HEALTH POLICY MEMO
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Picking a Part D Plan: Déjà Vu All Over Again?

The annual enrollment period for Medicare Part D is here. Beneficiaries have from November 15 until December 31, 2006, to pick a plan for 2007. Last year, millions of seniors and Americans with disabilities puzzled over the multiple drug coverage options and struggled to make the best decisions based on their needs. This year, if beneficiaries do nothing, they will remain in their current plan. The administration advises that "Seniors who are satisfied with their current coverage will not have to take any action. We expect most of them will not want to change."[1] Though reassuring, this advice is misguided. Beneficiaries, advocates, and health care providers should be aware of potential changes in private Part D plans that will affect coverage in 2007.

Plans Are Disappearing, Merging, and Changing Names

In 2007, not every plan from 2006 will still be available. Insurance companies may terminate one of the plans they offer in favor of offering fewer plans. Carriers may also be ending Part D coverage altogether, or merging with other carriers. Beneficiaries should watch their mail very closely. Plans that are no longer participating in Part D were required to send notification to their members in October 2006.

> ***Example:*** In 2006, PacifiCare and United HealthCare merged. In 2007, the three national PacifiCare plans will no longer be available. Members of PacifiCare Saver, PacifiCare Select, and PacifiCare Comprehensive plans will be enrolled in United HealthCare plans if they do not elect a different plan before December 31. These new plans will have different premiums, formularies, cost-sharing, and restrictions.

A Whole New Plan Landscape

During the initial Part D enrollment period, seniors made careful decisions about their drug coverage based on a delicate balance of variables: plan formularies, utilization restrictions, premiums, cost-sharing, and doughnut hole coverage. Unfortunately, all of these factors have the potential to change, forcing seniors to reevaluate the plan they chose last year and work through the complex equation all over again.

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Families USA studied 13 popular Part D prescription drug plans covering the state of Ohio. We compared coverage in 2006 to coverage of the corresponding plans beginning January 2007. We examined what happened to 25 drugs, including the top 20 drugs prescribed to seniors and five specialty drugs, in order to observe trends in all tiers employed by the plans.[2] We discuss the results of our examination below.

■ Formularies

Just like last year, beneficiaries need to make sure that their plan covers their drugs in the dosages they require. Plans may have removed drugs from the formulary completely or moved drugs from one cost-sharing tier to another, resulting in higher copayments for beneficiaries.

> ***Example:*** Our study examined 13 plans and found that half dropped coverage for at least one of the 20 most commonly prescribed drugs. Ten of the plans moved drugs from a lower tier to a higher tier with higher copayments.

■ Utilization Management

Even if a Medicare drug plan covers a drug, it may restrict access to the drug in a number of ways. Plans can, for example, limit how many pills are covered per month or require that members try alternate drugs before the plan will cover the drug prescribed. Beneficiaries can appeal these restrictions, but even those who won an "exception" in 2006 to obtain a prescribed drug are not necessarily worry-free. Plans are not required to respect these decisions the following year, and the restrictions may apply in 2007, forcing people to appeal all over again. What's more, plans may have added new restrictions to drugs that were previously unrestricted.

> ***Example:*** All of the 13 plans we examined added new utilization management requirements for 2007. Community Care Choice (a product of Member Health, Inc.) added 15 new restrictions. Members of PacifiCare Saver and Select plans who will be enrolled in United Health plans will face nine new restrictions.

■ Premiums

Although CMS Administrator Mark McClellan announced in August 2006 that "we will actually see premiums go down on average in 2007,"[3] most people in Part D plans will see their premiums increase. Nationally, Part D plan premiums increased by 13.2 percent in 2007.[4]

> ***Example:*** Premiums increased in 10 of the 13 plans we studied, with an average premium increase in these 10 plans of 23 percent. Premiums for members of the United MedAdvance plan increased by 46 percent in 2007. Humana PDP Complete premiums increased by 33 percent, and Humana PDP Enhanced premiums rose by 36.7 percent.

- ### Copayments

  Plans can also raise copayments on covered drugs, meaning beneficiaries must pay more out of pocket.

