure, Congress tried to address this problem previously in the Medicare Catastrophic Coverage Act of 1988 (MCCA), ¹² which authorized Medicare to cover the cost of prescription drugs.¹³ MCCA financed the cost of this new coverage through a monthly premium of \$4 and fifteen-percent surtax on the federal tax liability of Medicare enrollees with tax liabilities in excess of \$150. 14 This surtax was limited to a maximum of \$800 per person (or \$1,600 per married couple), ¹⁵ and only the wealthiest 5 percent of Medicare beneficiaries were expected to pay the maximum amount.¹⁶ Indeed, only about 36 percent of Medicare enrollees were projected to owe any surtax at all.¹⁷ Nevertheless, the outcry from those senior citizens who anticipated that they would pay this additional charge was so vociferous that Congress repealed MCAA's financing provisions and the associated drug benefit the very next year. 18 The widely televised scene of angry senior citizens (who were dubbed the "Gray Panthers") literally assaulting the Chairman of the House Ways and Means Committee and preventing him from getting into his car¹⁹ seared the collective memory of the Congress and affected how they approached the issue of adding prescription drugs to Medicare in 2003.

D. Political Development of the Medicare Drug Issue

The repeal of MCAA, however, did not eliminate the problem of paying for increasingly expensive prescription drugs. Less than a decade later, older Americans made adding a prescription drug benefit to Medicare a hot political issue. Candidates competed for the votes of this politically engaged and well-organized constituency by offering various plans, with different levels of co-payments, deductibles, annual limitations, and other key programmatic parameters.²⁰ This issue was a major focus in the election of 2000,²¹ though nothing actually passed the Congress. The issue gained

- 15. Id.
- 16. Id.
- 17. *Id*.
- 18. Id. at 96.
- 19. Id. at 29-31.
- See Stephen B. Soumerai & Dennis Ross-Degnan, Inadequate Prescription-Drug Coverage for Medicare Enrollees—A Call to Action, 340 New Eng. J. Med. 722, 724-27 (1999) (discussing Congressional proposals for adding drug coverage to Medicare); see also Laurie McGinley & Jacob M. Schlesinger, Clinton Drug-Benefit Plan Recasts Medicare Debate, Wall St. J. A28 (June 28, 1999).
- See, e.g., Laurie McGinley & Shailagh Murray, Lawmakers Sweeten Drug-Benefit Plans to Gain Edge With Voters, Wall St. J. A48 (June 26, 2000); David Brown, For Medicare, An Inadequate Prescription, Wash. Post A1 (June 26, 2000); Jackie Calmes & Laurie McGinley, Bush Unveils

^{12.} Pub. L. No. 110-360, 102 Stat. 683 (1988); see generally Theodore R. Marmor, The Politics of Medicare 110 (2d ed. Aldine de Gruyter 2000).

^{13.} Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 110-360, § 202, 102 Stat. 683, 702 (1988).

^{14.} See Richard Himelfarb, Catastrophic Politics: The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988 40 (Pennsylvania State Univ. Press 1995).

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renewed prominence in the mid-term elections of 2002,²² and President George W. Bush did not want to go into the 2004 election with no resolution of this issue, especially since his own Republican Party had controlled both the House of Representatives and the Senate throughout his presidential term.²³ The product of these political imperatives was a concerted effort throughout 2003 to provide a drug benefit in Medicare that would update that program's coverage without engendering the sort of uncontrollable anger that doomed MCCA fourteen years earlier.²⁴ The need to address this issue was bolstered by a survey that was conducted by AARP in 2002.²⁵ That survey asked respondents who were at least 45 years old the following question "How would you feel if the Senate fails to pass a prescription-drug bill this year?" Fully 61 percent replied "angry." ²⁶

Congress passed the Act in 2003 after much internal wrangling,²⁷ and President Bush signed it on December 8 of that year. It provided some interim relief in the form of drug discount cards²⁸ that became available in mid-2004, but the real drug benefit, Medicare Part D, starts in 2006.

III. THE ACT'S DRUG COVERAGE

A. Design Objectives

In fashioning a drug benefit for Medicare, Congress had several objectives that affected the design of the program that was ultimately adopted. First, it had to be

- Prescription-Drug Benefit for Medicare as Remedy for Campaign, Wall St. J. A28 (Sept. 6, 2000); Helen Dewar, Medicare Drug Benefits: A Case of Conflicting Claims, Wash. Post A11 (Oct. 3, 2000); Shailagh Murray, A Couple Wonders: Which Drug Plan Will Help Them?, Wall St. J. A20 (Oct. 27, 2000).
- 22. See Sarah Lueck, Why Drug-Benefit Bills Abound Despite Long Odds, Wall St. J. A4 (May 2, 2002); Sarah Lueck, Senior Drug Plan Hits the Campaign Trail, Wall St. J. A4 (Aug. 12, 2002); Sarah Lueck et al., Risky Business: Bush's Medicare Plan, Wall St. J. A4 (Dec. 23, 2002).
- 23. See Iglehart, supra n. 2, at 826.
- 24. See William G. Weissert, Medicare Rx: Just a Few of the Reasons Why It Was So Difficult to Pass, Pub. Pol'y & Aging Rep. (Fall 2003), at 1; see also Thomas R. Oliver et al., A Political History of Medicare and Prescription Drug Coverage, 82 Milbank Q. 283 (2004).
- 25. See Sarah Lueck, Senior Drug Plan Hits the Campaign Trail, Wall St. J. A4 (Aug. 12, 2002) (reporting survey conducted between July 31 and August 4, 2002).
- 26. Id.
- 27. See, e.g., David Wessel, Medicare Cures: Easy to Prescribe, Tricky to Predict, Wall St. J. A1 (June 30, 2003); Laurie McGinley & Sarah Lueck, Medicare Bill: Prescription for Politics, Wall St J. A4 (July 14, 2003); Laurie McGinley & Sarah Lueck, You Say 'Protect' and I Say 'Improve', Wall St. J. A4 (July 29, 2003); Sarah Lueck, Drug Plan: Condition Critical?, Wall St. J. A4 (Sept. 24, 2003); David Rogers, Medicare Talks Stall at Ideological Impasse, Wall St. J. A4 (Nov. 6, 2003); Laurie McGinley & Sarah Lueck, Behind Drug-Benefit Debate: How to Mix Medicare, Markets, Wall St. J. A1 (Nov. 17, 2003). See generally Iglehart, supra n. 2, at 827-29; Oliver et al., supra n. 24, at 309-16.
- 28. Act § 101(a)(2), 117 Stat. 2131-2148, adding Social Security Act § 1860D-31. See generally Keith D. Lind, Medicare Drug Discount Card Program: How Much Does Card Choice Affect Price Paid? (AARP Pub. Pol'y Inst. 2004).

