

HHS SECRETARY’S PRESS RELEASE ABOUT 2007 DRUG PLAN OPTIONS PAINTS A ROSIER PICTURE THAN THE DATA INDICATE

Secretary of Health and Human Services Michael Leavitt’s September 29, 2006 press release concerning data on 2007 Medicare Part D drug plan options¹ paints a rosier picture than the data on the Secretary’s own beneficiary-focused web site indicate. Although the Secretary claims that beneficiaries in 2007 will have more plan options for about the same average premium as in 2006, a review of the plan options available on the web site, <http://www.medicare.gov/medicarerereform/local-plans-2007.asp>, reveals that most beneficiaries will be paying substantially more for their drug coverage. Further, some of the most vulnerable beneficiaries will have fewer, not more, options in 2007 than in 2006.

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<p>“The monthly premium beneficiaries will pay in 2007 will average \$24 if they stay in their current plan – about the same as in 2006.” (Page 1)</p>	<p>A review of the monthly premium amounts included in the Landscape of Plan Options for each state calls into question the Secretary’s math concerning an average premium amount of \$24. The options in Alabama are typical of options available in every other state. Only 5 of the 57 PDPs available in Alabama have premiums at or below the \$24 amount. At least one plan has a premium of \$123.40, almost \$100 more than the average premium identified by the Secretary²</p>
<p>“While some people will see an increase in their current plan premiums, they have the option to switch plans. Nationally, 83 percent of beneficiaries will have access to plans with premiums lower than they are paying this year, and beneficiaries will also have access to plans with premiums of less than \$20 per month.” (Page 1)</p>	<p>The cost of the lowest price plan has increased in virtually every state, and in some states the cost has more than doubled. For example, in Montana the premium for the lowest priced plan will increase five-fold from \$1.87 per month in 2006 to \$10.60 in 2007. Thus, people who enrolled in a low-cost plan to reduce their expenses will actually be paying substantially more in 2007 for their premiums. Contrary to what the Secretary says, they cannot switch to a lower-priced PDP because none exists.³</p> <p>Residents of Montana will indeed have access to plans with premiums of less than \$20 per month but, as indicated, those in the lowest cost plan in 2006 will still pay substantially more in 2007.</p>

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<p>“Beneficiaries will have more plan options that offer enhanced coverage, including zero deductibles and coverage in the gap for both generics and preferred brand name drugs.” (Page 1)</p>	<p>PDPs that offer coverage in the donut hole are expensive and the coverage they offer is limited.</p> <p>A PDP with a large market share that provided coverage in nearly every state for both generics and brand name drugs in the gap in 2006 has eliminated coverage for brand name drugs in the gap in 2007. Medicare beneficiaries who are enrolled in this plan and who want coverage for brand name drugs in the gap will have to change their drug plan, even if they were otherwise not planning to change their drug plan for 2006.</p> <p>Beneficiaries have to pay higher premiums for plans that provide enhanced coverage, including coverage for some drugs in the gap. According to the press release (page 2), the lowest monthly premium for such coverage is \$38.70, or almost \$15 more per month than the “average” monthly premium amount of \$24.</p> <p>In determining whether paying the additional monthly premium will save them money in the long run, beneficiaries first need to make sure that the drugs they take are covered in the gap.⁴ Most plans that offer donut hole coverage will apparently limit their coverage for brand name drugs. For example:</p>

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(Cont.)	<ul style="list-style-type: none"> • In Connecticut only 3 of the 12 plans that provide gap coverage provide coverage for brand name drugs, and those 3 plans provide coverage only for preferred brand name drugs. • In the region that covers Delaware, Maryland and the District of Columbia, one plan provides gap coverage for “all formulary drugs.” The premium for that plan is 103.20 per month, almost 9 times the premium (\$12.20) for the lowest cost plan in that region. <p>Do more choices really mean better drug coverage? Although HHS applauds the increased number of drug plans in 2007, health policy analysts have long questioned the value of increased health care choices to older people and people with disabilities. They particularly question the value of health care choices when, as with Part D, the variety in plan benefit structures makes comparison more difficult. Some analysts have concluded that having to choose among many options creates a burden on beneficiaries and increases their difficulty in making an informed and meaningful decision.⁵</p>
<p>“Beneficiaries with limited incomes who qualify for the extra help will have a range of options available for comprehensive coverage... Nationally, over 95 percent of low income beneficiaries will not need to change plans to continue to receive this coverage for a zero premium.”</p>	<p>Many of the most vulnerable beneficiaries face disruptions in their drug coverage again in 2007.</p> <p>While 95% of beneficiaries who receive the full low-income subsidy (LIS) will not need to change plans to get the complete extra help,⁶ 5% of beneficiaries will be subject to the disruptions in drug coverage caused by changing plans because their current drug plan no longer qualifies for LIS.</p>