  > ***Example:*** Of the plans we examined, nine increased copayments for at least one of the 20 most commonly prescribed drugs. Members of the PacifiCare Comprehensive Plan who do not change plans may experience copayment increases of up to 67.7 percent for drugs in tiers 2 and 3.

- ### Doughnut Hole Coverage

  The Medicare drug benefit includes a large gap in coverage, called the "doughnut hole." While beneficiaries are in the doughnut hole, their plan pays nothing toward their drug costs. The doughnut hole grew in 2007—beneficiaries fall into the hole after their total drug expenses reach $2,400. Plans do not begin paying for prescriptions again until a beneficiary's drug spending reaches a catastrophic level ($5,451.25 in 2007). The majority of beneficiaries who fall into the coverage gap will not spend their way out before the following year. In 2006, a few plans offered comprehensive coverage through the doughnut hole. Unfortunately, plans that provided such coverage scaled back this benefit significantly in 2007.

  > ***Example:*** In Ohio, Humana PDP Complete was the only plan that provided full coverage through the doughnut hole in 2006, covering both generic and non-generic drugs. In 2007, though premiums increased by 33 percent, the plan will cover only generic drugs in the doughnut hole.

Less Time for Tough Choices

In Part D's inaugural year, the enrollment period lasted six months, from November 15, 2005, until May 15, 2006. Beneficiaries could also change plans once before the enrollment deadline if they weren't satisfied with their initial choice. This year is a different story. After December 31, 2006, beneficiaries who have not selected a new plan will not have an opportunity to switch plans until fall 2007 for coverage starting in 2008. Beneficiaries, their family members, health care providers, and advocates should not heed the guidance of Medicare officials who suggest staying put. Moreover, Medicare has said that beneficiaries who wish to change plans should sign up by December 8 to ensure a smooth transition to a new plan on January 1, 2007—leaving beneficiaries with just three weeks to make an informed decision.

Conclusion: Medicare Consumers Beware

Beneficiaries, their family members, health care providers, and advocates should not heed the guidance of Medicare officials who advise beneficiaries to take no action if they are satisfied with their current coverage. Even if a plan has met a beneficiary's needs in 2006, the plan may not be a good fit in 2007. All beneficiaries need, once again, to examine premiums, drug costs, formularies, and drug restrictions to find the best Medicare drug plan for themselves.

Dual Eligible Beneficiaries at Risk Again

Beneficiaries who are dually eligible for Medicare and Medicaid were automatically enrolled in federally subsidized drug plans last year. The enrollments were problematic for a wide array of reasons, leaving many low-income seniors and people with disabilities without access to necessary medications. This year, hundreds of thousands of dual eligibles will be forced to switch plans once more because their plan's premium has increased faster than the premium subsidy. This coverage disruption, along with most of the other changes discussed in this memo, could cause a recurrence of last year's problems. Beneficiaries may find themselves in plans that place obstructive restrictions on their drugs or that do not cover their drugs at all, leaving them to pay for their medications out of pocket, an expense that this vulnerable group cannot afford.

"This is like déjà vu all over again."
–Yogi Berra

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[1] U.S. Department of Health and Human Services, *News Release: Medicare Releases Data on 2007 Drug Plan Options* (Washington: U.S. Department of Health and Human Services, September 29, 2006).

[2] Data are for the 20 most frequently prescribed drugs in 2004 in the Pennsylvania Pharmaceutical Assistance Contract for the Elderly. We added five specialty drugs to our study to represent all the levels of coverage in the plan.

[3] Centers for Medicare and Medicaid Services, *News Release: National Benchmark Shows Impact of Strong Competitive Bidding and Smart Beneficiary Choices* (Washington: Centers for Medicare and Medicaid Services, August 15, 2006).

[4] Letter from Henry A. Waxman, Ranking Minority Member, to Michael O. Leavitt, Secretary, Department of Health and Human Services, October 12, 2006, available online at http://www.democrats.reform.house.gov/Documents/20061012124517-46697.pdf.