

## Lessons Learned

### Updated 12/29/05

#### CMS Drug Plan Finder [www.medicare.gov](http://www.medicare.gov)

**Q. Why do prices change in the plan finder? Why would a different plan show up among the top 3 plans one day and not show up another day?**

A. *Keep in mind that the Annual Total Cost is an ESTIMATE.* The plan finder is a dynamic tool and relies on data provided by all of the different drug plans. CMS reviews the information for outliers and inaccuracies on a weekly basis and updates information as quickly as possible. For this reason, you may see different pricing on a different day.

Other reasons why prices might be different for the same plan and same drug(s):

-If you select a specific pharmacy, prices can alter dramatically if the pharmacy has not contracted with the drug plan (out-of-network), or slightly based on the pharmacy's dispensing fee and prices.

-Drug prices can fluctuate in the market. Prices are based on the national average wholesale prices that can go up or down over time.

**Q. What happens if someone enrolls in a plan now but realizes later that another plan is a better choice for them?**

A. *All Medicare beneficiaries have TWO opportunities in choosing plans in between now and May 15, 2006.* A person can enroll in Plan X and use Plan X for several months, decide they prefer Plan Z and enroll in Plan Z before May 15, 2006. Hopefully this will alleviate some fears in making choices; you do have another opportunity to choose within this initial enrollment period.

Dually eligible beneficiaries can change plans every month.

**NEW → Q. If someone is auto-enrolled into a plan that does not cover their drugs and they want to enroll in another plan that does cover all their drugs, what should they do?**

A. They should compare the plans and enroll in a plan that does cover their drugs. When the person enrolls into another plan, they are automatically dis-enrolled from the previous plan.

**NEW → Q. What does a person who was auto-enrolled in a plan do if they have employer or retiree coverage that is creditable?**

A. The person must opt out of Part D. To do this, they must call 1-800-Medicare. They must request the Disenrollment Unit once they speak to an agent. They will be transferred to the Disenrollment Unit and will need to request to affirmatively decline or

opt out of Part D altogether. The Disenrollment Unit operates from 5:00 a.m. to 5:00 p.m. EST.

**Q. Why can't I calculate the annual cost that matches what the plan finder gives as the Annual Cost Estimate?**

A. You cannot reach the annual cost estimate by taking the deductible + [premium x 12] + [monthly costs x 12]. Individuals must first meet the deductible before the monthly prescription costs kick in (for most plans, they pay full retail during that period). Full retail price is not given in the plan finder unless someone falls into the gap and the plan does not offer gap coverage.

Whether/when an individual hits the gap or catastrophic level is dependent on the order the drugs are filled. The plan finder applies drugs in the order they are listed in the tool (alphabetically, not by cost).

Since we are not dealing with claims data and the fact that drug prices do vary we cannot exactly determine the cost for each plan for a given 12 month period. The premium and deductible are fixed costs that will not change, if there is a co-pay for a plan that will not change; however, if a plan charges a coinsurance or if the individual hits the gap or catastrophic level, the costs may vary because of variations in drug prices.

For how we handle costs that cross the different coverage levels [in the same month] please refer to the information below:

**Threshold Cost Sharing Rules:**

***Deductible – Initial Coverage Level:*** Beneficiary pays the balance of the full drug cost up to the deductible + the lesser of: the full co-pay/co-insurance for that drug during the Initial Coverage Limit - OR - the remaining cost balance.

***Initial Coverage Limit – Gap:*** Beneficiary pays full co-pay/co-insurance for that drug during the Initial Coverage Limit + the remaining cost balance.

***Gap – Catastrophic Coverage Level:*** Beneficiary pays the balance of the full drug cost up to the OOP threshold (\$3,600) + the lesser of: the full co-pay/co-insurance for that drug during catastrophic coverage - OR - the remaining cost balance.

Please see the attached excel spreadsheet for an example of the break down of costs.

If the totals still seem highly unexplainable, please contact [Ashley.katz@cms.hhs.gov](mailto:Ashley.katz@cms.hhs.gov) with all the information you used for your search.

**Q. I entered a dually eligible person's personal information into the plan finder but their auto-assigned plan did not appear. Why?**

A. All 5 of the personal information fields MUST match the database in order to identify a person correctly. We think the ZIP CODE field is particularly problematic. You may try other local zip codes or a previous zip code if the client remembers a last address. You may also try to use the Medicare Part B Effective date, even if it is the same date as Part A.

1-800 Medicare can confirm someone's dual eligible status and what plan they were automatically enrolled into. They can also request duplicate letters regarding their auto-assigned plans (yellow paper).

