



CMA Weekly Alert – September 28, 2006

PART D OPEN ENROLLMENT STARTS NOVEMBER 15, 2006: EVERYONE NEEDS TO REVIEW THEIR COVERAGE AND OPTIONS*

Amid the current chaos of erroneous premium reductions and donut hole woes, Medicare beneficiaries need to be aware of the looming Annual Coordinated Election Period for Medicare Part D drug coverage, which starts November 15, 2006 and goes through December 31, 2006. During this period, Medicare beneficiaries who do not have a Part D plan can enroll in one, and those who do have coverage can change plans. *Beneficiaries who take no action will remain in their current plan, with some exceptions for those who receive the low-income subsidy.* However, since plans may change their formularies (list of covered drugs), tiers, utilization management tools, exceptions and appeals processes, and other aspects of their Part D plans, even beneficiaries who were satisfied with their plan in 2006 need to review their options.

Multiple sources and large quantities of information will be available to beneficiaries about their options for 2007. While beneficiaries can begin enrolling or changing plans November 15, they do not have to make a decision until December 31, 2006, and in fact may purposely choose to wait in order to make the most informed decision possible. Waiting to make an informed decision is especially important as Part D plans will begin marketing their plans October 1, 2006, while Medicare will not publish information about 2007 in the Medicare & You Handbook until late October. The Centers for Medicare & Medicaid Services (CMS) has indicated, however, that beneficiaries who enroll or change plans after December 8th may experience delays in getting evidence of their enrollment in their new plan.

Every person with Medicare can be affected by changes to their drug coverage for 2007 and should therefore review his or her options.

Part D plans may make changes to their benefit package for 2007, including changes in covered drugs, utilization management tools, and premiums. For example, Plan ABC offered in 2006 and 2007 will not necessarily have the same benefits in 2007, even though it is offered by the same company and has the same name as in 2006. It is therefore imperative that all beneficiaries review their current drug coverage - whether they are already enrolled in a plan, have retiree or other creditable coverage, or have no coverage at all - and reevaluate their options for 2007, even if they were satisfied with their plan in 2006.

Factors to consider when renewing membership in a plan or choosing a new plan:

- The amount of the monthly premium
 - Whether enrollees in the plan who are eligible for the low-income subsidy (LIS or extra help) will have to pay a portion of their premium
 - If the plan was a low-income subsidy plan in 2006, whether it will remain a low-income subsidy plan in 2007
 - If not, the amount of premium people eligible for the full extra help will have to pay
 - Whether the beneficiary will have a premium penalty for not enrolling in 2006. The amount of the penalty for those who enroll late is \$1.91 per month in addition to the plan's premium.¹

¹ The late enrollment penalty is 1% of the base beneficiary premium for 2007, times the number of months the beneficiary was eligible for but without Part D coverage or creditable coverage. The base premium is \$27.35/month in 2007. A beneficiary who
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- Whether the plan formulary includes or continues to include:
 - The particular drugs needed by the Medicare beneficiary
 - The strengths, packaging, and dosages of the drugs needed by the beneficiary
 - The number of days covered in each prescription (Example: 30, 60, 90 days)
 - Coverage for off-label drug usage
- If the beneficiary received an exception from the plan in 2006 to cover a drug that is not on the formulary, by-pass utilization management requirements, or to reduce the beneficiary's cost-sharing:
 - Whether the plan will honor the exception in 2007 and continue to cover the drug, and what the beneficiary has to do to make sure coverage will continue
 - Whether the beneficiary must file a new exception request for 2007, when can the new exception request be filed, and what is the process for doing so
 - Whether another plan includes the drug on its formulary so the beneficiary does not need to request an exception
- The plan's utilization management tools
 - Whether utilization management tools have been added to drugs that were on the formulary in 2006
 - The prior authorization requirements (Requirement that plan approve prescription for a formulary drug before it will cover or pay for the medication.)
 - Whether the plan requires step therapy (Requirement that certain medication(s) be tried before that prescribed by the beneficiary's physician)
 - Whether the plan uses tiered cost sharing (Different co-pays for generics, brands, or for specific drugs)
 - The number of tiers
 - The co-payments/co-insurance per tier
 - The placement of the drug on a specialty tier for costly drugs; specialty tiers often require large cost sharing
 - Whether the plan offers therapeutic substitutions
 - Whether there are quantity limitations
 - On number of prescriptions in a month
 - On number of pills in a prescription
 - On dosage strength
- Whether the pharmacies in the plan's network include:
 - The pharmacies used by the beneficiary
 - The pharmacy used by the long-term care facility in which the beneficiary resides
- Whether there are price differentials among pharmacies in the network
- Whether mail-order is allowed or required
 - The price differential for mail order
 - The number of days covered in each prescription (Example: 30, 60, 90 days)
- Whether the plan offers supplemental benefits
 - Coverage in the donut hole
 - Coverage for generic drugs only
 - Coverage for generic and brand name drug

