

II. Types of Drug Plans

This section covers:

- *Two main types of plans (PDPs and MA-PDs)*
- *Plan variations (drug plan benefit designs)*

A. Two Main Types of Plans

The Part D prescription drug benefit is only available through Medicare-approved plans from private insurance companies, called plan sponsors. The MMA authorizes the plan sponsors to offer two major types of Medicare Part D drug plans. These are **Prescription Drug Plans (PDPs)** and **Medicare Advantage plans with Part D (MA-PDs)**. The law gives plan sponsors a lot of room to design PDPs and MA-PDs with varied cost-sharing and formulary features. This section describes the two main types of plans and some of the variations that the law allows.

Prescription Drug Plans (PDP)

- **PDPs** are stand-alone plans that *only* offer prescription drug benefits under Medicare.
- Beneficiaries remain in Original (traditional, fee-for-service) Medicare for their Parts A & B coverage.
- The MMA says that beneficiaries must have the ability to choose from at least two different types of Medicare Part D plans where they reside. One plan must be a PDP.¹

For Example: Charlie has been enrolled in Original Medicare, Parts A & B, since 1988. He pays for an individual Medicare Supplement (Medigap) policy that costs \$120 per month and has no prescription drug coverage. Until recently he took very few medications. But when he began taking Lipitor and Hydrochlorothiazide and using Xalatan eye drops, his retail drug costs became very expensive. He wanted to keep his Medigap policy and all of his Medicare hospital and doctor coverage the same, but wanted to pay less for his medications. Charlie joined a PDP, “Just Drugs,” and pays a \$25.00 monthly premium for prescription drug coverage.

Medicare Advantage plans with Part D (MA-PD)

¹ Beneficiaries residing in the U.S. Territories, including American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands, may not have access to two qualifying plans. This requirement may be waived for the territories (Code of Federal Regulations, 42 CFR 423.859(c)).

- **MA-PDs** offer a Part D prescription drug benefit along with other Medicare-covered benefits including physician, hospital, diagnostic, home health care and durable medical equipment services, through contracted provider networks.
- Beneficiaries still pay their Part B premiums and have Medicare, but they opt out of Original Medicare. The MA-PD delivers their Medicare benefits and serves as their primary insurer.
- MA-PDs include Medicare PPOs (preferred provider organizations), HMOs (health maintenance organizations), PFFS (private fee-for-service), SNPs (Special Needs Plans), and POS (point of service) plans. They operate under Medicare Part C and were formerly known as Medicare + Choice plans. All types of MA-PDs have variations among them.

Please refer to Section IV “Relationship to Medicare Advantage” for more in-depth information about Medicare Advantage plans and how they work with Medicare.

Counseling Tip: While enrolled in an MA-PD, one cannot use his Original Medicare Card (red, white & blue) for any health care needs including emergencies. One must use the MA-PD plan’s card for all health transactions so claims can be paid. It’s a good idea, though, to instruct clients to keep their red, white and blue card in a safe place.

For Example: Ingrid is newly retired and has no supplemental insurance to pay for the co-insurance and deductible costs in Original Medicare. Since her doctor and local hospital are in the “All In One Place” Medicare HMO’s provider network, she decided to enroll in one of its MA-PD plans. She gets Part D prescription drug coverage with a zero monthly premium and no annual deductible.

B. Plan Variations

Standard and Alternative Coverage Designs

CMS's Prescription Drug Benefit Manual (http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp#TopOfPage) sets forth guidelines for four varieties of Medicare Part D plans. The first is the "defined Standard Prescription Drug Coverage" benefit design. The value of its coverage is the baseline by which CMS approves all other drug plan benefit designs. Plan sponsors may offer Part D plans that precisely follow the defined Standard Coverage model, or offer instead an "Actuarially Equivalent Standard Coverage" plan. Both have the same annual deductible (\$275 in 2008). The main difference between them is that actuarially equivalent standard coverage benefit designs have tiered co-payments rather than a 25 percent coinsurance charge. In its "Landscape of Plan Options," CMS refers to both of these standard coverage designs as "Basic" drug benefit types.

Medicare guidelines also allow for two types of "Alternative Prescription Drug Coverage." One is called "Basic Alternative Coverage." The other is "Enhanced Alternative Coverage." Basic Alternative Coverage plans must be equal in value to standard prescription drug coverage, but may have lower deductibles and different cost-sharing designs that are actuarially equivalent to the 25 percent coinsurance in the standard coverage benefit design. The Enhanced Alternative Coverage benefit design permits supplemental benefits that may include reduced cost-sharing amounts and broader formularies. The Landscape of Plan Options refers to these enhanced coverage plan designs as "Enhanced" drug benefit types. They offer benefits that exceed the value of the standard coverage designs and their basic drug benefits. Monthly premiums for alternative and enhanced plans are often higher than those for standard plans.