**Q. Why does the plan finder show that the co-pays for dually eligible persons as \$2/5, when they are supposed to have \$1/3 co-pays?**

A. The plan finder is unable to differentiate between full benefit dual eligibles and others getting Medicaid assistance. The plan shows the higher of the two options \$2/5 based on the logic that it would be better to give someone slightly higher prices and pay less when they go to the pharmacy rather than see slightly lower prices and be required to pay more when they go to the pharmacy.

You should rely on the information provided in the Social Security award letter as accurate regarding an individual's premiums (if any) and co-pays.

**Q. If I want the plan finder to show the \$1/3 co-pays for a dually eligible person, is my only option to use the general search and indicate the person gets drug coverage through Medicaid?**

A. This was true. However, in order to be consistent, the plan finder will soon change and only reflect \$2/5 co-pays for all low-income beneficiaries. You will not see \$1/3 co-pays for anyone. This does **not** mean the \$1/3 co-pays for dually eligible persons has gone away.

**Q. Do the Annual Estimated Costs include non-formulary drug costs (full retail price)?**

A. Yes.

**Q. Can plans change prices without giving notice?**

A. Yes. However, plans must give 60 days notice to the beneficiary if they are going to remove a drug from their formulary or change tiering of a drug (move a Tier 2 drug up to a Tier 3 classification).

**Q. Why can't I find a certain drug plan on the plan finder tool now?**

A. CMS checks for accuracy in pricing weekly. If CMS identifies data issues submitted that are not be reflective of the plan and could be detrimental to a beneficiary, CMS will suppress or hide the plan from its web tool until the plan is able to update or correct their information. These plans will be missing from your searches. You are still able to enroll in these plans or get information directly from the plans.

CMS is adding language to the web tool that will appear on the plan comparison page addressing any missing plans. We hope to provide a specific list of the current suppressed plans in a pop-up window, along with a link to their website in the future.

**NEW → Q. What is the difference between in-network and out-of-network pharmacies? Preferred and non-preferred?**

A. Pharmacy Terms:

- **In-network:** pharmacies contracted with the plans
  - **Preferred:** these pharmacies could have lower prices than non-preferred
  - **Non-preferred:** these pharmacies could have higher prices than the preferred pharmacies.
- **Out-of network:** these pharmacies do not have contracts with the plans. If you go to these pharmacies you may pay full price. The plan will generally only reimburse you up to the amount an in-network pharmacy will charge.

Pharmacies can all vary in price even if they are in-network of a plan. Generally, the in-network pharmacies' prices should only vary slightly from each other. Their prices depend on their contract with the plan and their dispensing fee.

**\*\*A Note on Pharmacy Selection\*\***

We suggest you do NOT select a pharmacy in your initial search for plans. Instead, after you initiate a search and see the list of the top 5 plans, note those prices and then add the pharmacy (option at the bottom of the page). You may see a change in prices based on this pharmacy selection and can determine from there if continuing to use that pharmacy is ideal.

If you do not complete a search with all pharmacies you can be overlooking plans that are significantly cheaper. If you select a pharmacy that is out-of-network for a plan, your annual total cost could be \$7,000 when it would be \$2,000 at an in-network pharmacy.

**Q. When I look at the pharmacies that come up with the plan search, I can't find my pharmacy. Does this mean I have to choose another pharmacy?**

A. Not necessarily. It is likely that your pharmacy is in a zip code other than yours. After you've done a search, go to the pharmacy selection. Where it lists the zip code, use the drop down menu to expand the radius up to 25 miles from your zip code. You will often find the pharmacy you are looking for this way.

**Q. If you get any Extra Help (dually eligible, QMB, SLMB, QI, SSI, low-income) do you have to go to an in-network pharmacy?**

A. Yes. If you go to an out-of-network pharmacy you will likely have to pay full-price for drugs and the plan will only reimburse you the co-pay you would have paid (\$1/3 or \$2/5) at an in-network pharmacy.

**Q. When you use the plan compare feature, the tool does not tell you if a drug is not covered on a plan's formulary. How can you tell? Can the tool add a percentage of covered drugs column?**

A. The only way to check that a drug is on a plan's formulary is to click on the plan name so that you see the specific details and costs for that plan. Adding such a feature was considered when the tool was designed but was too problematic to implement because of the numerous variables. It is a good idea to print out the individual plan details for this reason, in addition to the information given on step therapy, prior authorization, etc. that is only provided on this page.