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voluntary. The overriding lesson that was taken from the enactment of MCCA and its subsequent repeal was that many seniors do not want to pay for a benefit that they personally do not need. For that reason, only those persons who choose to be part of the new program are assessed monthly premiums to pay for it. Those who do not want its benefits have the option of nonenrollment and avoidance of additional costs.

Second, and a direct correlate of this voluntariness principle, the program must provide real benefits at a fairly modest level of annual drug expenditures. That is, like most medical phenomena, the distribution of drug expenses is highly concentrated, with most patients having minimal financial exposure and a relatively few patients having very significant expense²⁹ But to better spread the risks of insuring this population, the program must appeal to a broad range of Medicare enrollees and not just to those with the highest anticipated drug costs.

Third, government funds are always limited, so the program must choose its targets carefully. Indeed, some lawmakers opposed creating *any* drug benefit in Medicare because such an addition necessarily increases that program's long-term financial solvency problems. Thus, some programmatic limits were politically required, but there was considerable agreement that Medicare should provide significant benefits to those with minimal financial resources and to those whose drug needs are particularly expensive.

B. The Act's Coverage Components

To accommodate the plan design objectives just described, Medicare Part D was fashioned like no other pharmaceutical coverage in the world. It has several distinct components:

- Premiums of approximately \$35 per month, according to the best available current estimates.³⁰
- Annual deductible of \$250, for which the enrollee pays all of the cost.³¹
- A 25 percent coinsurance for the next \$2,000 of annual pharmaceutical expenditures; i.e., for annual drug costs of \$2,250.³²
- A 100 percent coinsurance that is, no benefits whatsoever for the next \$2,850 of annual pharmaceutical expenses; i.e, annual costs of \$5,100, colloquially referred to as the "doughnut hole."
- A 5 percent coinsurance for all remaining pharmaceutical expenses; i.e., annual drug costs in excess of \$5,100.³³

^{29.} *See* Michael E. Gluck, *A Medicare Prescription Drug Benefit*, Nat'l Acad. Soc. Insurance Medicare Brief No. 1, http://www.nasi.org/Medicare/Briefs/medbr1.htm (April 1999).

AARP Bulletin, What Does the New Medicare Drug Benefit Mean to You?, http://www.aarp.org/bulletin/prescription/Articles/a2003-11-26-foryou.html (December 2003).

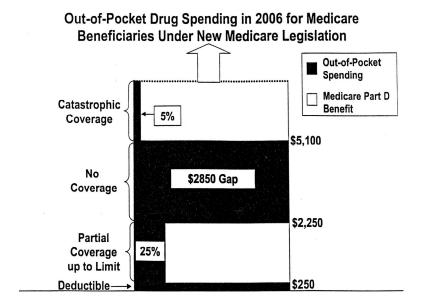
^{31.} Act § 101(a)(2), 117 Stat. 2077, adding Social Security Act § 1860D-2(b)(1). The \$250 annual deductible will be indexed after 2006.

^{32.} Act § 101(a)(2), 117 Stat. 2077, adding Social Security Act § 1860D-2(b)(2), (3). The \$2,250 upper benefit limit will be indexed after 2006.

^{33.} Act § 101(a)(2), 117 Stat. 2077-2078, adding Social Security Act § 1860D-2(b)(4). The \$5,100

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This bizarre scheme can be represented graphically³⁴ as follows:



From this brief description, several key features are evident. First, monthly premiums of \$35 (approximately) translate into an annual cost of \$420, which when combined with the plan's annual deductible of \$250, means that persons who anticipate drug costs of less that \$670 per year may choose not to enroll in Medicare Part D. Accordingly, there is significant potential for "adverse selection" whereby only those persons who expect to pay more than \$670 per year for prescription drugs will enroll in this plan. And, a plan that contains only persons who expect to receive benefits in excess of their contributions cannot fulfill the "risk spreading" function that is the essence of insurance.³⁵

Second, all of the plan's parameters depend upon cumulative expenditures. Part D enrollees must therefore maintain ongoing records of total drug costs or utilize a single pharmaceutical outlet that will keep track of these costs. Once the so-called "doughnut hole" level is reached in which Part D pays no benefits (i.e., annual costs between \$2,250 and \$5,100), these records become even more important, because they ensure that the final level of 5 percent coinsurance (i.e., annual costs exceeding \$5,100) is accurately monitored.

threshold will be indexed after 2006. At this level, the consumer will pay \$2 per prescription for generic drugs and \$5 per prescription for brand name drugs, if these amounts exceed 5 percent of the drugs' cost.

^{34.} Adapted from The Medicare Prescription Drug Benefit, http://www.kff.org/medicare/medicarebenefitataglance.cfm (last accessed Sept. 15, 2005).

^{35.} See Congressional Budget Office, Issues in Designing A Prescription Drug Benefit for Medicare 20 (2002).

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Third, this arrangement requires its enrollees to pay substantial sums before benefits are received. For example, after the \$2,250 tier is reached, the enrollee must incur annual drug expenses of another \$2,850 before a single penny of Medicare benefit is obtained. As a result, Medicare Part D potentially leaves significant costs in the hands of its enrollees.

