Patients Need Help on Out-of-Pocket Expenses

BY JENNIFER SILVERMAN
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WASHINGTON — The full cost of drugs obtained through patient-assistance programs should be counted as out-of-pocket expenses under the new Medicare Part D prescription drug benefit, according to council members at a meeting of the Practicing Physicians Advisory Council.

The Centers for Medicare and Medicaid Services (CMS) should work with the Health and Human Services Department's Office of Inspector General to give final guidance on this issue, the panel stated.

Under the coming Part D benefit, until the patient has met his or her out-of-pocket expense limit, the patient has to pay for the drug, said PPAC member Barbara McAneny, M.D., an oncologist from Albuquerque. If the patient can't afford it, but "we obtain it for free from the pharmaceutical companies, and if it doesn't count toward true out-of-pocket expenses, the patient will never get through the out-of-pocket [limit] and into the benefit."

Jeffrey Kelman, M.D., medical officer with the CMS Center for Beneficiary Choices told the council that there are circumstances in which out-of-pocket expenses would be covered: Payments made by qualified state pharmaceutical assistance programs toward copays or other cost sharing would count toward true out-of-pocket expenses, for example, in terms of reaching the $3,600 out-of-pocket limit before reinsurance, he said.

However, payments from a third-party insurance company—or from government agency policies—would not, he said.

"There needs to be guidance as to what that means," he acknowledged.

For the Part D benefit, CMS has divided the country into 34 regions, and all will have robust coverage with several Part D drug plans available for beneficiaries of all incomes and for dual eligible patients in the Medicare and Medicaid programs, Dr. Kelman told the PPAC.

He expressed confidence that beneficiaries would be able to afford the benefit. The average monthly premium for the benefit is $32.30 nationally, lower than what the agency expected, he said.

"All regions will have plans with premiums well below that average," he said. (See box.) In addition, all of the formularies submitted for the program are much more robust than most commercial formularies or any state formulary. "That's going to make the transition in January much easier," Dr. Kelman said.

CMS is developing a new Web tool aimed at making it easier for patients to navigate the process for enrolling to receive the new Part D benefit.

Dr. McAneny noted that rumors were floating around regarding whether Part B drugs—such as oral chemotherapy agents that are covered under the medical benefit as opposed to the pharmacy benefit—would be moving over to Part D.

"At the moment, those drugs aren't moving anywhere," Dr. Kelman said. "There's talk of it because, starting in January, there will be two drug benefits, and there is a potential for confusion, particularly over the oral drugs or chemo drugs, because all those drugs in theory could be [Part] B or D drugs."

It's an issue that will be looked at again, he said.

In the months leading up to the January start of Part D, CMS has actively been spending time on the education of, communication with, and enrollment of beneficiaries, but outreach to physicians about the drug benefit is an area that needs work, Dr. Kelman said. "Is it toolkits, training sessions, CME?" he asked the panel.

Such tools are important, he noted, as "it's very clear that the practicing physician will be the point of contact for the beneficiary" who needs guidance on what to do about the new benefit.

No physician wants patients to miss out on the Part D benefit, Dr. Kelman noted, "especially because the low-income subsidy is a good benefit. There [are] no premiums, no gap, a minimum copay, no deductible, and a full catastrophic benefit."

Medicare also needs input on how it could interact with physicians on formulary changes, such as matching the formulary with the patient's current drug list, Dr. Kelman said.

In a resolution, PPAC indicated it would complement the efforts of CMS to disseminate information to the public about the Part D benefit program.

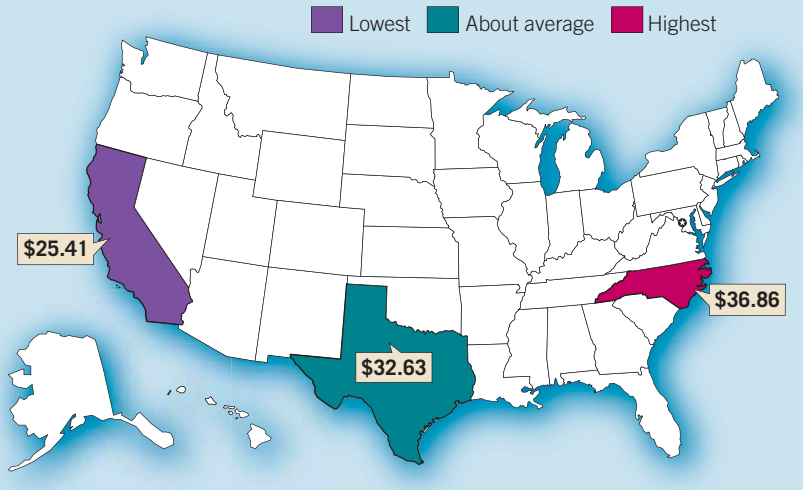
CMS, meanwhile, is developing a new Web tool aimed at making it easier for patients to navigate the process for enrolling to receive the Part D benefit, he said.

