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policy brief

MEDICARE MODERNIZATION ACT:

AN EARLY LOOK AT MEDICARE DRUG PLAN OPTIONS FOR CONNECTICUT'S MEDICARE BENEFICIARIES

Since Nov. 15, 2005, Medicare beneficiaries in Connecticut have had the opportunity to sign up for a Medicare drug plan under the new, federal "Part D" program, with coverage effective on Jan. 1, 2006. This policy brief, which is the third in a series that examines the implications of Medicare Part D for Connecticut, provides an early look at the array of plan options available to Connecticut Medicare beneficiaries, using the experiences of three "prototype" beneficiaries with extensive medication needs as a guide. It also reviews the state's plans to fill the gaps in coverage that are expected to emerge for beneficiaries who receive both Medicare and Medicaid (dual eligibles) and the state's publicly-financed prescription drug program for seniors and people with disabilities (ConnPACE) under Part D.

Connecticut has adopted ambitious plans to address gaps in coverage emerging under Part D plans for ConnPACE beneficiaries and dual eligibles, effectively transferring the burden of coping with shortcomings in Part D from these populations to the state.

Connecticut Health Foundation

KEY FINDINGS

- The state has adopted ambitious plans to address gaps in coverage emerging under Part D plans for ConnPACE beneficiaries and dual eligibles, effectively transferring the burden of coping with shortcomings in Part D from these populations to the state. However, questions remain unanswered, including whether the $5 million the state has set aside to cover non-formulary drugs will be adequate.

- The Connecticut Part D plans vary sharply and randomly in the extent to which they cover the medications needed by three prototype Medicare beneficiaries, highlighting the importance of providing help to Connecticut Medicare beneficiaries in navigating the bewildering array of 44 different stand-alone plan options available in the state.

- The "benchmark" plans to which Connecticut's 65,000 dual eligibles will be randomly assigned by the federal government often fail to cover medications that they need and impose access restrictions — with significant fiscal implications for the state.

OVERVIEW OF CONNECTICUT'S PLANS TO PROTECT LOW-INCOME MEDICARE BENEFICIARIES

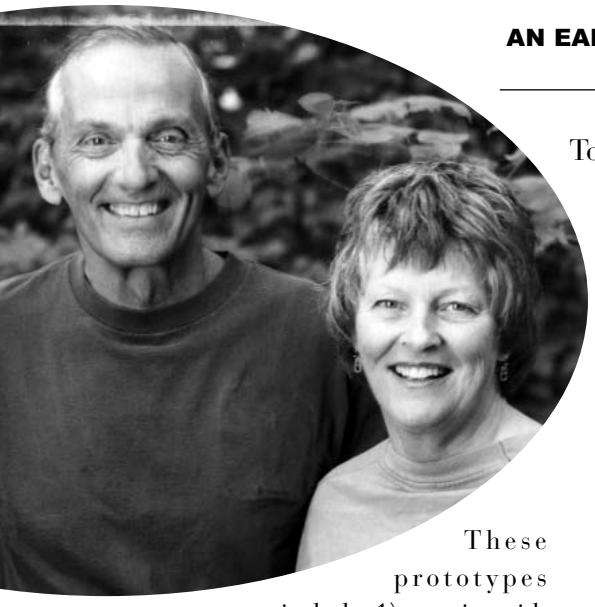
On Dec. 1, 2005, Governor M. Jodi Rell signed a new "hold harmless" bill (House Bill 7702), which prevents Medicaid and ConnPACE beneficiaries from being worse off under Part D. The state will act to prevent dual eligibles and ConnPACE beneficiaries from facing any new cost-sharing obligations under Part D. It also will cover "non-formulary" drugs on their behalf, which is to say FDA-approved medications that could be covered by a basic Part D plan, but are not. To help minimize the size of gaps that it must fill, the state will play an active role in helping ConnPACE beneficiaries and dual eligibles enroll in the plans that best meet their individualized needs.

As a result of these actions, many of the gaps in coverage identified in this early review will be addressed by the state (Table 1). Although questions remain about how they will be implemented, these actions will transfer much of the burden of coping with shortcomings in Part D from individual Medicaid and ConnPACE beneficiaries to the state of Connecticut.

Table 1

Connecticut's Response to Emerging Issues

EMERGING ISSUES	CONNECTICUT'S RESPONSE	OUTSTANDING QUESTIONS
Complexity of Part D plan options	• The state will advise ConnPACE beneficiaries which plans are most cost-effective given their medication usage. • If ConnPACE beneficiaries still do not select a plan, the state will assign them to the most cost-effective one. • Medicaid beneficiaries will receive a $12 voucher for an individualized Part D counseling session with a pharmacist. • The state has provided funding to CHOICES and the Center for Medicare Advocacy to counsel beneficiaries.	• Will concerns arise about the state playing such an active role in selecting a plan? • Is the level of funding available to support plan selection counseling ($1 million) sufficient? • What steps will be taken to ensure pharmacists are unbiased in the advice they provide to dual eligibles?
Out-of-pocket costs	The state will pay Part D cost-sharing (i.e., $1 to $5 per prescription) for dual eligibles and all cost-sharing in excess of $16.25 per prescription for ConnPACE beneficiaries.	
Key medications may not be covered	The state has established a $5 million fund to cover medically necessary non-formulary drugs in fiscal year 2006 (FY2006).	• Is $5 million sufficient? • What steps will people be required to take, if any, to secure coverage of non-formulary medications? • Are there circumstances under which the state will cover medications that are "on formulary," but subject to onerous prior authorization requirements?