In this connection, consider Lynette whose medical condition requires her to spend \$500 per month, or \$6,000 per year, on prescription drugs. Under Medicare Part D, her portion of these costs would be determined as follows:

| Monthly premium (\$35, estimated) for twelve months | \$420 |
|---|---------|
| Annual deductible | 250 |
| Co-payment of 25 percent for costs between | |
| \$250 and \$2,250 (i.e., \$2,000) | 500 |
| All costs between \$2,250 and \$5,100 | 2,850 |
| Co-payment of 5 percent for costs exceeding | |
| \$5,100 (i.e., \$6,000 - \$5,100 = \$900) | 45 |
| Total costs to Lynette | \$4,065 |

Thus, even with Medicare Part D, Lynette ends up paying more than two-thirds of her total drug expenditures.

The impact of this multi-level cost-sharing arrangement is illustrated by the following chart:³⁶

| Annual Drug Costs | Enrollee Pays* | Net Savings |
|-------------------|----------------|-------------|
| \$ 500 | \$ 732.50 | \$ 0 |
| \$ 1,000 | \$ 857.50 | \$ 142.50 |
| \$ 1,500 | \$ 982.50 | \$ 517.50 |
| \$ 2,000 | \$1,107.50 | \$ 892.50 |
| \$ 2,500 | \$1,420.00 | \$1,080.00 |
| \$ 3,000 | \$1,920.00 | \$1,080.00 |
| \$ 5,000 | \$3,920.00 | \$ 1,080.00 |
| \$10,000 | \$4,265.00 | \$5,735.00 |
| | | |

^{*} Includes \$250 annual deductible and estimated \$35 monthly premiums.

Notice that even at a fairly catastrophic level of \$10,000 per year of annual drug costs, the enrollee pays nearly 43 percent of the total bill.

^{36.} Adapted by author from Patricia Barry, 'An Opportunity We Can't Let Pass', AARP Bulletin (Dec. 2003), at 4.

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Recognizing that this scheme would be particularly harsh on lower-income enrollees, Congress provided more generous benefits to persons with limited income. Beneficiaries with limited savings and incomes below 135 percent of the federal poverty line receive the following: (1) no deductible, (2) no monthly premiums, (3) no gap in coverage, (4) co-payments of \$2 for generic drugs and \$5 for all other drugs, up to an out-of-pocket limit of \$3,600, and (5) no co-payment for prescriptions once the out-of-pocket limit is reached.³⁷ In 2006, 135 percent of poverty is projected to require annual incomes below \$13,000 for a single individual and \$17,000 for married couples.³⁸

Beneficiaries with limited savings and incomes below 150 percent of the federal poverty line receive the following: (1) a sliding scale monthly premium that would be about \$35 for beneficiaries with incomes of 150 percent of the federal poverty level, (2) an annual deductible of \$50, (3) no gap in coverage, (4) coinsurance of 15 percent up to an out-of-pocket limit of \$3,600, and (5) co-payment of \$2 or \$5 once the out-of-pocket limit is reached.³⁹ In 2006, 150 percent of poverty is projected to require annual incomes below \$14,000 for a single individual and about \$19,000 for a married couple.⁴⁰

For persons whose income exceeds 150 percent of federal poverty levels, Medicare Part D's benefit structure applies as explained above.

C. Delayed Enrollment Penalty

To counter the adverse selection phenomenon that a voluntary program like Medicare Part D necessarily has, the Act provides that delaying enrollment has a financial cost. A late enrollee will be accepted regardless of his or her medical condition—unlike the medical underwriting that private insurance plans employ. But the premium that will be charged will be increased as long as that enrollee remains in Medicare Part D. Thus, a decision to defer enrollment in Part D has financial consequences if an eligible person eventually chooses to enroll in this program.

Subject to certain actuarial limits, the penalty is 1 percent for every month during which a beneficiary did not have "creditable" prescription drug coverage. For example, assume that Paul decides not to obtain any drug coverage in the first five years during which he was eligible to enroll in Medicare Part D. Five years is sixty months, so Paul will face a 60 percent penalty if he subsequently enrolls in Part D. If the monthly premium by then is, say \$45, Paul will pay 60 percent (i.e., \$27) more, resulting in a monthly premium of \$72 instead of \$45. And as the monthly Part D premium increases over time, the 60 percent penalty will be applied to whatever the

^{37.} Act § 101(a)(2), 117 Stat. 2107-2108, adding Social Security Act § 1860D-14(a)(1).

^{38.} U.S. Dep't Health Human Services, *Medicare Modernization Act Briefing Book* (2004), at sec. 2-19.

^{39.} Act § 101(a)(2), 117 Stat. 2108-2109, adding Social Security Act § 1860D-14(a)(2).

U.S. Dep't Health Human Services, Medicare Modernization Act Briefing Book (2004), at sec. 2-19.

^{41.} Act § 101(a)(2), 117 Stat. 2104, adding Social Security Act § 1860D-13(b)(1).

^{42.} Act § 101(a)(2), 117 Stat. 2104, adding Social Security Act § 1860D-13(b)(3)(A).

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current charge becomes. This 60 percent surcharge continues, it should be emphasized, as long as Paul remains in Medicare Part D. It never ceases.

This penalty does not apply, however, if a Medicare beneficiary has "creditable" coverage prior to that person's enrolling in Medicare Part D.⁴³ "Creditable" coverage is drug coverage that meets or exceeds the actuarial value of the Medicare Part D prescription drug coverage.⁴⁴ "Creditable" coverage can be:

- A prescription drug plan or managed care plan with drug benefits;
- Medicaid:
- A group health plan (including the Federal Employees Health Benefit plan and a "qualified retiree prescription drug plan");
- A state pharmaceutical assistance program;
- Veterans' coverage of prescription drugs;
- Prescription drug coverage under a medigap plan;
- Military coverage,: and
- Any other coverage that the government determines is appropriate.

