HEALTH POLICY MEMO

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Buyer Beware:
Higher Costs, More Confusion for the 2008 Part D Enrollment Season

The Annual Enrollment Period for the Medicare Part D drug program begins on November 15, 2007, and runs until December 31, 2007. During this period, all Medicare beneficiaries in a Part D prescription drug plan will have the opportunity to switch plans. Many Part D plans are making changes for 2008 that will result in significantly higher costs for beneficiaries. This makes it especially important for all Part D enrollees to examine their plans carefully to see if the plans will continue to suit their needs.

The structure of the Part D program makes comparing plans difficult. Beneficiaries must consider premiums, cost-sharing, and what costs are covered in the doughnut hole, if any. They must also check if the drugs they use will be covered by their plan next year, and under what conditions. Moreover, without changes in the Part D law, these cost increases and coverage changes will repeat in future years. Below, we discuss several areas of particular concern for beneficiaries for the coming year.

Rising Premiums Will Affect Many

Many beneficiaries will see significant increases in their Part D premiums for 2008. The "national average" premium of around $25 a month, cited by the Centers for Medicare and Medicaid Services (CMS),[1] is misleading. This average includes the premiums of both Medicare Advantage (MA) drug coverage plans and stand-alone prescription drug plans (PDPs). Medicare Advantage drug premiums are very low (even $0 in many cases) because they are heavily subsidized by the 12 percent overpayment that Medicare makes to the private insurance companies that provide MA plans. These MA plans generally have more restrictions on medical services than traditional Medicare, and even after enrollment growth in recent years, only about one-fifth of people with Medicare are in MA plans. The remaining four-fifths of Medicare beneficiaries are in traditional Medicare and do not benefit from this subsidy. What matters to them are premiums for stand-alone PDPs.

■ Stand-Alone PDP Premiums Are Increasing

In 2008, premiums for the average beneficiary in a stand-alone PDP will increase by 21 percent.[2] Some of the largest plans are raising premiums by much more. United HealthCare, the biggest provider of Part D plans, is raising premiums for its popular Medicare Rx AARP Plan-Saver PDP by an average of 89 percent. Humana, the second largest Part D company, is increasing the premium

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for its most popular plan (Humana PDP Standard) by 69 percent.[3] In some parts of the country, the increase is even more dramatic. For example, over the two years since Part D began, premiums for Humana PDP Standard in the seven states in the upper Midwest region[4] have increased by more than 1,300 percent—from $1.87 a month in 2006 to $24.80 a month in 2008.

Last year, very few Medicare beneficiaries changed plans. Part D plans may be expecting consumers to stay put again this year, even in the face of substantially higher premiums. Rising premiums may, however, lead consumers to reconsider their choice of plan. But premiums are not the only factor to weigh in selecting a plan: what drugs the plan covers, as well as the copayments or co-insurance charged for those drugs, are also very important. Staying with the same plan, even if it was satisfactory this past year, may not be to a consumer's advantage.

A Widening and Unavoidable Doughnut Hole

Medicare Part D has a gap in coverage known colloquially as the "doughnut hole." Under the law that created Part D, the size of that gap grows each year. In 2007, the gap begins after beneficiaries incur a total of $2,400 in drug costs. Coverage does not resume until they have spent a total of $5,451—a gap of $3,051. In 2008, the gap will begin after beneficiaries have incurred total drug costs of $2,510. Coverage will resume when their total drug spending reaches $5,726—a gap of $3,216.

■ Less Doughnut Hole Protection Is Available

In a significant change, in 2008, it will be impossible for beneficiaries to purchase comprehensive protection for the doughnut hole. In 2007, at least one company offered doughnut hole coverage in many states, though it came with high premiums. However, this plan experienced heavy financial losses, and it is not offering brand-name coverage in the doughnut hole for 2008.[5] There are no stand-alone plans that cover both brand-name and generic drugs in the doughnut hole next year.[6] Several plans will offer coverage for at least some generic drugs in the coverage gap. But generic-only coverage, while helpful, is inadequate for many beneficiaries. The majority of the most common drugs used by seniors are not available in generic form.[7] As a result, people with significant drug costs—generally those with more serious health care needs—will be unable to protect themselves from the doughnut hole.

Changes in Coverage

Each year, plans can change their formularies (which drugs they cover), pricing tiers (what they charge for different drugs), and their utilization management rules (the policies used to limit access to drugs, such as prior authorization). Even if beneficiaries were satisfied with their coverage this past year, they need to check to see if their plan will still cover the same drugs, at what costs, and under what conditions.

