

## Medicare Part D: Risks and Opportunities for Practitioners

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### Introduction

The beginning of the New Year saw the inception of the largest expansion of the Medicare program since its inauguration 40 years ago during the administration of Lyndon Baines Johnson. On January 1, 2006, Medicare's "Part D" became effective, providing broad coverage for prescription drug costs.

*MPM's* inaugural issue contains a number of articles on Medicare Part D, including a fine piece by Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD, its Editor-in-Chief. Normally, we would seek to avoid articles on the same subject. However, for a program so extraordinary in its scope—in transforming the health care system, its impact on program beneficiaries, its risks and opportunities for health care providers, and perhaps its impact on the federal budget—we'll take the risk.

Medicare Part D reflects the profound transformation of health care delivery since 1965. In 1965, health care costs that were unaffordable to seniors were hospital costs, particularly inpatient hospital costs. By the 21st century, our health care system had shifted its focus to outpatient and physician care, and the portion of health care costs spent on prescription drugs had skyrocketed. The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (PL 108-173) (the "Act") recognized that transformation.

In addition, the Act also reflects the political transformation of the United States since 1965. Thus, for the first time since then, this major

component of the Medicare program involves:

- choice (indeed, to many, bewildering choice, rather than rigid standardization);
- reliance on the private sector; and
- competition among components in the private sector.

### Overview of Part D Benefits

Before we turn to specific parts of the Part D program on which physicians, especially those with a heavy Medicare practice, may choose to focus, it is worthwhile to review the basics of Part D. Without an understanding of its basic elements, an examination of the Act's "edges," or its areas of risk and opportunity for physicians, could lead to uninformed conclusions and poor advice.

- Medicare Part D is available to all those who are Medicare-eligible. The benefit cannot be denied on the basis of financial status or health condition.
- Unlike previous Medicare programs, there is no single or mandated drug plan under the Act. Rather, in order to participate, a beneficiary must enroll in an approved plan offered by a private insurer.
- Participation in Part D is voluntary. However, a Medicare participant not covered by another plan that offers benefits equal to the Act's standards may face *serious financial penalties* upon later enrollment if he or she does not enroll in a Part D plan when first eligible. More on this later.
- Under the "standard" Part D benefit plan (projected to cost \$32/month in 2006), after an annual deductible of \$250, Medicare would pay 75% of the next \$2000 in drug costs.
- Following the initial coverage described above (again under the "standard" Part D plan) comes the infamous "donut hole," or coverage gap. Under the coverage gap in a standard plan, the beneficiary is fully responsible for the next \$2850 in costs before Medicare kicks in again.
- Once eligible drug expenses exceed the coverage gap, the plan's benefits cover up to 95% of prescription costs for the remainder of the year. There is no upper limit to this "catastrophic" coverage.

- Because Part D is premised upon a competitive market among private insurers, a “standard” plan may be available at a premium below the projected \$32 per month. In addition, insurers often offer plans with “richer” benefits (such as smaller annual deductibles or co-payments, or partial or complete coverage in the standard plan’s coverage gap); though, of course, premiums for such plans will be higher.
- Each insurer has considerable latitude in establishing the plan’s “formulary” or preferred drug list. As discussed below, in selecting a plan, beneficiaries should carefully review the plan’s formulary and compare it to their current drug usage.
- Once a plan has been selected, a beneficiary generally may not switch to another plan until the following year. Thus, while beneficiaries are not “locked in” forever, poor plan selection could have significant adverse financial consequences.
- The Act’s provisions include substantial financial assistance to low-income persons. Individuals whose annual income is <\$14,355 (or <\$19,245 if married and living with his

to know about the provisions of Medicare Part D? The obvious answer is “because their patients will ask them.” The broader, and somewhat more difficult question, is whether and to what extent a practicing physician (or the physician’s staff) should be involved in patients’ decision-making process about Part D. Traditional conservative legal advice would be, “Stay out of it. It’s not your job. You’re not a benefits consultant. You’ll get blamed for every poor choice, and you’ll get blamed for poor plan performance too. You might even get sued.”