Clearly, many alternatives are available, but if an enrollee "goes bare," as Paul did in the preceding example, the deferred enrollment penalty will apply if the enrollee subsequently enrolls in Medicare Part D.

IV. CLIENT-CENTERED DECISION-MAKING

The prescription drug benefit in Medicare Part D will appeal to many clients, but for other clients, the decision will be more complicated. The source of this complication is that three out of four Medicare beneficiaries already had some sort of drug coverage before Medicare Part D was enacted. According to the Centers for Medicare and Medicaid Services, the administrative agency that operates Medicare, approximately 12 percent had drug coverage through Medicaid based on their dual eligibility, and another 5 percent had such coverage through the Veterans' Administration, Department of Defense, or certain income-based state programs outside of Medicaid. For these persons, the new drug benefit in Medicare probably changes relatively little.

But fully 33 percent of Medicare beneficiaries had some degree of drug coverage through employer-sponsored plans, 15 percent had such coverage through private medigap insurance, and another 11 percent were enrolled in Medicare managed care plans. In other words, of those Medicare beneficiaries who have drug coverage presently, nearly four out of five face the dilemma of staying with their present arrangement or electing Medicare Part D in its place. This section focuses on their situations.

^{43.} Act § 101(a)(2), 117 Stat. 2104, adding Social Security Act § 1860D-13(b)(2).

^{44.} Act § 101(a)(2), 117 Stat. 2105, adding Social Security Act § 1860D-13(b)(5).

^{45.} Act § 101(a)(2), 117 Stat. 2104-2105, adding Social Security Act § 1860D-13(b)(4).

^{46.} Editorial, Medicare Moment of Truth, Wall St. J. A20 (Oct. 22, 2003).

^{47.} See id.

^{48.} See id.

^{49.} Employer-sponsored plans (33%) + medigap (15%) + managed care (11%) = 59%, which as a

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A. Employer-Sponsored Coverage

Employer-sponsored health insurance for retirees usually includes some degree of drug coverage. But such plans come in a wide array of variations, with differing levels of monthly premiums, co-payment levels for individual prescriptions, and lists of included pharmaceuticals. Many of these plans simply continue benefits that the retiree received while he or she worked at the plans' sponsoring employer.

1. Patterns of Declining Coverage

Many people with such coverage, however, are concerned that they might lose their benefits or that the existing coverage will be curtailed in the future. Such concerns have a substantial basis in fact. Health benefits generally are an increasingly expensive component of employee compensation packages, and drug benefits in particular are often targeted for cutbacks of one sort or another. After all, employers have no legal obligation, barring union contracts or other binding arrangements, to provide *any* drug coverage. And when changes in existing plans are contemplated, which group of beneficiaries is an employer more likely to select to bear a larger share of these costs—current employees or retirees? As a result, employers regularly make changes in retiree health benefit plans, whether by increasing the monthly charge paid by retirees, increasing the co-payment amount or percent paid by retirees for covered services, or restricting the formulary to specified medications or their generic equivalents.⁵⁰

Overall, the percentage of private-sector employers that offer health benefits to Medicare-eligible retirees has declined from 20 percent in 1997 to 13 percent in 2002.⁵¹ Even among very large such employers, those with 1,000 or more employees, the percentage that provides health benefits to their retirees has declined from 80 percent in 1991 to 56 percent in 2003.⁵² Moreover, a survey of employers about anticipated changes in existing retiree health benefit plans revealed that the most likely change was to increase the retirees' share of the premium cost.⁵³ Making the plans more generous was considered unlikely by nine out of ten responding employers.⁵⁴ Little wonder then that even retirees with retiree health plans that include drug benefits are fearful of what changes may be forthcoming to their plans.

This fear became especially palpable on April 23, 2004 when a federal agency, the Equal Employment Opportunity Commission (EEOC), approved a rule that explicitly allows employers to reduce or eliminate company-provided health benefits

percent of the 76% of Medicare enrollees who have prescription drug coverage, is 78%.

See Ellen E. Schultz & Theo Francis, Employers' Caps Raise Retirees' Health-Care Costs, Wall St. J. B1 (Nov. 25, 2003); Paul Fronstin, Retiree Health Benefits: Trends and Outlook, Emp. Ben. Res. Inst. Issue Brief No. 236 (2001), at 9.

^{51.} Paul Fronstin, *The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees*, Emp. Ben. Res. Inst. Issue Brief No. 279 (2005), at 4.

^{52.} *Id.* at 7.

^{53.} Id. at 11.

^{54.} *Id*.

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to Medicare-eligible retirees.⁵⁵ This rule reversed the EEOC's prior policy that held such changes to violate the Age Discrimination in Employment Act.⁵⁶ In fact, this new rule purports to overturn a court victory by retirees who challenged an employer that offered lower benefits to Medicare-eligible retirees than to retirees who were not yet eligible for Medicare benefits.⁵⁷ Whether the new EEOC policy will be upheld in court remains to be seen,⁵⁸ but it is difficult to interpret this change as anything other than a green light to employers who want to lower their operating expenses by curtailing health benefits for former employees.

2. Stay or Switch to Medicare Part D

For persons who presently have employer-sponsored coverage of prescription drugs, the question of whether they should switch to Medicare Part D is particularly difficult. Without a doubt, the most problematic aspect of this dilemma is trying to divine what the employer-sponsored plan will look like in the future. Will the employer raise the monthly premium that the retiree pays? Will the co-payment level be increased? Will the plan's drug coverage apply only to generic pharmaceuticals or those available from so-called "multiple sources"? Will an annual cap be imposed or an existing cap lowered? Will the plan be terminated in its entirety? This last concern was critical even before the EEOC's ruling that employers may terminate plans for Medicare-eligible retirees without violating the age discrimination statute. How much *more* likely will employers be to terminate their plans now that Medicare Part D provides an alternative?

