



C.E.A.S.E. Myth-Making about Part D Drug Plans (Choice, Enrollment, Affordability, Security, Efficiency)

Choice

Myth:

"[T]he more options a senior has to choose from, the more likely it is that the benefit is going to be tailored to his or her needs," President Bush, Silver Spring, MD (03/15/06).

Fact:

People do not want many private drug plan choices. They want the security of getting their drugs with their Medicare card through traditional Medicare. Part D does not allow them to make an informed choice about whether a drug plan will meet their needs since their needs may change, and they must base their choice on cost and coverage information that the drug plans can change at any time.¹

Enrollment

"Twenty-six million seniors so far have taken a look and said, I think it's worthwhile to sign up," President Bush, Canandaigua, NY (03/14/06).

23.9 million people have Part D, of which only 11 million people voluntarily enrolled—less than half the number touted by President Bush. The other 12.9 million were auto-enrolled through Medicaid or by their Medicare Advantage Plan. An additional 10.3 million people have drug coverage from an employer or union comparable to or better than coverage under Part D, while as many as 4 million people have little or no coverage.²

Affordability

"You can save literally thousands of dollars on your drug costs," CMS administrator Mark McClellan, Canandaigua, NY (03/14/06).

To make drugs affordable for people with high drug costs, Medicare needs to negotiate prices with drug companies. One in three older Americans do not believe Part D helps people with Medicare save money. Many people with Medicaid and Medicare or who were enrolled in state or pharmaceutical company assistance programs are now paying more for their drugs. Many people in drug plans cannot afford their copays for many "covered" drugs or the \$3,850 in out-of-pocket costs before they get catastrophic coverage. Costs will only increase.³

Security and reliability

"You can be protected for the rest of your life against high prescription drug costs in the future," Mark McClellan, Canandaigua, NY (03/14/06).

People cannot know whether a drug plan will meet their needs since their needs can change as can the drugs their plans cover at any time. Drug plans impose obstacles to filling prescriptions—prior authorization, step therapy, quantity limits—that keep people from getting their medicines even when they are on the plan's formulary. The drug benefit provides inadequate coverage for people with costly medication needs.⁴

Efficiency and competition

"The competition is good for consumers; it happens to be good for our taxpayers, too," said President Bush in Canandaigua, New York (3/14/2006).

The drug benefit wastes tens of billions of taxpayer dollars a year and allows the drug companies to continue to charge Americans high drug prices. In a free market, buyers and sellers negotiate a price that suits both. Part D prohibits Medicare from using its bulk buying power to negotiate a better price. It's not a free market; it's a seller's market.⁵

¹ MYTH #1: CHOICE

According to a 2006 WSJ Online/Harris Interactive Health-Care Poll, most older adults who have enrolled in a Medicare drug plan say they found it difficult to choose a plan (60 percent) and difficult to understand the benefits (63 percent). (“Medicare-Plan Enrollment is Still Challenging for Seniors, Poll Shows,” [The Wall Street Journal Online](#), February 15, 2006).

A study on Medicare HMO disenrollment found that 60 percent of Medicare + Choice enrollees chose to move with their provider when forced to choose between their provider and staying with their health plan. Continuity of care is especially important to older Americans and people with disabilities who have chronic conditions (“[The 2002 Medicare + Choice Plan Lock-In: Should It be Delayed?](#)” Commonwealth Fund, November 2001).

² MYTH #2: ENROLLMENT

Based on an updated fact sheet released by the Kaiser Family Foundation, some 11 million people with Medicare are enrolled in a stand-alone Part D plan, while 10.3 million people have kept their employer or union-sponsored coverage and 4.9 million people continue to rely upon other creditable coverage (“[The Medicare Prescription Drug Benefit - An Updated Fact Sheet](#),” Kaiser Family Foundation, October 2007).

HHS projected that 8.2 million people would be eligible for the low-income subsidy (LIS), excluding those dually eligible for Medicare and Medicaid. Of that total, HHS estimated that 4.6 million would receive the low-income subsidy in 2006 (MMA Final Rule, 2005). As of October, 2007, SSA has qualified only 2.3 million Medicare beneficiaries for low-income subsidies (“[The Medicare Prescription Drug Benefit - An Updated Fact Sheet](#),” Kaiser Family Foundation, October 2007).

³ MYTH #3: AFFORDABILITY

Comparing the top 20 drugs prescribed to older Americans in 2004, one report found that the lowest price offered by any Medicare prescription drug plan was at least 48.2 percent higher than the lowest price available through the Department of Veterans Affairs (VA). The report found that the lowest price negotiated by the VA was, in every case but one, lower—often substantially so—than the lowest drug price available through any Medicare prescription drug plan operating in either Region 5, which covers the District of Columbia, Maryland and Delaware, or Region 14, which covers Ohio (“[Falling Short: Medicare Prescription Drug Plans Offer Meager Savings](#),” Families USA, December 2005).

