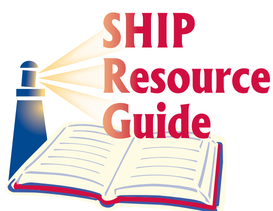

Types of Drug Plans

This section covers:

- The Two Main Categories
- Plan Variations

The Two Main Categories

The Part D prescription drug benefit is available only 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 significant 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 federal law allows.

Prescription Drug Plans (PDPs)

- PDPs are stand-alone plans that offer only prescription drug benefits under Medicare.
- Generally, beneficiaries remain in Original (traditional, fee-for-service) Medicare for their Part A and Part 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. (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.) Since most regions of the country (aside from the territories) have many more than two plans, this rule is interesting more than it is useful.

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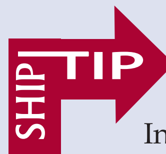
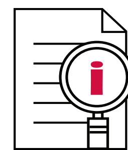
Medicare Advantage Plans with Part D (MA-PDs)

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 must pay their Part B premiums and they do have Medicare. Enrolling in Medicare Advantage essentially is an opt-out of Original Medicare. The MA-PD delivers Medicare benefits and serves as a primary insurer. MA-PDs include Medicare PPOs (Preferred Provider Organizations), HMOs (Health Maintenance Organizations), PFFS (Private Fee-for-Service) plans, SNPs (Special Needs Plans), among others. They operate under Medicare Part C and were formerly known as Medicare+Choice plans. All types of MA-PDs have variations among them.



Beneficiaries enrolled in MA-PD plans cannot use their Medicare Health Insurance cards (i.e., the red, white, and blue card) for any of their health care needs, including emergencies. They must use the MA-PD plans' cards every time they go to a doctor or hospital, so the plans will pay their claims. It's a good idea, though, to instruct clients to keep their Medicare Health Insurance cards in a safe place.



For more information about Medicare Advantage Plans, see Relationship to Medicare Advantage on page 25.

EXAMPLE *Pamela is newly retired and has no supplemental insurance to pay for the coinsurance and deductible costs in Original Medicare. Since her doctor and local hospital are in the Premiere Gold HMO's provider network, she decided to enroll in that MA-PD plan. She gets Part D prescription drug coverage with a zero monthly premium and no annual deductible.*

Plan Variations

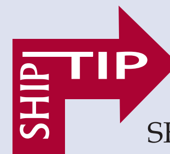
Standard and Alternative Coverage Designs

Guidelines for the four varieties of Medicare Part D plans are set forth in CMS's *Medicare Prescription Drug Benefit Manual (PDBM)*, available online at http://www.cms.hhs.gov/PrescriptionDrugCovContra/12_PartDManuals.asp.

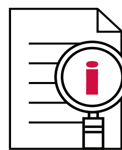
1. The first is the defined standard prescription drug coverage benefit design. CMS approves all other drug plan benefit designs based on the value of this standard, defined coverage.
2. The second type of Part D plan is an actuarially equivalent standard plan. Both this plan and the defined standard plan have the same annual deductible ($310 in 2010). The main difference between these two types is the actuarially equivalent plans have tiered copayments rather than a 25 percent coinsurance charge. In its *PBDM*, CMS refers to both of these standard designs as "basic" drug benefit types.

3. The third type of Part D plan is a basic alternative plan. The basic alternative plans must be equal in value to standard plans but may have lower deductibles and different cost-sharing structures.
4. The fourth type of Part D plan, the enhanced alternative plan, has supplemental benefits that may include reduced cost-sharing amounts and broader formularies. Monthly premiums for alternative and enhanced plans are sometimes higher than those for standard plans.

The drug plans themselves vary considerably in terms of monthly premiums and cost-sharing structures—some use set copayments 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.



Because Part D plan costs change annually, SHIP counselors can provide beneficiaries a valuable service by offering to run plan comparisons for their clients. Your client's needs and the plans themselves change, so the "best" plan for this year might not be the best for next year.



For more information, see Access to Drugs and Formularies on page 55.

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

1. Defined Standard Plan (Basic Benefit)

The MMA defines the costs of the standard benefit as a plan with:

- A monthly premium
- A $310 annual deductible (for 2010)
- A 25 percent coinsurance for the cost of covered drugs up to an initial coverage limit of $2,830 (2010)
- A coverage gap ("doughnut hole") between $2,830 and $6,440 (in 2010) in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of $2.50 for a generic or preferred drug and $6.30 for other drugs for the rest of 2010

2. Actuarially Equivalent Standard Plan (Basic Benefit)

The MMA defines the costs of the actuarially equivalent standard benefit as a plan with:

- A monthly premium
- A $310 annual deductible (for 2010)

- A cost-sharing structure that may have flat copayments instead of a 25 percent co-insurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to the initial coverage limit of $2,830 (for 2010)
- A coverage gap ("doughnut hole") between $2,830 and $6,440 (in 2010) in costs for covered drugs
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of $2.50 for a generic or preferred drug and $6.30 for other drugs for the rest of 2010

3. Basic Alternative Plan (Basic Benefit)

The MMA defines the costs of the basic alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible (ranging from $0 to $310 in 2010)
- A cost-sharing structure that may have flat copayments instead of a 25 percent coinsurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit that is no less than $2,830 (for 2010).
- A coverage gap ("doughnut hole") between $2,830 and $6,440 (in 2010) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans
- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of $2.50 for a generic or preferred drug and $6.30 for other drugs for the rest of 2010

4. Enhanced Alternative Plan (Enhanced Benefit)

The MMA defines the costs and coverage of the enhanced alternative benefit as a plan with:

- A monthly premium
- A reduced or eliminated annual deductible (ranging from $0 to $310 in 2010)
- A cost-sharing structure that may have flat copayments instead of a 25 percent co-insurance or uses a combination of copayments and coinsurance charges. Enrollees pay these costs for their covered drugs up to an initial coverage limit that is no less than $2,830 (for 2010).
- If included, a coverage gap ("doughnut hole") between $2,830 and $6,440 (in 2010) in costs for covered drugs. If the initial coverage limit is raised, the coverage gap will be smaller in these plans. Some enhanced alternative plans will offer some coverage throughout the coverage gap

- Catastrophic coverage where the beneficiary pays the greater of 5 percent coinsurance or a copayment of $2.50 for a generic or preferred drug and $6.30 for other drugs for the rest of 2010
- Formularies may be broader, and may cover drugs that are generally excluded from Part D coverage

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. This information about each plan is available each year on the Landscape of Plans, at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/. Note that the *Medicare Prescription Drug Plan Finder* (Plan Finder), available at http://www.medicare.gov/MPDPF, does not distinguish plans in this way.

Example *Maria takes a costly maintenance medication for a rare condition. When a SHIP counselor helped Maria compare formulary lists on the Medicare Prescription Drug Plan Finder, they found only two plans that cover her medication at the dosage prescribed. Both are enhanced plans; no basic plans covered her medication. One of the enhanced plans even covers Maria's medication through the coverage gap; therefore she decides to enroll in that plan. This choice allows Maria to keep her annual costs more predictable.*