This issue of "crowding out," of Medicare Part D encouraging employers to drop their existing coverage of retirees' drug costs, was an extremely critical issue in the Act's development.⁵⁹ Indeed, this issue was one of the most contentious aspects of the Medicare drug debates and required some resolution or the Act might never have been enacted.⁶⁰ How, then, does the Act resolve this conundrum?

An employer may provide drug coverage that is better than the coverage provided by Medicare Part D. Alternatively, an employer may provide coverage to its retirees that supplements the prescription drug benefits provided under Medicare Part D, a Private Drug Plan (PDP), or a managed care alternative, the Medicare Advantage-Prescription Drug (MA-PD) plan. Because many seniors currently benefit from employer-sponsored health care coverage, the Act provides a federal subsidy to employers that maintain their current coverage of prescription drugs for retirees. Once

^{55.} See Laurie McGinley & Sara Schaefer Muñoz, EEOC Votes to Let Employers Cut Retirees' Health Benefits, Wall St. J. A6 (Apr. 23, 2004).

^{56. 29} U.S.C. § 621 (2000).

^{57.} Erie Co. Retirees Ass'n v. County of Erie, Pa., 220 F.3d 193 (3d Cir. 2000).

^{58.} See AARP v. Equal Employment Opportunity Comm'n, 34 Employee Benefit Cas. (BNA) 2138, 2005 WL 723991 (E.D. Pa.) (ruling that the EEOC's regulation is contrary to law and may not be implemented), vacated 2005 WL 2373863 (E.D. Pa.).

^{59.} See Weissert, supra n. 24, at 4; Wessel, supra n. 27, at A1.

^{60.} See Laurie McGinley et al., A Guide to Who Wins and Loses In Medicare Bill, Wall St. J. B1 (Nov. 18, 2003).

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certain criteria are met, an employer can receive a payment equal to 28 percent of the beneficiaries' drug costs between \$250 and \$5,000 per year. As a result, this federal subsidy will vary from employer to employer but might be as high as \$1330 per beneficiary per year.

To qualify for this subsidy, employers must take three steps to provide coverage that constitutes a "qualified retiree prescription drug plan." First, the employer or sponsor of the plan must prove to the government that the actuarial value of the employer's plan is at least equal to the actuarial value of the prescription drug coverage under Medicare Part D. Second, the employer or sponsor must provide the necessary documents to the government to verify the adequacy and payment of coverage. Third, the employer must notify individuals who are eligible for Medicare Part D if the employer's coverage does not meet the actuarial equivalence requirement, so these individuals can enroll in a prescription drug plan, a MA-PD plan, or apply for a waiver of the equivalency requirement.

The open question, of course, is how will employers react to the Act's proffered subsidy. After all, many employers already receive substantial federal tax benefits when they deduct the cost of prescription drug benefits from their taxable income. For taxable employers, this deduction is equivalent to a subsidy from the federal government of as much as 35 percent. Now, those employers will receive an *additional* 28 percent subsidy from the Act's provisions. This additional subsidy, moreover, is free of federal income tax. To be sure, some employers do not owe any federal income taxes; e.g., state and local governments, charitable organizations, and profit-seeking enterprises with substantial tax losses being carried forward to offset current income. But all employers can benefit from the 28 percent subsidy payments.

On the other hand, this subsidy relates to the cost of providing drug benefits only *up to* \$5,000 per year. More generous prescription drug benefits yield no additional federal subsidies to the sponsoring employers. Will those employers, therefore, modify their plans to cap an individual retiree's prescription medication expenditures at \$5,000 per year? Will the 28 percent subsidy be sufficient to overcome the other tendencies to curtail or limit existing retiree health coverage of prescription drugs? No one knows, but the stakes are huge, both for employers with existing drug benefit plans and for their retirees.

^{61.} Act § 101(a)(2), 117 Stat. 2126, adding Social Security Act § 1860D-22(a)(3)(A), (B). The \$250 and \$5,000 thresholds will be indexed after 2006.

^{62.} That is, the maximum qualifying coverage is \$4,750 (\$5,000 minus \$250), which when multiplied by 28 percent, yields \$1,330.

^{63.} Act § 101(a)(2), 117 Stat. 2125-2126, adding Social Security Act § 1860D-22(a)(2).

^{64.} Act § 101(a)(2), 117 Stat. 2125, adding Social Security Act § 1860D-22(a)(2)(A).

^{65.} Id. at § 1860D-22(a)(2)(B).

^{66.} Act § 101(a)(2), 117 Stat. 2105-2106, 2126, adding Social Security Act §§ 1860D-13(b)(6)(B)(ii), 1860D-22(a)(2)(C).

^{67.} A tax deduction reduces an employer's federal tax liability by the applicable tax rate, which can be as high as 35 percent. I.R.C. § 1(i)(2) (individual taxpayers), § 11(b)(1)(D) (corporations).

^{68.} Act § 1202(a), 117 Stat. 2480, adding I.R.C. § 139A.

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Some employers that do not currently provide drug coverage for their retirees might even be encouraged to start doing so. Such a development would undoubtedly benefit the retirees of these employers, since employer-sponsored drug benefit plans do not have the strange benefit structure that characterizes Medicare Part D, especially the coverage gap or "doughnut hole." But for employer plans with annual caps, some retirees might actually fare better under Medicare Part D. After all, once an enrollee reaches the last tier of benefits, annual drug costs of \$5,100, all further drug expenditures are covered by Medicare to the extent of 95 percent with no upper limit. Thus, definitive conclusions are not possible, but it is likely that new and different options will be created in response to the 28 percent employer subsidy for retiree drug benefits.

