SPEAKER NOTES

Huge Change in Coverage for Psychiatric Medications under MediCal and Medicare

Summarized by Thomas T. Thomas

Changes in the law for Medicare and MediCal will affect patients' access to psychiatric medications. As of January 1, 2006, MediCal will no longer pay for prescription medications, and patients must choose and sign up for one of the new privatized Medicare prescription drug plans in their region. The plans may limit the choice of or access to the medications available, which may be devastating for patients whose current medication is not offered. At our July 27 meeting, **Douglas Del Paggio, PharmD, MPA,** Director of Pharmacy Services for Alameda County Behavioral Health Care Services, explained what is currently known about how the new system will work.

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Dr. Del Paggio noted that he also teaches at the University of California, San Francisco Pharmacy School and volunteers with the Care Plus Foundation, which fights the stigma of mental illness. "I've worked with the chronically mentally ill in Alameda County for more than a decade," he said, "and a lot of the people I work with don't have a voice to speak out for them, like the friends and family of NAMI members." Patients will need that kind of support more than ever with the new rule changes.

"Medicare Part D, which was created in the Medicare Modernization Act of 2003, is coming fast," he said, "and it's complicated. We don't know all of the components, and not all of the answers will be available until October 2005."

The Federal Government's Medicare insurance program is offered in four parts. Part A pays for hospital care, and Part B for supplementary medical coverage such as doctor visits. Part C is called "Medicare+Choice" and allows private health care plans to offer Medicare benefits and may include medical savings accounts, managed care plans, and private fee-for-service plans. Part D is the new privatized prescription drug program.

Medicare Part D is voluntary for most Medicare recipients but mandatory for people with "dual eligibility." Dual eligibility means that the patient has Medicare coverage due to a chronic disability[1] and currently is also covered under the MediCal drug plan or a similar state-supported drug plan. The effects of dual

[1] A patient who is under 22 years of age and has never been self-supporting will be covered through the parent's Medicare insurance and receive Social Security Disability Insurance (SSDI) immediately. After two years, the patient will then receive Medicare coverage directly.

eligibility also depend on the patient's income in relation to the Federal Poverty Level (FPL).[2]

There are 34 million non-institutionalized Medicare recipients in the country, of which almost 14 million have no coverage for medications. Of those, about 7 million people have been identified as dually eligible, of which 1.1 million live in California, and 1,300 in Alameda County.

As of January 1, 2006, medication will be provided only by two types of private plans that will bid for, and only be at financial risk for, the medications provided to patients:

- Prescription Drug Plans (PDPs), which provide prescription drugs only and are a new model for providing medications.
- Medicare Advantage Prescription Drug Plans (MA-PDPs), which provide Medicare benefits and prescription drugs and have a model in the currently existing Medicare+Choice program.

To allow for market competition, there will not be just one plan but many plans with variable options, and none will be one-size-fits-all. The plans will have different procedures, different medication formularies, different prescription authorization processes, and different appeals processes. Only these plans will be responsible for providing prescription drugs—not the hospitals, pharmacies, or any other services.

Costs under these plans will vary, depending on the plan chosen. Some of the components will include a monthly premium of approximately $37, [3] a yearly deductible of $250, coverage of 25% of drug costs between $250 and $2,250, and monthly prescription co-payments. There is a gap, or "doughnut hole," in the coverage where the client will pay 100% of drug costs between $2,250 and $5,100, and then—after the client has paid a total of $3,600 in out-of-pocket costs—Medicare will cover 95% of prescription drug costs.

Under Part D, each section of the country—and California is a whole section—must have at least two Prescription Drug Plans in operation, although there may be as many as 70 or 100. The Centers for Medicare & Medicaid Services (CMS) is currently reviewing the proposed plans, will provide guidance on the overall plan development and requirements for the medication formulary, and will award contracts in each section in October 2005. There is currently little information on any of this.