**Q. Why is the price for Fosamax so high?**

A. Most beneficiaries are prescribed 1 Fosamax per WEEK or 4 per MONTH. The plan finder defaults to 30 per month. If you do not enter the correct quantity, the prices will be dramatically different.

**Q. How do you avoid entering someone's data twice if you want to try a different search method?**

A. The tool is designed to NOT SAVE anyone's information as privacy protection. This feature will not change.

**Q. If you go to Humana's website, they handle their \$0 deductible differently than what is given on the CMS website. Which is accurate?**

A. Humana was not providing the correct information. For their \$0 deductible plan, the person begins paying their co-pays immediately rather than paying the first \$250 retail price out-of-pocket. Humana has revised their website to reflect this.

**Q. If you have the Low-Income Subsidy or are dually eligible, what do you pay for higher tiered drugs such as a Tier 4 or Tier 5?**

A. \$3/fill for a dually eligible person and \$5/fill for all other LIS recipients.

**Q. What do you do if someone takes two different dosages of the same drug?**

A. The plan finder now has a feature allowing you to have two dosages of the same drug. You'll see this when you go to update dosage and quantity.

**Q. What is someone splits their pills and are only getting those prescriptions filled 6 months out of the year vs. 12 months?**

A. Unfortunately, you cannot indicate such in the plan finder. The only adjustment you could make would be to cut the price in half for this particular drug and manually estimate a reduced cost.

**Q. The plan finder shows that a drug is not covered, but when I call the plan directly, they report that the drug is covered.**

A. CMS has resolved many of these issues. CMS is dependant on the plans getting us their accurate information. It is always a good idea to double check directly with a plan. Most plans now have their formularies on their websites. See the Region X cheat sheet for direct links to these pages. Please e-mail [Ashley.katz@cms.hhs.gov](mailto:Ashley.katz@cms.hhs.gov) if you discover a drug is not listed on the web tool but should and we will ensure CO is alerted.

**Q. When I enter a drug, it is not found. Or, when I enter a drug, I don't find any plans that cover the drug. Why?**

A. More than likely the drug is one of the following: an over-the-counter, vitamin, mineral, weight loss/gain, Barbiturate or Benzodiazepine. See the list of Barbiturates & Benzodiazepines. If the drug is not one of these categories, please e-mail [Ashley.katz@cms.hhs.gov](mailto:Ashley.katz@cms.hhs.gov) with the information.

**Q. If you get the LIS, what should you do if you enroll in a plan and a drug is not covered?**

A. You must file for an appeal/exception after January 1, 2006.

**Q. Why doesn't the plan finder tool show the gap prices?**

A. The prices you would pay if you fall into the gap will NOT show up unless you actually fall into the gap.

**Q. The annual total cost given for someone is \$1,750. This is less than \$2,250, so why did they fall in the gap?**

A. Total drug costs (the actual retail price: what you pay + the remainder the plan picks up) is what drives the \$2,250 amount.

When your total drug costs (not your out-of-pocket) reach **\$2,250**, you fall into the gap.

When your out-of-pocket (not total drug costs) reach **\$3,600** you reach the catastrophic coverage level.

Note: Currently the web tool features language that is incorrect in this regard. If you fall into the gap you'll see:

***“Initial Coverage Limit (amount you have to spend before your co-pay or co-insurance changes)***

<i>Plan A</i>	<i>Plan B</i>	<i>Plan C</i>
<b>\$2,250</b>	<b>\$2,250</b>	<b>\$0 (Gap coverage such as Humana Complete)”</b>

The caption should read something like this: “Initial Coverage Limit (your co-pay or co-insurance will not change until your total drug costs reach this amount).” The change will be made within the next few weeks.

**Q. Why does the WellCare plan show that the beneficiary pays \$0 for all her drugs?**

A. WellCare offers a \$0 co-pay for all generic drugs (\$73 for brand names); the beneficiary must currently take only generic drugs. Community Care Rx Basic also offers \$0 for generics. Advantage Star Plan and Advantage Freedom Plan offers \$0 for select OTCs.

**Q. Are the Formulary Finder and Plan Finder tool connected?**

A. Yes. The Formulary Finder now uses the same data source as the plan finder. The formulary information for both tools is provided by the plans directly.

**Q. I use the Plan Finder and found a plan that covered most of a client’s medications. Then I had to enter the information again in the Formulary Finder to find out about Prior Authorizations and Step Therapy. How can I avoid entering the information twice into two tools?**

A. You can see information on Step Therapy, Prior Authorization, and tier levels by clicking directly on the plan when you are in the comparison chart in the plan finder. You have to look at each plan individually.