



CMA Weekly Alert – November 16, 2006

MEDICARE PART D: MYTHS AND MISINFORMATION FOR 2007

The annual coordinated election period (AEP) for Medicare Part D prescription drug plans began November 15, and the program remains as confusing and complicated as ever. Instead of reducing the number of plan options as it had promised, the Centers for Medicare & Medicaid Services (CMS) approved more plans for 2007. More choices mean more headaches and not necessarily better coverage for older people and people with disabilities. The following are common myths and misinformation that we have heard from beneficiaries, CMS and Part D plans.

MYTH: IF YOU WERE PLEASED WITH YOUR PLAN IN 2006 YOU DO NOT HAVE TO DO ANYTHING FOR 2007

All Medicare beneficiaries **MUST** review their drug plan information for 2006 to make sure that the plan they were in continues to meet their needs. Drug plans have increased premiums, increased beneficiary cost sharing, and changed their formularies. Some drug plans that provided “donut hole” coverage in 2006 have reduced or eliminated the coverage they will provide in 2007. Some plans that had “benchmark premiums” in 2006, that is, plans that qualified for premium assistance for those eligible for the low-income subsidy, are not offering plans with premiums at or below the benchmark amount for 2007. That means that low-income subsidy eligible individuals who remain in those plans will have to pay a portion of their premium.

MYTH: THE AVERAGE PART D PREMIUM IS LOWER IN 2007

According to a new study by the Kaiser Family Foundation, 77% of prescription drug plan (PDP) enrollees will pay higher premiums in 2007 if they remain in the plans in which they are currently enrolled.¹ The plan sponsor which generally offered the lowest cost plans across the country in 2006 substantially increased its premiums for its basic plan, with premiums in some areas increasing five-fold.

MYTH: MORE PLANS ARE PROVIDING DONUT HOLE COVERAGE IN 2007

More PDPs will offer some kind of donut hole or gap coverage in 2007 than in 2006, but the coverage they provide may not help every beneficiary. The majority of plans only provide gap coverage for generic drugs. Further, the options for coverage of brand name drugs are very

¹ Jack Hoadly, Elizabeth Hargrave, Katie Merrell, Juliette Cubanski, Tricia Neuman, *Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings* (Kaiser Family Foundation November 2006).

limited, and in fact non-existent in some states. One plan that covered some brand name drugs in the donut hole in 2006 will only be covering generic drugs in the gap in 2007. One plan that claims to cover “preferred brand name drugs” is in fact covering only five brand name drugs that are on the first tier of their benefit structure. There are 11 states in which no plans will offer coverage of brand-name drugs during the donut hole. Thus, individuals who rely on medicine for which there is no generic equivalent, or who cannot take the generic version, will have little relief from the donut hole. Additionally, donut hole coverage is expensive, costing on average three times as much as plans that do not provide protection in the gap.² Beneficiaries will have to look carefully at the drugs covered by plans with gap coverage to determine whether they will achieve savings to offset the increased premiums.

MYTH: FORMULARIES ARE MORE GENEROUS IN 2007

The Kaiser report points out that relying on the aggregate number of drugs on a plan’s formulary does not always tell the true story. While some plans may have increased the total number of drugs that they cover, they may have added coverage of generic drugs while reducing coverage of brand name drugs. Additionally, some of the drugs added to formularies have been placed on specialty tiers which have high cost sharing requirements; plans also moved drugs that were already on their formulary to a specialty tier. In 2007 more drugs will be subject to quantity limits, including drugs in the “protected classes” of drugs where all or substantially all of the drugs must be included on a formulary. Plans are changing prior authorization and step therapy (fail first) requirements. The bottom line is: Beneficiaries need to check whether the drugs they use remain on the formulary; whether they will have to switch to a generic; whether they will have to pay more for their drugs; and whether their drugs will be subject to a new or different utilization management tool.³

MYTH: DRUG COSTS WILL REMAIN THE SAME OR DECREASE IN 2007

According to the Kaiser report, beneficiaries will pay more for some of the most commonly prescribed brand name drugs in 2007. Changes will occur because the negotiated price increased and/or the plan changed the tier placement of the drug. In some plans the cost of generic drugs may decrease, primarily because the drugs were moved to a lower cost-sharing tier. At least one of the plans with the largest market share has increased the cost for generic drugs, however.⁴

MYTH: VERY FEW BENEFICIARIES WILL BE REASSIGNED TO A NEW PLAN BECAUSE THEIR PREVIOUS PLAN PREMIUM FOR 2007 IS ABOVE THE BENCHMARK FOR THE LOW-INCOME SUBSIDY

CMS contends that only 288,000 people who are eligible for the low-income subsidy (LIS) will be reassigned to a different drug plan because the premium in 2007 for their previous plan will exceed the benchmark.⁵ This number is misleading. It only includes those individuals who will

² *Benefit Design and Formularies of Medicare Drug Plans, supra.*

³ *Benefit Design and Formularies of Medicare Drug Plans, supra.*

⁴ *Benefit Design and Formularies of Medicare Drug Plans, supra.*

⁵ Beneficiaries will NOT be reassigned to a new plan if the premium for 2007 exceeds the benchmark amount by \$2 or less.