B. Medigap Insurance

Many Medicare beneficiaries purchase private insurance policies that purport to fill in the gaps in Medicare's various coverages. These policies, collectively styled "medigap" insurance, come in ten standardized versions, only the three most comprehensive of which (Plans H, I, and J) have any coverage of prescription drugs. Typically, these policies are also the most expensive medigap policies available. And since medigap policies are not subsidized by the federal government, individual policyholders bear the entire cost of these policies in the typical circumstance. In any case, medigap premiums are not guaranteed and are subject to periodic—if not annual—increases. At some point, medigap policyholders may feel the need to drop their policies or perhaps switch to a less expensive, and therefore less comprehensive, medigap policy. In those situations, the new medigap policy is usually one of the seven versions that have no coverage of prescription medications.

Even those medigap policies that cover prescription drugs provide less than what some retirees need. For example, medigap Plans H and I cover prescription drugs but have an annual cap of only \$1,250—a figure that has not been adjusted for inflation since medigap policy benefits were standardized in 1990.⁷¹ This cap applies, moreover, after an annual deductible of \$250 has been met and a 50 percent coinsurance amount has been applied.⁷² That is, a medigap policyholder pays the first \$250 of annual drug expenses and then pays half of all further costs until the annual drug tab reaches \$2,750.⁷³ After that point, the policyholder bears *all* of the additional drug costs!

^{69.} See Frank B. McArdle et al., Large Firms' Retiree Health Benefits Before Medicare Reform: 2003 Survey Results, Health Aff.-Web exclusive (2004). http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.7v1 (last accessed July 26, 2005).

^{70.} See Frolik & Kaplan, supra n. 9, at 93-95.

^{71.} Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4351(a)(3), 104 Stat. 1388-126 to 1388-128 (1990) (codified at 42 U.S.C. § 1395ss(p) (2000)).

^{72.} See Frolik & Kaplan, supra n. 9, at 95.

^{73.} Medigap benefit of \$1,250 represents half of drug costs of \$2,500, plus an annual deductible of \$250, equals total drug costs of \$2,750.

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The only way to obtain more extensive drug coverage in a medigap policy is to opt for Plan J, the most comprehensive and most expensive medigap policy that is available. This plan has an annual cap of \$3,000 with the same \$250 annual deductible and 50 percent coinsurance features, so benefits continue until a policyholder's prescription drug expenditures exceed \$6,250 per year. Because of the high premium cost associated with Plan J, however, most people choose some other medigap policy, at least initially. But if a retiree does not obtain a medigap policy within the first six months of becoming eligible for Medicare benefits generally, the private companies that provide medigap policies may decline coverage because of a retiree's medical condition. As a result, unless a person buys an expensive medigap policy very early in his or her retirement, that person may find that such a policy is unavailable at any price.

In any case, the medigap decision becomes more complicated when drug benefits are available through Medicare Part D. Both alternatives involve out-of-pocket premiums and an annual deductible of \$250, but the similarities end there. As noted previously, medigap policies split the costs incurred after the annual deductible 50-50, while Part D picks up 75 percent of the tab. Medigap Plans H and I cap their benefits at an annual drug expenditure level of \$2,750, while Part D stops at \$2,250. Medigap Plan J continues to provide coverage until annual drug expenditures reach \$6,250, after which no further benefits are paid. In contrast, Medicare Part D has no upper limit as such and is actually quite generous once its final tier of benefits is reached; i.e., when annual drug expenditures exceed \$5,100. On the other hand, Medicare Part D has that odd coverage gap, or "doughnut hole," where no benefits are provided for annual drug costs that exceed \$2,250 but are less than \$5,100. How then to compare these alternatives, ⁷⁶ especially for Medicare beneficiaries who might face varying drug costs from year to year?

This dilemma is made more complicated still by the Act's provision that medigap policies with drug coverage may not be sold once Medicare Part D becomes effective. That is, current Medicare beneficiaries who obtain a medigap policy with drug benefits *before 2006* may renew that policy thereafter if they choose to do so. 78

^{74.} Medigap benefit of \$3,000 represents half of drug costs of \$6,000, plus an annual deductible of \$250, equals total drug costs of \$6,250.

^{75.} Persons applying for medigap insurance within the first six months of their Medicare Part B eligibility may not be declined because of their medical condition. 42 U.S.C. § 1395ss(s)(2)(A) (2000).

^{76.} For an attempt to undertake such a comparison, see Jack Rogers & John Stell, *The Medicare Prescription Drug Benefit: Potential Impact on Beneficiaries* 27-29 (AARP Pub. Pol'y Inst. (2004). Such efforts, however, are highly problematic, even if a client's projected drug costs are precisely knowable in advance, because premiums for medigap policies vary considerably across different localities and even among different insurers within the same locality. *See id.* at 28 n. 38. Moreover, medigap policies with drug benefits include 8-12 additional unrelated benefits, depending upon the particular plan, and determining the premium cost for the drug benefit alone requires "assumptions" that may be very conjectural. *See id.* at 28 n. 37.

^{77.} Act § 104(a)(1), 117 Stat. 2161, adding Social Security Act § 1882(v)(1)(A).

^{78.} Act § 104(a)(1), 117 Stat. 2161, adding Social Security Act § 1882(v)(1)(B).

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But *after 2005*, no one else can obtain a medigap policy with drug benefits; the only medigap insurance that will remain available are policies without any drug coverage. Thus, current Medicare beneficiaries who do not have a medigap Plan H, I, or J have a use-it-or-lose-it opportunity to acquire such a policy during 2005. After that year, drug coverage will no longer be available through medigap policies.

Moreover, a Medicare beneficiary who currently has a medigap policy with drug benefits must choose between renewing that policy or enrolling in Medicare Part D instead. Once Medicare Part D takes effect, any person who enrolls in that program may not also have a medigap policy with drug benefits. Such coverage would certainly be duplicative in large respects, and rarely a sound financial proposition. But the point is that the Act precludes Medicare beneficiaries from hedging their bets by: (a) renewing an existing medigap policy with drug benefits, and (b) simultaneously enrolling in Part D. One, and only one, of these two alternatives is permissible. Furthermore, if a beneficiary does not renew a medigap policy that has drug benefits, that person cannot reinstate that medigap policy after 2005. Thus, the dilemma of choosing Medicare Part D or a medigap policy with drug benefits is fraught with one-time and essentially irreversible decisions.