AN EARLY REVIEW OF MEDICARE DRUG PLAN OPTIONS IN CONNECTICUT

To evaluate the adequacy of the Connecticut Part D plans, this review considered how three, "prototype" Medicare beneficiaries would fare under the plan options available to them.

These prototypes include: 1) a senior with multiple health conditions who uses six of the most frequently prescribed medications in ConnPACE (i.e., Fosamax, Lipitor, and Celebrex); 2) a person with schizophrenia who also has developed diabetes, high blood pressure, and high cholesterol (commonly occuring co-morbidities); and 3) a person with AIDS with HIV-related myelopathy (a neurological condition) and AIDS wasting (see page 6 for details of drugs taken by prototype individuals). These three prototypes are not intended to be representative of the "average" Medicare beneficiary in Connecticut. They were selected to explore the adequacy of Connecticut's Part D plans for extensive medication users, many of whom are disproportionately represented in Connecticut's Medicaid and ConnPACE populations. Since the state plans to fill most of the gaps that emerge for these populations, the review identifies the scope of the task that it has taken on in "holding harmless" Medicaid and ConnPACE beneficiaries.

The analysis was conducted in late November and early December of 2005 using the web-based tool (the "plan finder") developed by the Centers for Medicare and Medicaid Services (CMS) to allow Medicare beneficiaries to compare plan options (available at www.medicare.gov). The plan finder is updated regularly to address errors and incorporate changes, which means the results could differ if the analysis were reconducted at a later date. Only the 44 stand-alone prescription drug plans (PDPs) operating in Connecticut were examined; the state's 16 Medicare Advantage plans were not included.

CONNECTICUT PART D PLANS VARY SHARPLY AND RANDOMLY IN THEIR COVERAGE OF PRESCRIPTION DRUG COSTS, MAKING IT CHALLENGING FOR INDIVIDUALS TO SELECT A PLAN ON THEIR OWN

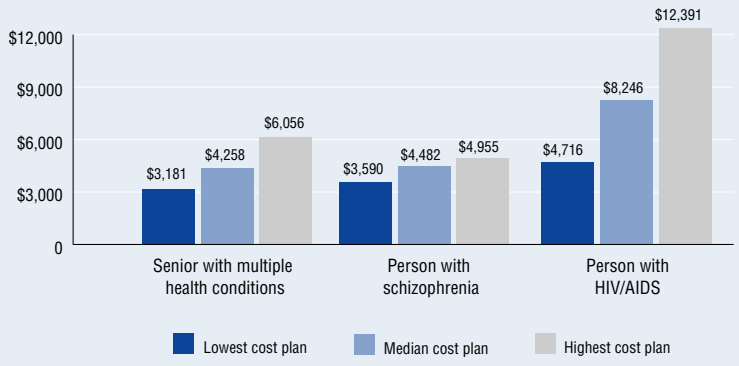
The plan choices in Connecticut are vast and enormously complicated. The 44 plans vary along multiple dimensions, including the premium, the deductible, co-payment obligations, and the size of coverage gaps (i.e., the "doughnut hole"). They also differ in the medications that they cover, in the extent to which they require people to meet prior authorization requirements; and in their pharmacy networks. As a result of this variation, a Medicare beneficiary's total out-of-pocket costs for medications (including premiums, a deductible, cost-sharing, and the cost of non-formulary medications) can vary sharply from one plan to another (Figure 1).

For example, assuming that she does not qualify for Part D's low-income subsidy program, the out-of-pocket costs the prototype senior would face range from $3,181 in the least costly plan available in Connecticut (as measured by total out-of-pocket costs) to $6,056 in the most costly plan. Her costs are nearly $3,000 higher under the most costly plan because it fails to cover one of her medications (Prevacid, for reflux), but, more importantly, because it charges relatively high cost-sharing for those medications which are covered. For example, she is expected to pay $60 for Lipitor (cholesterol lowering medication that costs the plan $71); $60 for Celebrex (pain reliever that costs the plan $85); and $30 for Norvasc (high blood pressure medication that costs the plan $46).

There is some correlation in the Connecticut plans that fare badly across the three prototypes, but, in general, this review did not find that there were "good" and "bad" plans in Connecticut. For example, four of the ten "worst" plans for the person with schizophrenia did a better-than-average job covering the medications of the prototype senior. As such, the review highlights that the best plan for an individual often is a highly specific function of the particular medication needs.