- ### More Price Tiers

  Several plans are introducing new pricing tiers for 2008, especially for generic drugs. In previous years, all generic drugs were usually placed in the same pricing tier. Now, many plans have created subcategories of generic drugs: “value,” “preferred,” and “non-preferred.” Each of these subcategories will be subject to different cost-sharing. This change in classification of generic drugs means consumers will have to re-evaluate their own plan to see how any generic drugs they take will be categorized and what they will have to pay. What’s more, the addition of new subcategories of generics will make it even more difficult for consumers to compare plans.

Disruptions for Low-Income Beneficiaries

Dual eligibles (those who are covered by both Medicare and Medicaid) and others who receive the low-income subsidy will experience some of the most significant changes to their Part D coverage. About one out of six beneficiaries who are eligible for the low-income subsidy—2.1 million people—will have to change to another Part D plan in 2008 because their current plan’s premium will be higher than the value of their premium subsidy. If they do not change plans, they will have to pay the portion of the premium that exceeds the subsidy amount.

CMS will notify those beneficiaries who will have to change plans by a letter mailed in late October. Those whom CMS automatically enrolled in a plan when they joined Part D (the vast majority of low-income beneficiaries) will be automatically enrolled in another subsidy-eligible plan chosen at random from among the available subsidy-eligible plans.[8] As with auto-enrollment at the start of the Part D benefit in 2006, this random assignment will be made without regard to beneficiaries’ drug needs. Beneficiaries who actively selected their current plan themselves will stay in their current plan and pay a premium starting in January unless they chose another plan.

These changes will hurt low-income people with Medicare, who are typically sicker and have more limited financial resources than other Medicare beneficiaries. They are the beneficiaries least able to adapt quickly to change. In the short run, these beneficiaries and those who help them must manage as best they can. They should evaluate their new plan carefully to see if it suits their needs, and change to another plan if appropriate. They should work with their pharmacist, as well, to ensure that they receive appropriate transitional benefits (such as temporary refills of non-formulary drugs) during the first month of 2008 when they first use their new plan.

- ### More Disruptions Are Likely in the Future

  Similar disruptions in low-income coverage are likely to reoccur in the future unless the Part D laws are changed. The low-income premium subsidy level is falling in many states for several reasons, each of which is likely to repeat itself in future years:

  - The value of the subsidy is calculated based on the average premium in a region, weighted by enrollment. Because more people have joined the less expensive plans, those plans are given greater weight in calculating the value of the premium subsidy. As a result, the value of the subsidy decreases.

- The formula for calculating the premium subsidy includes the cost of premiums in Medicare Advantage drug plans. Many MA plans charge $0 premiums because their sponsors receive large subsidies from the federal government. Including these MA drug plan premiums decreases the value of the premium subsidy further, even though most low-income beneficiaries, especially dual eligibles, would not benefit from joining an MA plan.
- Several of the largest plans that were subsidy-eligible in 2007 have raised their premiums significantly for 2008, to the point that they exceed the subsidy level in several states.

This problem highlights the instability inherent in the Part D program, which is entirely dependent on private plans to deliver care. If Medicare beneficiaries, especially low-income people, were offered a plan run by Medicare, many of these problems could be avoided.

Conclusion: Rising Costs, More Complications Are the Norm in Part D

In many ways, the 2008 Part D plan changes exemplify the flawed design of the Part D program. A program intended to serve older and sicker consumers should have made stability and affordability its primary goals. Instead, the creators of Part D focused on promoting an exclusively privately delivered benefit that results in rising costs and an overwhelming array of confusing choices. Unfortunately, there is no reason to believe that the sorts of changes coming in 2008 are unique. Without changes in the law, premiums will continue to rise in future years, coverage rules will change, and the doughnut hole will grow. Many low-income beneficiaries will experience disruptions in coverage every year. Part D needs major improvements to better protect Medicare consumers.

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[1] Centers for Medicare and Medicaid Services, *Medicare Part D Plan Premiums for 2008 Show Continued Impact of Strong Competition* (Washington: Centers for Medicare and Medicaid Services, August 13, 2007).

[2] Avalere Health LLC, *Average Medicare Prescription Drug Premiums to Rise 21%* (Washington: Avalere Health LLC, October 5, 2007).

[3] Ibid.

[4] The seven states in the upper Midwest region are Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming.

[5] Sierra Health Services Inc., *Sierra to Incur Loss on Enhanced Medicare Part D Prescription Drug Product Offering* (Las Vegas: Sierra Health Services Inc., February 27, 2007).

[6] One plan in Florida will offer coverage for some brand-name drugs.

[7] Of the top 25 drugs used by seniors, at most 17 are expected to be available as generics in 2008. See Marc Steinberg, *Coverage through the "Doughnut Hole" Grows Scarcer in 2007* (Washington: Families USA, November 2006).

[8] Roughly 900,000 of these 2.1 million beneficiaries will be assigned to another plan offered by their current insurer. The rest will be assigned to an entirely new company and plan.