BETTER BENEFITS – MORE CHOICES

Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!

The New Medicare Prescription Drug Benefit: Coverage/Formularies

Beginning in 2006, Medicare beneficiaries will be able to choose the new comprehensive prescription drug benefit. With this new benefit, seniors will cut their bills in half – not their pills.

Coverage/Formularies:

- The Medicare drug benefit will cover all FDA-approved drugs and biologicals normally covered in the Medicaid program, as well as insulin and supplies associated with taking insulin. In addition the Medicare drug benefit will cover drugs that help people to stop smoking.

- Individual Medicare prescription drug plans will be able to set up selective formularies. These formularies may be closed formularies, in which the plan only covers certain drugs, or open formularies, in which all drugs are covered, but beneficiaries receive preferred drugs for lower co-pays than non-preferred drugs. In either case, the plans are required to include at least two drugs in each therapeutic category on their formularies, and beneficiaries will be able to check whether specific drugs they need are
  covered by a plan before enrolling in it.

- In setting up a formulary, the plan must have a pharmacy and therapeutic committee consisting of practicing doctors and pharmacists, including some members who have expertise in the treatment of seniors and the disabled. When choosing drugs for the formulary, the plans must also consider drug's specific therapeutic advantages.

- Formularies and variable co-pays are important tools for plans to manage drug costs and keep the Medicare drug benefit affordable. They enable plans to steer drug utilization to preferred drugs and generics, saving beneficiaries money through rebates that the plans negotiate with drug manufacturers.

- When approving plans, Medicare will review the formulary to make sure that it is not designed to discourage enrollment by people with certain types of medical conditions.

- If a beneficiary finds that the drug he or she needs is not on the plan's formulary (or is on a non-preferred cost-sharing tier), then an appeal is possible. A doctor would need to certify that the drugs on the formulary are not as effective or would adversely affect the beneficiary. If the appeal is successful, then the beneficiary can get the drug as though it were on the formulary (or preferred tier), and any cost-sharing amounts paid will count toward the out-of-pocket limit.