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(Cont.)	<p>Looking at the numbers on a national level hides the impact of the problem in individual states. The hardest hit states include:</p> <ul style="list-style-type: none"> • Louisiana (21% of full LIS eligible beneficiaries) • New York (14%) • Nevada (14%) • Alabama (13%) • Hawaii (12%) <p>About 7.3 million people (55%)⁷ who receive the full LIS are deemed eligible and do not have to apply for the benefit. Approximately 6 million of those who are deemed eligible qualify because they are “dually eligible” for both Medicare and full Medicaid benefits. Dually eligible individuals tend to be poorer and sicker than the average Medicare beneficiary, and they generally use more prescription drugs.⁸ Because of their greater need for prescription drug coverage, they are more likely to encounter disruptions in their drug coverage due to the change in drug plans.</p> <p>CMS will automatically re-assign to a subsidy-eligible plan those beneficiaries who remained in the plan to which they were originally enrolled by CMS in 2006. They will receive a blue re-assignment letter. While these individuals will not have to pay premiums, they will have to evaluate whether their new plan covers their prescriptions and includes their pharmacies.</p>

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(Cont.)	Beneficiaries who are eligible for the full LIS and who changed drug plans WILL NOT be re-enrolled in a different drug plan that qualifies for LIS. ⁹ CMS WILL NOT notify these affected beneficiaries that their current drug plan no longer qualifies for the low-income subsidy, and that if they remain in the plan they will have to start paying a premium in January. They will be expected to read the Annual Notice of Change (ANOC) provided by their drug plan. Those who have full or partial Medicaid coverage will be able to change plans, even in 2007, if they discover after the open enrollment period that they have to pay premiums for their plan. Those who were deemed eligible because they receive SSI but not Medicaid, and those who applied for and were found eligible for LIS, will not be able to change plans if they discover they have to pay a premium after the open enrollment period ends on December 31.
<p>“Nationwide the average number of drugs included on a plan formulary will increase by approximately 13 percent, and plans will also use utilization management tools at a lower rate.”</p> <p>“If you’re satisfied with your coverage, you do not have to do anything during the Open Enrollment period.” (Page 2)</p>	<p>Individual beneficiaries will not know whether the drugs they currently use will be included on a specific drug plan’s formulary and whether the drug will be subject to prior authorization, step therapy, quantity limits until they analyze each individual plan.</p> <p>ALL BENEFICIARIES NEED TO REVIEW THEIR CURRENT PLAN TO MAKE SURE</p> <ul style="list-style-type: none"> • Their drugs remain on their plan’s formulary and are not subject to utilization management tools. • The costs of the formulary drugs they take, and whether the price has changed, whether the tier placement has changed, and whether the co-payments for each tier have changed. • Their pharmacy remains in their plan’s network. • If they are eligible for full LIS, their plan still qualifies as an LIS plan. • They do not need to file a new

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(Cont.)	<p>exception in 2007 to get coverage for a non-formulary drug for which they got an exception in 2006.</p> <p>BENEFICIARIES SHOULD REVIEW ALL AVAILABLE PDPs TO DETERMINE WHETHER</p> <ul style="list-style-type: none"> • Another PDP covers all of their drugs, including drugs for which they needed to request an exception in 2006 and/or drugs for which they paid out-of-pocket. • Another PDP provides the same or better coverage for a lower premium. • They can save money by enrolling in a more costly PDP that provides coverage in the donut hole.

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¹ <http://www.hhs.gov/news/press/2006pres/20060929.html>

² <http://www.medicare.gov/medicarereform/mapdpdocs2007/PDPLandscapeAL07.pdf>

³ Beneficiaries could enroll in a Medicare Advantage plan to reduce their Part D premiums, but a change from original Medicare to a MA-PD involves a large number of other decisions, including potential restrictions on providers and the possible need to change doctors.

⁴ Beneficiaries will need to wait until the Medicare interactive plan finder is available on the Medicare beneficiary web site some time in the middle of October to do the formulary check. They will need to compare the information from the plan finder with the information they receive from their drug plan's annual notice of change (ANOC), which they should receive by the end of October, to be clearer about the drugs that are covered in the donut hole or otherwise.

⁵ See, e.g., Biles, Dallek, and Nicholas, *Medicare Advantage: Déjà vu All Over Again?* Health Affairs web-exclusive (December 15, 2004); Hibbard, Slovic, Peters, Finucane, Tusler, *Is The Informed-Choice Policy Approach Appropriate For Medicare Beneficiaries?* 20 Health Affairs 199 (May/June 2001); Schwartz, *The Paradox of Choice: Why More Is Less* (Ecco/HarpurCollins Publishers 2004).

⁶ Those whose plans still qualify for the full low-income subsidy may be required to change drug plans if their current plan no longer covers their drugs or has imposed additional restrictions on their drugs.

⁷ *Low-Income Assistance Under the Medicare Drug Benefit* (Kaiser Family Foundation May 2006).

⁸ *Dual Eligibles and Medicare Part D* (Kaiser Family Foundation May 2006).

⁹ *Reassignment of LIS-Eligible PDP Members Effective January 1, 2007* (Block Memo, September 22, 2006) http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/MemoReassign_09.22.06.pdf.