did not enroll in 2006 had 7 months without creditable coverage (June-December), and therefore would have 1% x \$27.35 x 7 months, or \$1.91 per month, added to his or her plan premium. Source: CMS August 17, 2006.

- How the plan coordinates with the State Pharmaceutical Assistance Program (e.g. ConnPACE in Connecticut or Circuitbreaker in Illinois. See <http://www.medicare.gov/spap.asp> for an up-to-date list of SPAPs that work with Part D)
- Who is the plan sponsor? Has the entity been in the community for a while? Is it reliable?
- The “Transition” process used by the plan (Temporary use of drug not covered by plan)
- The “Exceptions” process used by the plan (Appeal if beneficiary’s drug is not covered by the plan)
 - The prior authorization process to get approval for a formulary drug
- Whether the individual has other insurance that covers prescription drugs
 - Through a Medicare HMO or other Medicare Advantage plan. If so, the individual must keep getting drug coverage through that plan if she wants to stay in that plan
 - Through a retiree health plan. If so, has the former employer told the individual whether the insurance is as good as or better than Medicare's coverage (i.e., "creditable coverage) for 2007? If it is creditable coverage, the individual may stay in that plan without getting a late penalty on the premium if he or she later decides to change to a Medicare drug plan.
 - Employers may change the coverage they provide. Drug coverage that was creditable in 2006 may not be creditable in 2007. Some employers that offered creditable drug coverage in 2006 may want retirees to enroll in a Part D plan in 2007, and will subsidize some Part D costs.
 - Through a Medigap (Medicare supplemental) policy. If so, has the insurer told the individual whether the insurance is creditable coverage for 2007? If it is not, the individual will have to pay a late penalty on the premium if she keeps his or her Medigap drug coverage and later enrolls in a Medicare prescription drug plan.
 - Individuals with coverage through the Veteran's Administration, TRICARE, Federal Health Employee Benefit Plan, Railroad Retirement Board, Program All-Inclusive Care for the Elderly (PACE), or Indian Health Service, may continue receiving prescription drug coverage through one of those plans if that coverage is as good as what is offered from Medicare prescription drug coverage.

The Center’s extensive tip sheet is available for printing by itself at http://fairmedicare.org/Resources/06_09.28.FactorsToConsider.pdf

For a timeline of important dates during the 2007 enrollment process, see http://fairmedicare.org/Resources/06_09.28.timeline.pdf

***ASK THE CENTER!**

Still have questions or concerns about the upcoming Part D enrollment? Tomorrow, Friday September 29th at 3:00 pm Eastern time (12:00 pm Pacific), the Center for Medicare Advocacy will launch its first online text-chat, featuring Vicki Gottlich, Senior Policy Attorney and author of this Alert. This will be the first test of a new technology. If you’d like to try it with us, you can access the chat at http://www.fairmedicare.org/dia/organizations/fairmedicare/blog/comments.jsp?blog_entry_KEY=21661&t=BLOGCHAT.dwt. If you have any questions regarding this event, please contact Matt Shepard (mshepard@medicareadvocacy.org) at (860) 456-7790.

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