If the Centers for Medicare and Medicaid Services (CMS) were to negotiate drug prices down to the level of what other industrialized nations pay, it could close the “doughnut hole,” established by the Medicare Modernization Act of 2003, which in 2007 leaves people without coverage for drug expenses that exceed \$2,400. Coverage resumes when a person reaches \$5,451.25 in drug expenses ([Testimony of Professor Gerard Anderson, Johns Hopkins University, before the Senate Finance Committee](#), April 27, 2004).

According to a study released by the Kaiser Family Foundation and the Harvard School of Public Health, 32 percent of 718 survey respondents ages 65 and over did not agree that Part D helps people on Medicare save money on their prescriptions. In addition, sixty-six percent favored the option of a drug benefit administered directly by Medicare (“[Seniors and the Medicare Prescription Drug Benefit](#),” Kaiser Family Foundation, December 2006).

A report comparing the prices for the 10 most popular drugs used by older adults in December 2005 and February 2006 found that Medicare drug plans increased prices on average by over 4 percent. Over three-fourths of the drug prices analyzed increased during the seven-week period. Under one plan, the price of the heartburn drug Nexium increased from \$78 in December to \$129 in February (“[Medicare Drug Plan Prices Are Increasing Rapidly](#),” Committee on Government Reform-Minority Staff, Special Investigations Division, February 2006).

According to the Kaiser Family Foundation, in 2006, when most did not receive full-year Part D coverage, 1.5 million Part D enrollees reached the coverage gap (donut hole). The Foundation estimates that by the end of 2007, 3 million Part D enrollees will have reached the gap, when most have received full-year coverage (“[Medicare Part D 2008 Data Spotlight: The Coverage Gap](#),” Kaiser Family Foundation, November 2007).

Multiple sources of health care coverage increase administrative costs for people with Medicare, providers and Medicare itself. In 2001, 90 percent of people with Medicare had more than one source of coverage, including retiree (32.6 percent), Medigap (28.1 percent) and Medicaid (12.2 percent) (“[Medicare: Making It a Force for Innovation and Efficiency](#),” Commonwealth Fund, July 2005).

People who join a plan in 2007 will pay about seven percent larger share of their drug costs, according to CMS administrator Mark McClellan (“Medicare Chief Puts Positive Spin on Increase,” [The Plain Dealer](#), April 9, 2006).

⁴ MYTH #4: SECURITY AND RELIABILITY

The Medicare prescription drug program's complex tangle of rules, paperwork and telephone delays is keeping some patients from drugs they have taken for years, doctors say. Problems cited include: insurers requiring “prior authorization” on some drugs, including those to treat depression, psychosis and convulsions—even for patients who have long taken the drugs; strict dosage or quantity limits on some drugs, sometimes well below what a patient takes; long delays on calls to insurers to make requests, then delays of days in getting a response. (“[Medicare Red Tape Snares Drugs](#),” [USA TODAY](#), February 27, 2006.)

On average, Part D plans cover 81 percent of the drugs in the sample, ranging from 64 percent in the most restrictive formulary to 97 percent in the least restrictive formulary. None of the studied drug plans cover all 152 generic and brand-name drugs, selected to include both drugs commonly used by people with Medicare. Plans also vary significantly in the frequency that they restrict enrollees’ access to specific drugs through quantity limits, prior-authorization requirements, and step-therapy provisions (that require enrollees to try a less costly drug before receiving a more expensive alternative). Four of the studied plans use these tools on fewer than one in 10 of their covered drugs, while 13 plans do so on at least one in four covered drugs (“[An In-Depth Examination of Formularies and Other Features of Medicare Drug Plans](#),” Kaiser Family Foundation, April 11, 2006).

⁵ MYTH #5: EFFICIENCY AND COMPETITION

If the Centers for Medicare and Medicaid Services (CMS) were to negotiate drug prices down to the level of what other industrialized nations pay, it could close the “doughnut hole,” established by the Medicare Modernization Act of 2003, which in 2007 leaves people without coverage for drug expenses that exceed \$2,400. Coverage resumes when a person reaches \$5,451.25 in drug expenses ([Testimony of Professor Gerard Anderson, Johns Hopkins University, before the Senate Finance Committee](#), April 27, 2004).

The waste and inefficiency built into the structure of the MMA will add more than \$800 billion to the cost of prescription drugs over its first decade, compared to a drug bill designed to maximize efficiency. The most simple and efficient way to cover the cost of prescription drugs would have been to establish a simple add-on to the basic Medicare program, comparable to the prescription drug benefit provided by most private health insurers. (“[The Excess Cost of the Medicare Drug Benefit](#),” Center for Economic and Policy Research/Institute for America’s Future, February 2006).

As of February 2006, for the 10-year period from 2006-2015, the “total” Medicare drug benefit cost, without accounting for Medicaid savings, is estimated to be about \$797 billion. The net cost to the federal government for the drug coverage in 2006 is expected to be \$30.5 billion, (“[Medicare Drug Costs Drop Substantially](#),” Centers for Medicare & Medicaid Services, February 2, 2006).