To make the transition from medigap to Medicare Part D a little less jarring, the Act provides that persons who drop their medigap coverage when they enroll in Medicare Part D may purchase a medigap Plan A, B, C, or F policy on a guaranteed basis. That is, persons in this circumstance cannot be declined one of the four specified types of medigap policies based on their medical condition. That provision is necessary because people in this situation would usually be beyond their first six months of Medicare eligibility, and thus no longer protected by the guaranteed-issuance provision that applies to medigap policies generally.

Still another alternative for medigap policyholders who enroll in Medicare Part D is to renew their existing medigap policy, but without the drug coverage that those policies currently provide. ⁸² In that case, the Act requires that the premium cost of these truncated medigap policies must be lowered to take account of the reduced benefits being offered.

C. Managed Care Plans

For some time now, Medicare has offered its enrollees the option of managed care plans, sometimes styled Medicare health maintenance organizations, Medicare preferred provider organizations, Medicare + Choice, or most recently, Medicare Advantage. Regardless of their label, these alternative arrangements parallel the managed care trade-off that confronts Americans of any age—namely, in exchange for restricting one's choice of physicians, hospitals, pharmacies, and other health care

^{79.} Act § 104(a)(1), 117 Stat. 2161, adding Social Security Act § 1882(v)(2)(A).

^{80.} Act § 104(a)(1), 117 Stat. 2163, adding Social Security Act § 1882(v)(3)(A).

^{81.} Such a person is also protected from discriminatory pricing of policies or from imposition of a preexisting condition exclusion. Act § 104(a)(1), 117 Stat. 2163, adding Social Security Act § 1882(v)(3)(A)(ii), (iii).

^{82.} Act § 104(a)(1), 117 Stat. 2161, 2162, adding Social Security Act § 1882(v)(2)(A)(i)(II), (C)(i).

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providers, an enrollee receives Medicare benefits without the customary array of deductibles and co-payments. 83 Paperwork is greatly simplified as well.

But the principal reason that Medicare beneficiaries choose a managed care plan is that these arrangements usually include prescription drugs in their package of benefits. To be sure, there are often significant limits on this drug coverage. For example, certain medications may not be in the plan's formulary, while others are available but only at a higher co-pay than other medications. Indeed, the majority of Medicare managed care plans provide prescription drug coverage only for generic medications. In addition, co-payments are customarily imposed on a per-prescription basis, typically \$10 per monthly refill. Most such plans have annual caps on the amount of this benefit, in some instances, as low as \$600 per year. Moreover, changes are made frequently, and these changes affect current enrollees as well. These changes include removing a medication from the approved formulary, increasing the per-prescription co-payment, imposing or lowering an annual cap on drug benefits, or some combination of all three.

But the biggest change comes when a Medicare HMO or other managed care plan simply discontinues its participation in the Medicare program. Several months' notice is usually given to current enrollees, but those enrollees often have no other Medicare HMO servicing their geographic area. ⁸⁸ As a consequence, Medicare beneficiaries who previously had satisfactory coverage for their prescription drug costs may find that comparable coverage is no longer available. ⁸⁹ While persons in this predicament could try to obtain a medigap policy, they are undoubtedly outside the six-month window when a medigap insurer may not refuse to cover them for medical reasons. Federal law does provide that persons in this situation can obtain certain medigap policies regardless of their medical condition. ⁹⁰ But the types of medigap policies that are subject to this guarantee—Plans A, B, C, and F—do *not* include prescription drug coverage in their package of benefits. As a result, many Medicare beneficiaries who thought they had arranged for prescription drug coverage by joining a Medicare HMO

^{83.} See Frolik & Kaplan, supra n. 9, at 97-98.

^{84.} See Nancy Ann Jeffery, Seniors In Medicare HMOs Should Know the Drugs That Prescription Plans Cover, Wall St. J. C1 (May 16, 1997); Melynda Dovel Wilcox, Choosing a Medicare HMO, Kiplinger's Personal Fin. (Aug. 1996), at 73.

^{85.} See Jeffrey, supra n. 84, at C1.

^{86.} See John Rother, Advocating for a Medicare Prescription Drug Benefit, 3 Yale J. Health Pol'y, L. & Ethics 279, 282-83 (2003).

^{87.} Soumerai & Ross-Degnan, supra n. 20, at 722.

^{88.} See Rother, supra n. 86, at 283; Michael Waldholz, Medicare Seniors Face Confusion as HMOs Bail Out of Program, Wall St. J. D4 (Oct. 3, 2002).

^{89.} John Thomas, H.M.O.'s to Drop Many Elderly and Disabled People: Health Experts Predict Most Severe Consequences Will Be Loss of Prescription Drug Benefits, N.Y. Times A14 (Dec. 31, 2000). In addition, some Medicare HMOs remained in the program but discontinued their drug coverage. See Milt Freudenheim, Many H.M.O.'s For the Elderly Cut or Abolish Drug Coverage, N.Y. Times C1 (Jan. 25, 2002).

^{90. 42} U.S.C. § 1395ss(s)(3)(A), (B)(iii), (C)(i) (2000).

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find to their dismay that such is not the case and that replacement coverage may not be available, regardless of cost.

This possibility, moreover, becomes less theoretical and more poignant when one examines the enrollment pattern of Medicare beneficiaries in managed care plans. Enrollment in Medicare managed care plans as a percentage of the Medicare population peaked at about 16 percent in 2000 and has declined steadily since then. Presently, only 11 percent of Medicare enrollees participate in a managed care plan. 91

Given this history and the availability of drug benefits in Medicare Part D without the restrictions that accompany managed care, the question of whether to join a Medicare managed care plan becomes particularly problematic. The Act requires that all Medicare managed care plans, collectively called Medicare Advantage (MA), offer at least one plan in their service areas that includes Medicare Part D coverage. ⁹² These plans may offer plans with additional drug benefits as well, and some plans undoubtedly will do so by eliminating Part D's coverage gap, the infamous "doughnut hole." In any case, MA enrollees who want Part D coverage must receive that coverage through their MA plan.93 That is, they may not obtain a freestanding Part D prescription drug plan like those that are available to persons who stay in traditional Medicare for their basic Medicare coverage. 94 Thus, the decision to join a MA plan must now consider whether the drug benefits offered by that MA plan are more appealing than a stand-alone Medicare Part D plan. Indeed, this exclusive sourcing rule might also affect the willingness of managed care providers to offer MA plans at all, since their enrollees must receive whatever drug benefits they get from their MA plan.