While I will not dismiss the risks underlying such conservative advice, I will argue that a physician—especially a physician who wishes to cater to the “senior market”—*should* be involved in that process, *should* provide information about the program and urge eligible patients to inform themselves promptly about it, and *should* actively assist patients (if requested) in making good program choices. Aside from the marketing or practice-building aspects of such a strategy (which are outside my bailiwick), it can be argued credibly that patients have a legitimate expectation of such expertise and assistance from their physicians, particularly those who specialize or focus their practices on seniors. Naturally, a staff person, rather than the physician, can provide much of this help to patients.

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or her spouse) and whose assets are below the program’s threshold. These individuals may have lower co-payments, not have to pay premiums, or be subject to deductibles and a coverage gap.

### **The Physician’s Role**

Why should a practicing physician care or need

### **General Program Information**

Here then are a few areas in which a physician and a physician’s staff can provide assistance.

Certainly, physicians can provide general information about Medicare Part D. Although there are numerous Web sites (both governmental and private organizational sites) that provide good information, seniors often are not able to access these sites readily or are uncomfortable doing so. There are, however, many printed brochures available. One of the best, in my view, is available from AARP.

### **The Decision to Enroll**

During the program’s first 6 weeks of enrollment, voluntary enrollment in a Medicare prescription drug plan (as contrasted with “auto-enrollment, in which the government automatically enrolled Medicaid and enrollees in certain other programs) was far below ex-

pectations. Most experts believe that the bewildering complexity of the program and its choices were simply too overwhelming for many seniors. Yet for a great many seniors, failure to enroll by May 15, 2006, will be a very poor choice, with serious financial ramifications.

One of Part D's more controversial provisions (some might say diabolical) imposes a premium penalty payable on later enrollment in the program. For each month of "late" enrollment, patients will have to pay an additional premium of 1%. For current Medicare-eligible persons, other than those within allowable exceptions, the deadline for open enrollment is May 15, 2006. Moreover, aside from the premium penalty, eligible persons who fail to enroll by the May 15 deadline will, in all likelihood, be unable to enroll in any plan until next January. Upon enrollment during the following January, their premiums will be set at 107% of the then-applicable premium (ie, a 1% penalty for each month from May to January). In addition, that 7% penalty will be applied to the premium payments as long as these individuals remain enrolled in the Medicare Part D program.

The principal exceptions to the penalty provisions are for:

- persons with prescription drug coverage, such as through an employer- or union-sponsored plan, which is equal in value to or better than the standard Part D plan (in Medicare jargon, "creditable coverage"); and
- persons who first become eligible for Medicare after January 1, 2006 (who, of course, may enroll after their date of eligibility).

The purpose of the penalty provision is an understandable one. It is to prevent what is called in the insurance business "adverse selection," in which only the sickest segment of the population (or, more properly, only those who are heavy users of prescriptions drugs) apply for coverage. Nevertheless, the phrase by which lawyers describe such terms is an "in terrorem" provision.

Patients need to understand clearly that they should make an informed decision prior to May 15, 2006. Physicians would be doing such patients a valuable service by emphasizing that point to them.

## Plan Selection and the Formulary

The selection of the most appropriate Part D plan involves a number of factors. A physician or the physician's staff can assist with respect to many of those factors. One in particular, however, is highly relevant to the physician's practice and the physician-patient relationship.

As mentioned previously, each carrier has considerable discretion in establishing the formulary, or preferred drug list, for its plans. Thus, in selecting a plan, a patient most certainly should compare his or her current list of prescription drugs to the plan's formulary. That, however, does not end the analysis. Drugs that are not on the plan's formulary may have adequate substitutes, which do appear on the list. Only the physician can properly assist the patient in evaluating that question. Moreover, since the program requires that plans have exception and appeal processes with respect to medically necessary drugs that do not appear on the plan's formulary, the physician might make some assessment for the patient on the likelihood of success in establishing an exception. Still, all other things being equal, the patient is undoubtedly better off with a plan that covers the necessary prescriptions without reliance on the exception and appeal processes.

## Conclusion

The Medicare Part D prescription drug coverage program, while providing valuable benefits to millions of our citizens, is bewildering in its complexity, posing daunting challenges to seniors. Medicare patients' confusion and uncertainty pose risks to their physicians, but also afford physicians an opportunity to provide a valuable service to their patients—a service that will assist them financially *and* improve patient outcomes. Physicians desiring to serve the senior community should seize the opportunity. MPM

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