The drug plans themselves vary considerably in terms of premium prices and cost-sharing structures—some use set co-payments and others have percentage-based coinsurance charges. It is important to note that many specific features of these plans change from year to year, including the premiums, annual deductible and coverage limits. Plan sponsors also can alter the cost-sharing structures, the scope of their formularies, and their cost-control systems. CMS and the plan sponsors agree to their Part D contracts on an annual basis. *Please refer to Section VII "Access to Drugs and Formularies" for more information.*

Below are more details on the four varieties of Medicare Part D plans:

- Defined Standard Prescription Drug Coverage (Basic Benefit)
 - The model Part D benefit design described in the MMA
 - It has a monthly premium, a \$275 annual deductible (for 2008), 75 percent coverage and 25 percent co-insurance for the cost of covered drugs up to an initial coverage limit of \$2,510 (2008), a coverage gap ("doughnut hole") up to \$5,726.25 (2008) in costs for covered drugs, and catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance,

or a co-payment of \$2.25 a generic or preferred drug and \$5.60 for other drugs for the rest of 2008.

For Example: Esther pays a monthly premium of \$25.40 for her PDP. She takes two medications, the annual cost of which totals more than her annual deductible of \$275 in 2008. After she pays the \$275 out-of-pocket at her local pharmacy, the plan pays 75 percent of the cost of her medications, while she pays 25 percent, up to \$2,510 in total drug costs. After Esther reaches this initial coverage limit for the year, she enters the coverage gap (or “doughnut hole”) in which she owes 100 percent of her drug costs up to \$5,726.25 in total drug costs. At this point, she has spent \$4,050 out-of-pocket on the deductible and coinsurance charges. When she reaches this catastrophic coverage limit, the plan pays 95 percent and she pays 5 percent of the cost per medication until December 31.

- Actuarially Equivalent Standard Coverage (Basic Benefit)
 - It has the same total annual value of the defined Standard Coverage benefit.
 - This design allows plan sponsors to alter the cost-sharing structure by, for example, using flat co-payments instead of the 25 percent coinsurance charge, or by using combinations of co-payments and coinsurance charges for different kinds of drugs.
 - This design also allows plan sponsors to use different co-payment tiers with lower out-of-pocket costs for generic drugs and higher co-payments for brand-name and specialty drugs. In some of these plans, the co-payment levels for some brand-name drugs may exceed the 25 percent coinsurance charge in a Standard Drug Benefit plan.
 - This design has an annual deductible of \$275 (in 2008).

For Example: Eloisa pays a monthly premium of \$21.10 for her PDP. She meets the plan’s \$275 annual deductible after paying the cost of her prescriptions for three months. Thereafter, she pays \$10 co-pays for all of her generic medications through the initial coverage limit. She pays 15 percent of the cost for brand-name drugs and more if she uses a non-preferred pharmacy. When Eloisa’s total drug costs reach the \$2,510 initial coverage limit for 2008, she pays out-of-pocket the full cost for all of her medications until she reaches the catastrophic coverage level of \$5,726.25, after which the plan pays 95 percent of the cost for the rest of 2007.

- Basic Alternative Coverage (Basic Benefit)
 - The total value of its drug coverage is equal to the Standard Coverage benefit designs, above, but CMS guidelines allow plan sponsors to use this

design to offer plans with no deductible and a reduced yearly initial coverage limit.

- Enhanced Alternative Coverage (Enhanced Benefit)
 - The total value of the plan exceeds the value of the three basic benefit variations.
 - This plan design allows for more coverage and lower out-of-pocket costs.
 - Plan sponsors can offer lower co-payments and coinsurance charges, a lower annual deductible, and a higher threshold for the annual initial coverage gap.
 - Formularies may be broader, and may cover drugs that are generally excluded from Part D coverage.
 - Enhanced plans may cover some medications, including brand-name drugs, while beneficiaries are in the coverage gap (doughnut hole).

When counseling clients about which type of plan to choose, it is important to understand the major differences between these four Part D plan designs. Keep in mind, however, that CMS does not require the plan sponsors to distinguish these plans by type, other than to denote them as basic or enhanced benefit designs.

Counseling Tip: Enhanced plans typically have a higher monthly premium. Those receiving the Low-Income Subsidy generally must pay a portion of the premium for an enhanced plan.

For Example: Dominique pays \$59.30 per month for her PDP. After her spending exceeds the plan's \$100 annual deductible, she faces \$5 co-payments for all generic medications and \$20 co-payments for brand name medications. The plan's coverage gap, however, is only half the amount of the Standard Drug Benefit. With the enhanced plan, she is able to delay the point at which she pays the full cost of her drugs out-of-pocket. However, she pays a monthly premium that is higher than many plans offered in her area. For Dominique, the ability to spread her drugs cost out over the year and delay the coverage gap is important.

For Example: Joe takes a maintenance medication for a rare condition in his white blood cells. When a SHIP counselor helped Joe compare formulary lists on the Medicare Prescription Plan Finder, they found only two plans to cover his medication at the dosage prescribed. Both were listed as "enhanced" plans.

Counseling Tip: The Plan Finder at www.medicare.gov does not consistently identify the drug plans by basic and enhanced benefit types. This information is available from the "Landscape of Local Plans" at: <http://www.medicare.gov/medicarerreform/local-plans-2008>