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2008 PART D COVERAGE - MAJOR CHANGES ARE COMING

An August 13, 2007 press release from the Centers for Medicare & Medicaid Services (CMS) declared victory for Medicare Part D, claiming that the average premium of $25 was nearly forty percent (40%) lower than had been predicted when the drug benefit was first enacted into law. The CMS Press Release, while accurate, does not tell the entire story. In 2008 most beneficiaries will be paying substantially more for their drug coverage, and many will be getting less coverage.

Part D Premiums Are Up

CMS calculates the average premium by taking into account both stand alone prescription drug plans (PDPs) and Medicare Advantage plans with drug coverage (MA-PDs). However, it is important to remember that the federal government overpays Medicare Advantage plans (see the CMA *Weekly Alert* discussing MA subsidies at http://www.medicareadvocacy.org/MA_Overpayments.htm). MA-PDs can then use these overpayments to reduce the cost of their drug coverage, often charging no premium or a small premium to their enrollees. Without this unfair subsidy, it is unlikely that any plan would reduce their premium.

Contrary to what CMS indicates, most people who do not want to be locked into receiving all their coverage from an MA plan, and thus would rather stay in traditional Medicare with a PDP, will actually see their premiums increase in 2008 – and in some cases the increases will be substantial. For example, in Connecticut, thirty-two of the forty-six returning PDPs increased their premiums. The Humana standard PDP, the lowest premium plan in Connecticut in 2006 ($7.32), will cost $24 in 2008. At the high end of the premium range, costs are up nearly 52% ($65.58 in 2006 to $99.50 in 2008). Further, in 2006, people in Montana, for example, could purchase a PDP for $1.87; the lowest premium PDP in Montana in 2008 will cost $13.90. In fact, according to the Kaiser Family Foundation, only one state, Arizona, will have a PDP with a premium below $10 in 2008, and that premium is $9.80. (http://www.kff.org/medicare/upload/7426_04.pdf).

Cost Sharing is Up

Beneficiaries may have to pay more for their prescriptions as well. In 2006, PDPs basically had four Tiers of drugs: Tier 1 (generic), Tier 2 (preferred brand), Tier 3 (non-preferred brand) and Tier 4 (specialty and injectable drugs). In 2008, generics are further sub-classified into categories that are placed at Tiers 2, 3 and even 4. These classifications are: "value" generics, "preferred/non-preferred" generics and "specialty" generics. CMS has provided no definition of these terms; each plan is free to determine the category into which a generic drug is placed. **The addition of these sub-tiers is expected to have a major effect on the cost of co-pays for generic drugs.** In Connecticut, which is typical of other states, the co-payments for generic drugs range from $0 to as much as $75.60 for a "non-preferred" generic, and it is unclear how high co-payments would range for "specialty generic" drugs, which would have up to 33% co-insurance.

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The addition of multiple "sub-tiers" among the generic drugs makes it increasingly difficult to make a true comparison of plan-to-plan costs. Professionals and those beneficiaries who can access and manipulate the CMS Plan Finder tool can still make these comparisons, but people without computers or computer skills – including many of the country's elderly and disabled – will be at a loss to compare plans without assistance.

Coverage in the "Donut Hole" Gap is Down

No PDP will provide coverage for all brand name drugs in the "Donut Hole" (or "coverage gap") in 2008. The Kaiser Family Foundation reports that only one PDP in Florida offers brand name gap coverage, but that plan, Citrus Health plan, will not cover all brand name drugs. This is a significant change for some people, and will increase costs for people who must rely on brand name drugs. While all states will have PDPs that offer some coverage during the Donut Hole, the extent of the coverage varies, with many plans only covering some, but not all, generic drugs on their formularies.

The Kaiser Foundation also reports that all states except Delaware and the District of Columbia will have at least one MA-PD that offers some brand name gap coverage. In most states Humana will offer some brand-name gap coverage through a "private fee-for-service" (PFFS) plan. Advocates should exercise extreme caution when discussing this plan with their clients. See the recent CMA *Weekly Alert* discussing PFFS plans, http://www.medicareadvocacy.org/MA_PFFSReport.htm. Advocates are also advised to remember that in 2006 Humana offered one PDP with brand-name drug coverage in the gap, but dropped that coverage in 2007 because of the cost. PDPs and MA-PDs can change their benefit structures on a yearly basis. Thus, advocates and beneficiaries need to be aware, based on Humana's history, that the company may decide to drop the brand name Donut Hole gap coverage in future years.

