Medicare Part D: Implications for Inpatient Care

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The new Medicare Drug benefit, Medicare Part D, went into effect on January 1st of this year. While hailed by some as the most important advancement for Medicare beneficiaries since the inception of Medicare in 1965, many others have characterized the benefit as poorly designed with large gaps in coverage and of more benefit to drug companies than to Medicare beneficiaries. What cannot be disputed is the incredible complexity of the benefit, and the difficulty that beneficiaries are having in understanding what it is they need to do. **Medications added or changed during inpatient stays may not be covered after discharge.**

The basics. All Medicare beneficiaries are eligible. In Massachusetts, beneficiaries may choose to sign up with one of 44 plans offered by 17 organizations. (Those in Medicare Advantage plans such as First Seniority must enroll in a plan offered by their HMO). While costs borne by the beneficiary vary from plan to plan, a standard plan requires payment of a $250 annual deductible, a monthly premium, which averages $37 nationally, and co-insurance or co-payments for each drug. After the deductible, the beneficiary pays 25% of the next $2000 in drug costs. After that, the beneficiary reaches what is called the "donut hole," with the beneficiary responsible for 100% of all costs until s/he spends another $2,850. Once the $2,850 is spent, the beneficiary becomes eligible for catastrophic coverage and pays 5% of the costs of further prescriptions for the rest of the calendar year. This translates into the beneficiary having to pay $3,600 annually in drug costs plus the monthly premium before the catastrophic coverage begins.

Low-income beneficiaries. Those with low incomes and assets can have their premiums and out-of-pocket costs paid for, but they must apply for "extra help" through the Social Security Administration. While it is unclear whether benefits will outweigh costs for many eligible for Part D, those who qualify for full extra help will almost certainly benefit from enrolling. Dual eligibles—those with both Medicare and MassHealth (Medicaid)—have been automatically enrolled in a Medicare D Plan, with all costs covered except for a co-payment of between $1 and $5 depending on income and type of drug. Medicare beneficiaries who have been getting drugs through the Uncompensated Care Pool (Free Care), will be urged to enroll in a Part D Plan. The Pool will then act as an insurance "wrap," covering co-pays, deductibles, and other gaps in coverage. The Pool cannot cover monthly premiums; they will be covered for BMC patients through a variety of mechanisms including some instances where BMC itself will pay the premiums.

Formularies. Each Drug Plan has its own formulary, with the requirement that at least 2 medications are available in every therapeutic class. If the beneficiary is on a drug not on the formulary, there are 3 alternatives: 1) the physician will need to find a substitute drug, 2) the physician will need to request an exception, or 3) the patient will need to change to a plan that has the drug on its formulary. There are, however, constraints on when a beneficiary can change plans.

Ramifications for the Inpatient Service. Medicare covers all medications while a beneficiary is an inpatient, but once discharged, only those on the Medicare D Plan's formulary will be covered. For this reason, it is important to be conservative when making substitutions. If a medication needs to be substituted because it is not on the hospital formulary, you should, when appropriate, change the medication at discharge back to what was prescribed prior to the hospital admission. This will minimize the number of problems that patients will encounter when they go to their pharmacy to fill their prescriptions.