be reassigned to a plan offered by a *different sponsoring organization*. Substantially more individuals will be reassigned to a different plan offered by the same sponsoring organization.⁶ Contrary to comments by CMS, different plans offered by the same company do not always have the same formulary. Drugs may have different utilization management requirements. Brand name drugs may be preferred on one formulary and not the other (affecting co-payments for LIS individuals). The number also does not count LIS-eligible individuals who are not in a plan to which CMS assigned them. CMS IS NOT reassigning these individuals, even though they may have to pay a small premium if they remain in their plan, on the grounds that they prefer the plan they chose themselves. This group of individuals will have to read through the Annual Notice Of Change (ANOC) they receive from their plan to determine that they will have to pay a small premium next year.

MYTH: IF YOU DID NOT ENROLL IN A PART D PLAN IN 2006 BECAUSE YOU HAD “CREDITABLE COVERAGE” YOU DO NOT HAVE TO ENROLL IN A PART D PLAN IN 2007

All beneficiaries who had creditable coverage (drug coverage at least as good as Medicare drug coverage) in 2006 should receive information about the status of their drug coverage for 2007. Employers can change drug coverage for their active employees and retirees at any time. Thus, some employers may have decided to reduce or eliminate drug coverage for 2007. Some are providing drug coverage to retirees by requiring their retirees to enroll in a Part D plan and then assisting them with premiums or other cost sharing. It is important for beneficiaries to understand whether their employee or retiree drug coverage still qualifies as creditable coverage.

MYTH: IF YOU DID NOT APPLY FOR THE LOW-INCOME SUBSIDY IN 2006 OR YOU DID NOT QUALIFY FOR THE SUBSIDY YOU CANNOT APPLY FOR 2007

Circumstances change. Individuals who may not have been eligible for LIS previously may become eligible because of a change in their income or resources or because of a change in their family status. Beneficiaries can apply for LIS through the Social Security Administration or through their state Medicaid office at any time during the year, regardless of whether they have been denied previously.

MYTH: THE COST OF ENROLLING IN A MEDICARE HMO OR PPO WITH DRUG COVERAGE IS LESS THAN THE COST OF A MEDICARE SUPPLEMENT (MEDIGAP) POLICY AND A PRESCRIPTION DRUG PLAN (PDP)

Look at costs very carefully. In 2007 the premiums for an HMO or PPO with drug coverage may be lower than, or the same as, the cost of a Medigap policy and a PDP, but individuals must look at other costs in addition to premiums. Many Medigap policies pay most or all of a beneficiary's out-of-pocket costs in traditional Medicare. Beneficiaries will still have to contribute out of their own pockets for Medicare services received through an HMO and PPO. Though some of these costs may be minimal, costs for some services such as home health care, skilled nursing care, or hospital care may be more expensive in an HMO or PPO than out-of-pocket costs in traditional

⁶ California advocates report that a representative of one of the largest sponsoring organizations said that the organization would be conducting 360,600 intra-sponsor reassignments.

Medicare. And, new regional PPOs have a combined Part A and Part B deductible. That means that people who use only doctor's services and not hospital services in a given year will have to pay more out-of-pocket for doctors' services than in traditional Medicare before their PPO starts paying.

MYTH: ENROLLEES CAN SAVE MONEY BY ENROLLING IN A PLAN WITH SET TIERED CO-PAYMENTS RATHER THAN BY ENROLLING IN A PLAN WITH THE STANDARD 25% CO-INSURANCE

Beneficiaries need to look at the cost-sharing structure of each plan very closely. In some cases the flat set co-payment for a drug may actually be higher than the cost of the drug itself, so that the beneficiary will still pay the full cost of the drug. For example, if a plan charges \$30 for preferred brand name drugs and the cost of a preferred brand name drug is \$27, then the beneficiary pays \$27. If the beneficiary had enrolled in a standard benefit plan with a 25% co-insurance amount, the beneficiary would pay \$6.75 for the same drug. Thus, beneficiaries will have to know the cost of each of their drugs in order to truly calculate which plan may provide them the greatest savings.

MYTH: PART D WILL REDUCE THE COST OF PRESCRIPTIONS

Because drug plans can change their drug pricing and their formulary lists throughout the year, and because a beneficiary's drug needs may change during that period, individuals will not be able to determine whether their Part D plan actually saved them money until the end of the year. We do know, however, that drug plans increased their price for virtually all of the drugs most commonly used by older people in the first few months of the drug program. We also know that the lowest price offered by Part D plans for the top 20 drugs was higher than the price offered by the Veteran's Administration.⁷ Thus, even if an individual saves money as a result of Part D, the amount of savings to the individual will be less than if Medicare could negotiate prices for drugs, and less than if the drug benefit were part of the traditional Medicare program.

For further discussion of Medicare myths and misinformation please contact Attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028, or attorney Judith Stein (jstein@medicareadvocacy.org) in the Center for Medicare Advocacy's Connecticut office at (860) 456-7790.

⁷ *Big Dollars, Little Sense: Rising Medicare Prescription Drug Prices* (Families USA, June 20, 2006).