This new tool "will allow the beneficiary and the physician to identify the plans that the [beneficiary] has been auto-enrolled into or has actively enrolled into," with additional information on the Medicare drug cards.

Auto-enrollment has been a big question in particular for the full-benefit dual-eligibles (those patients who are eligible for Medicare and Medicaid), he said. "Now they can do it on the Web or, more likely, their physician, pharmacist, or social worker can do it on the Web."

The council meets quarterly to advise the Department of Health and Human Services on proposed changes in Medicare regulations and carrier manual instructions related to physicians' services. ■

Average Monthly Premiums for Medicare Prescription Drug Plans



Note: The averages are weighted based on the number of plans offered in each state or region.
Source: Centers for Medicare and Medicaid Services

KEVIN FOLEY, RESEARCH

Prepare Now for Medicare Part D Launch in January 2006

BY ELAINE ZABLOCKI
Contributing Writer

SAN DIEGO — Physicians will face many questions about the new Medicare Part D benefit in coming months as patients decide whether to enroll and which plan to select in the voluntary prescription drug program, Elizabeth Carder-Thompson said at the annual meeting of the American Health Lawyers Association.

CMS has begun posting informational resources on its Web site, and additional materials will become available over the next few months. The best resource at this time is the "Outreach Toolkit," which is available by download or on CD-ROM, said Ms. Carder-Thompson, a lawyer with Reed Smith LLP.

"The Outreach Toolkit doesn't answer all the questions we want answered, but it's a good start," she said.

Enrollment for Part D begins on Nov. 15, 2005, and patients must enroll by May 15, 2006, or face a financial penalty when they do.

The new coverage goes into effect Jan. 1, 2006, and the interim discount drug card program ends at that time. This means Medicare beneficiaries will be required to make fairly complicated choices within a short time.

When a plan doesn't cover a prescribed drug, physicians will need to provide supporting statements in order to get an exception.

There will be at least two Part D prescription drug plans available in each geographic area, and plans may include several subplans.

A Kaiser Family Foundation survey, conducted March/April 2005, found that seniors are more likely to turn to their doctor (49%) or pharmacist (33%) for help in making these decisions, rather than to Medicare information sources (23%). About two-thirds (68%) of those surveyed said they did not have a good understanding of the new benefit.

In October 2005, Part D plans will start to send marketing materials. CMS will distribute its "Medicare and You," handbook to all beneficiaries via mail, with a description of the new benefit. A "Plan Comparison Web Tool" and "Medicare Personal Plan Finder" will be posted at www.medicare.gov, and there will be special mailings for low income beneficiaries.

"CMS says it will provide materials as they did for the drug discount card, but this is far more complicated than the card," Ms. Carder-Thompson said.

According to Robert J. Hill, also of Reed Smith LLP, the CMS marketing guidelines on Part D include a great deal of material that will affect physicians. For example, enrollment cannot be taken at the point of care, such as a physician's office. If physicians offer their patients information on any Part D plan then they must offer information on all available Part D plans.

CMS has not released the final version of its marketing guidelines, and Mr. Hill expects these issues to be dealt with in more detail in the second part.

Once Part D becomes effective, doctors will face a different set of concerns, Ms. Carder-Thompson said.

When a plan doesn't cover a prescribed drug, physicians will need to provide supporting statements in order to get an exception, but many details are not clear at this time.

"The regulation is confusing," Ms. Carder-Thompson said. "CMS says they don't want it to be hard to seek exceptions. However, it may well become an administrative burden. This is something that's going to evolve as we go along."

Ms. Carder-Thompson advised doctors to "stay tuned" on the details of Part D, because they seem to be changing every day. ■