V. CONCLUSION

Before the enactment of the new Medicare Act, senior citizens confronted an array of choices for prescription drug coverage. Many had retiree health benefit plans from their former employers, but these plans were subject to premium increases, perprescription co-payment increases, new restrictions on covered pharmaceuticals, and outright termination. Other people secured private medigap insurance, but such policies were usually expensive, because these medigap policies cover many different aspects of medical expenses in addition to prescription drugs. And prescription drug coverage appears in only the most comprehensive medigap policies.

Many senior citizens joined health maintenance organizations and other managed care arrangements, primarily to obtain coverage of their prescription medications. But these plans often employed restricted formularies and annual caps on allowable drug expenditures. Even worse, many such plans abandoned the Medicare program entirely, leaving former enrollees with no comparable replacement option in many cases. Still other

^{91.} See Geraldine Dallek et al., Lessons from Medicare + Choice for Medicare Reform 2, http://www.cmwf.org/publications/publications_show.htm?doc_id=221568 (2003).

^{92.} Act § 101(a)(2), 117 Stat. 2122, adding Social Security Act § 1860D-21(a)(1)(A).

^{93.} Act § 101(a)(2), 117 Stat. 2072, adding Social Security Act § 1860D-1(a)(1)(B)(i).

^{94.} Act § 101(a)(2), 117 Stat. 2072, adding Social Security Act § 1860D-1(a)(1)(B)(ii).

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people obtained their drugs through Medicaid or state pharmacy assistance programs for lower-income individuals. Finally, one in four Medicare beneficiaries had no prescription drug coverage at all.

Onto this disconnected patchwork of drug coverage arrangements, the Act fashions a new Part D program that is widely, though not universally, available. Medicare Part D has some fairly typical features, like monthly premiums and an annual deductible, but it also has some highly unusual features, like a \$2,850 coverage gap and a generous 95 percent benefit tier with no annual cap for persons with very high annual drug costs.

This new Part D, moreover, is voluntary, so clients now face even more choices than before. Should they remain in their existing employer-sponsored plan or switch to Medicare Part D? Should they renew their existing medigap policy or enroll in Medicare Part D, knowing that after 2005, new medigap plans with drug coverage are no longer available? Should they secure drug coverage from their managed care plan or enroll in Medicare Part D to supplement traditional Medicare? Finally, should they do nothing at all and simply wait until their medical needs become clearer, even though deferred enrollment in Medicare Part D includes a permanently assessed penalty that is determined by the length of time during which an enrollee had no comparable drug coverage?

This plethora of options inevitably results in client confusion. And that predicament is made worse when one considers that drug needs are not always perfectly predictable. For many Medicare beneficiaries, this aspect is the most problematic. People may know what drugs they need now and what they cost currently, but what will those drugs cost in the future? What if a specific drug that they need is removed from their plan's formulary, with the result that the client must pay substantially more for that drug? Such a development, which is increasingly common these days, changes the entire calculus of employer-sponsored plans and managed care plans, which typically offer widely differing prices for "included" and "not included" pharmaceuticals, versus medigap and Medicare Part D arrangements, which base their benefits on costs incurred.

The list of imponderables goes still further. What *new* medications might be developed in the future and what will those new drugs cost? That is, the very nature of pharmacology is that new drugs are being created where none existed before. Will drug benefit plans that limit their coverage to specified medications include these newly developed products, and if so, after how much time passes? Such questions are often critical for persons whose lives may depend on having access to these drug regimens as soon as possible.

Even more fundamentally, what new medical conditions will be diagnosed in the future for a specific Medicare beneficiary? That is, the choices that clients make in securing drug coverage are necessarily tied to their *present* state of health. Indeed, the entire matrix of drug benefit choices assumes no significant changes in this most important of key variables. But who knows what ailments will befall clients, or what newly discovered diseases they will develop? Thus, a drug plan—be it Medicare Part D or one of the alternatives—may be perfectly appropriate today and be totally inadequate in two years, even assuming no structural changes in the plans themselves or in the cost of medications. Clearly, Medicare Part D provides new options but the central dilemma of selecting the best alternative remains fraught with confusion and uncertainty.

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LATE DEVELOPMENTS

After the completion of this article, the Centers for Medicare and Medicaid Services (CMS) posted new information about Medicare Part D to the Medicare website (www.medicare.gov) in anticipation of the program's 2006 roll-out. According to this information, CMS claims that "most prescription drug coverage offered by Medigap policies, on average, is *not at least as good as* Medicare prescription drug coverage" (emphasis in the original) – even though medigap insurance is specifically listed in the 2003 Medicare Act as a possible category of "creditable coverage." Consequently, a client who keeps her medigap policy after 2005 and subsequently enrolls in Medicare Part D may be liable for that program's delayed enrollment penalty.

In addition, CMS claims that "most" Medicare Part D plans will utilize restricted formularies with different levels of co-payment for different classifications of covered pharmaceuticals. CMS plans to add a new feature on its website that will allow a client to enter the name, dose size, and dosage frequency of her current medications to locate the most appropriate Medicare Part D plan for her situation. These drug plans, however, may change their formularies *in the middle of the year*, as long as they provide at least 60 days' notice of such a change. Thus, the most appropriate Medicare Part D plan at enrollment may become less satisfactory as the year progresses.