Part D Deductibles Are Down – Look Beyond This When Choosing a Plan

Although the deductible for the standard Part D plan has increased to $275, more plans are choosing to offer zero or reduced deductible plans in 2008. Beneficiaries need to be cautious when choosing these plans, however. Part D plans generally must offer a benefit package that is the actuarial equivalent to the standard benefit package. Those plans with reduced deductibles often compensate by increasing the cost-sharing for their formulary drugs. For example, a beneficiary in a $0 deductible plan may pay the equivalent of 33% for a particular drug, rather than the 25% cost sharing in a standard drug plan that does have a deductible.

Low Income Subsidy (LIS) Eligible Plans Are Changing

The plans with premiums below the "benchmark", and are therefore eligible for auto-assignment of dually eligibles, will also change for 2008. CMS has announced that it expects that substantially more beneficiaries across the country will have to switch plans in 2008 – 1.6 million beneficiaries as compared to 250,000 beneficiaries in 2007. A number of states have seen a reduction in the number of such plans. For 2007 CMS instituted a "de minimis" rule that allowed plans to retain their dual eligible enrollees if their premiums were $2 or less above the benchmark. The de minimis threshold has been reduced from $2 in 2007 to $1 in 2008. Note that dual eligibles who selected their own plans (called choosers) and those who were assigned by a state pharmacy assistance program (SPAP) will not be reassigned automatically, but will have to choose their own new plan.[1] See the recent CMA *Weekly Alert* on LIS Issues at http://www.medicareadvocacy.org/PartD_07_09.13.LISUpdate.htm.

Of particular significance, the largest plan sponsors, UnitedHealth, Humana, and WellCare, are losing their low-income subsidy (LIS) status in many parts of the country. United is expected to lose 650,000

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LIS beneficiaries; its AARP plan will only be eligible for auto-enrollment in four states. Humana is estimated to lose more than 400,000 of its enrollees. CMS has recently released data about the number of individuals who will need to be reassigned, which is available at http://www.cms.hhs.gov/limitedincomeandresources/. California and Texas are the states most affected by these changes.

Low Income Subsidy (LIS) Cost Sharing is Up

At the same time that there are fewer plans available to those eligible for the Low Income Subsidy, LIS co-payments will increase. Full benefit dual-eligibles with incomes below 100% of the Federal Poverty Level (FPL) will pay $1.05 for Generic/Preferred Drugs - up 5% from 2007 - and $3.10 for other drugs (no change). Full benefit duals with incomes above 100% FPL will pay $2.25 for generic/preferred, and $5.60 for other drugs - both up almost 5%. Full benefit duals will still have no co-payment above the catastrophic limit. Partial subsidy eligible beneficiaries will pay a $56.00 deductible, up over 11% from 2007. They will continue to have a 15% co-pay up to the catastrophic limit, after which they will pay $2.25 for generic/preferred drugs, and $5.60 for others, each an almost 5% increase from 2007.

Conclusion

There are no "bargains" in Part D prescription drug coverage. People need to plan carefully in order to get coverage for the drugs they need during 2008. Notwithstanding the small decrease in the national average monthly premium ($27.32 in 2007 down to $25 in 2008), overall premium costs have risen tremendously since the program started two years ago. Beneficiaries should think carefully before enrolling in a plan that offers coverage during the Donut Hole as it may not be worth the extra premium dollars spent. Beneficiaries need to check to make sure that all of their generic drugs are covered. Those who qualify for the Low Income Subsidy may face the most disruption if they need to transfer to a different drug plan that qualifies for the subsidy, particularly if the remaining LIS-eligible plans do not cover all of their drugs.

For more information on Part D changes, contact attorney Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center for Medicare Advocacy's Washington, DC office at (202) 293-5760.

[1] CMS is sending a blue letter to beneficiaries who are being reassigned to a new plan and a tan letter to the "choosers." Copies of the letters are available at: http://www.cms.hhs.gov/limitedincomeandresources/.

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