In general, plans under Part D will be less generous than MediCal. The PDPs will be required to cover only two drugs per therapeutic class in their formularies, and since they are for-profit organizations, they can be expected to cover only the cheapest drugs. However, they will be required to cover all available medications in the classes of antidepressants, anti-psychotics, anticonvulsants, HIV, and cancer medications. (Note that anti-anxiety medications such as

[2] In 2005, the FPL stood at $9,570 for a one-person household and $12,830 for a two-person household. Households at 135% of this level would have income of $12,920 and $17,321, respectively; at 150%, $14,355 and $19,245.

[3] However, there will be a sliding scale of premiums, based on percentage of household income over the FPL. With income at or below 135% of the FPL, Medicare will pay 100% of the premium; at 135% to 140% of FPL, 75% of the premium; at 140% to 145%, 50% of the premium; and at 145% to 150%, 75% of the premium.

benzodiazepines are not in the protected classes, but they will continue to be covered in California through MediCal at least through 2006.) There will be no grandfathering of medications based on effectiveness. The PDPs will be able to block access to medications through "utilization management," which can take a variety of forms:

- Prior authorization—making the patient get permission before the prescription is written.
- Preferred drug lists—based on the medications' cost, not their effectiveness.
- Step therapy—a policy of making the patient fail with cheaper medications before trying more expensive drugs.
- Caps—limiting the number of prescriptions or tablets a patient may receive in a month.
- Co-pays—charging $1 to $50 per prescription.

There will be an exception to these utilization management requirements if a patient is already stabilized on one of the formulary's medications.

The plans will be able to change medications on their formularies with only 60 days' notice. They will not be required to provide emergency drug supplies, although a "transition process" will be required. There may be a lack of continuity in coverage to the patient.

Clearly, the plans will be complex and there will be too much information, too much choice, for patients—especially those with a debilitating mental illness—to choose wisely.

The Medicare Modernization Act of 2003 presents Part D as a theoretical saving to the states, because the cost of drugs for dual eligibles will be shifted from programs like MediCal to Medicare, and the states will get a subsidy for drug coverage for retirees. In reality, all states currently participate in a Federal drug manufacturers' rebate program, and California collects a supplemental rebate as well. Taking these away will finance Part D and cost California about $55 million in 2006, and about $760 million over the next four years.

For dual eligibles, the effects of Part D are coming fast. On October 15, information will become available through CMS or (800) MEDICARE. On November 15, enrollment will begin. And on January 1, 2006, MediCal drug coverage will end, and the patient's new plan under Part D takes effect. There will be no grace period under MediCal for people who are unaware of or unprepared for this. CMS will auto-enroll dual eligibles in one of the "average" or "basic" plans—defined as being in the midrange between the most and the least expensive plans—as of November 15. After this enrollment, the patient can change plans up until December 15, after which he or she is locked into the plan until the enrollment period opens again in the following month.

Regular Medicare participants will have an optional enrollment in Part D between November 15, 2005, and May 15, 2006. After that, they will face financial penalties if they are more than seven months beyond their 65th birthday and have no medication coverage or coverage less extensive than Part D.

Dual eligibles with income at or below the FPL will pay no premium, have no deductible, and pay no out-of-pocket drug costs, but will have a co-pay of $1 for each generic prescription and $3 for each brand prescription. With income

above the FPL, dual eligibles again have no premium, deductible, or out-of-pocket costs, but the co-pay rises to $3 for generics and $5 for brands. The pharmacies will not be allowed to waive these co-payments, and if the patient takes a lot of medications, the amounts will add up. Dual eligibles will pay the full cost for all non-formulary medications, and the plans will not cover over-the-counter (i.e., nonprescription) drugs, vitamins, and supplements.

With the limited time for outreach and education, dually eligible patients will have a difficult time adapting to Medicare Part D. There will be an appeals process for plan actions under Part D, but it will not be triggered at the pharmacy, will involve a confusing five levels of review over a period of six months, and entails loss of due process, because the patient will not have coverage during the appeal.

What can patients do now to prepare for the transition to Part D? They can:

- Stay informed—watch for mailings from CMS; go on the websites for CMS and the California HealthCare Foundation; and discuss the change with his or her current provider, physician, or case manager.
- Stay organized—keep a list of current medications and start a "rainy day medication fund."
- Be prepared in late December 2005 with a 90-day refill on all medications, if possible, to help get through the transition process.