Figure 1

Annual Costs for Connecticut Medicare Beneficiaries Not Enrolled in Extra Help Under Various Part D Plans *(CT Will Pay Most of These Costs for ConnPACE Beneficiaries)*



Source: Georgetown Health Policy Institute analysis for Connecticut Health Foundation, December 2005. Based on costs for persons ineligible for "Extra Help," the federal subsidy for low-income beneficiaries; compares out-of-pockets costs for all 44 prescription drug plans (PDPs) in Connecticut; does not include Medicare Advantage health plans.

The review also found that for people with significant medication needs, "shortcuts" to selecting a cost-effective plan are likely to work poorly. Connecticut Medicare beneficiaries who make a choice based on a plan charging a low monthly premium or even based on the plan covering all of their medications are at risk of paying far more than is necessary in total out-of-pocket costs. For example, the best Connecticut plan for the prototype senior with multiple health conditions has the fourth highest monthly premium among Connecticut plans. And, as noted above, in some Connecticut plans, co-payments for selected medications are so high that it makes little difference that they are technically "covered." Conversely, some prescription drugs are so inexpensive that it makes relatively little difference if a plan does not cover them.

The sharp and random variation in the performance of Connecticut plans for the three prototypes has two key implications for the state:

- **Confirms the importance of the state's decision to play an active role in helping ConnPACE beneficiaries enroll in good plans.** Since it will be liable for most of the out-of-pocket costs that ConnPACE beneficiaries otherwise would face due to shortcomings in their plans, the state has a strong fiscal interest in ensuring they are enrolled in the best one given their medications. The state already has developed plans for addressing this situation, but questions remain unanswered. For example, will some Part D plans dispute the state's process? In Florida and California, for example, Part D plans have objected to state-sponsored efforts to steer people into good plans for their medications.

- **Highlights the need for all Connecticut Medicare beneficiaries to receive individualized assistance.** Even Medicare beneficiaries who are not enrolled in ConnPACE or Medicaid will need assistance selecting a plan; indeed, since the state will not pick up their excess out-of-pocket costs, they actually have more at stake in picking a good plan. The state has made a substantial commitment to providing financial assistance to the CHOICES program in Connecticut and other Medicare Part D education and outreach initiatives, but it is not clear whether the resources set aside for this purpose will be sufficient.

GIVEN IT WILL PAY THEIR OUT-OF-POCKET EXPENSES, CONNECTICUT HAS MUCH AT STAKE IN ENROLLING DUAL ELIGIBLES IN APPROPRIATE PLANS

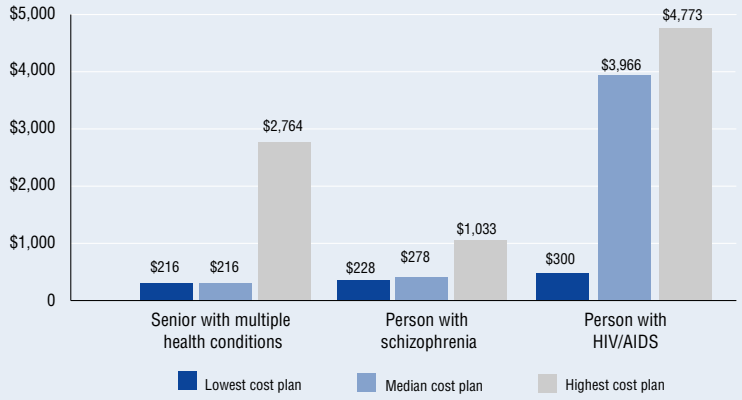
Medicaid prescription drug coverage is slated to end for Connecticut's 65,000 dual eligibles on Dec. 31, 2005. As of Jan. 1, 2006, they instead are expected to secure medications through a Part D plan. Under federal rules, these dual eligibles automatically qualify for "Extra Help" (a low-income subsidy program), which provides them with assistance in paying monthly premiums to their Part D plan and reduces their co-payment obligations to $1 to $5 per prescription. To minimize potential gaps when Medicaid drug coverage ends, the federal government will randomly assign dual eligibles to a Medicare drug plan with an average or low-cost premium. Connecticut's dual eligibles receive a full premium subsidy if they remain enrolled in one of these plans (often referred to as "benchmark" plans), 11 of which are available in Connecticut. Federal rules allow dual eligibles to switch Part D plans up to once a month.

If Connecticut's dual eligibles accept their random assignment to a plan, it increases the risk that they will incur substantial new out-of-pocket costs for their medications — and since the state plans to cover these costs on their behalf, it creates an unknown, yet potentially large financial obligation for the state. For each of the three prototypes considered in this analysis, a number of the "benchmark" plans to which Connecticut dual eligibles will be randomly assigned by the federal government failed to cover key medications, causing the out-of-pocket costs that the state would pay on their behalf to be strikingly high (Figure 2).

Figure 2

Annual Costs Connecticut Will Pay on Behalf of Dual Eligibles Under Various Part D Plans

(Costs will be lower if exceptions are granted or medications switched)



Source: Georgetown Health Policy Institute analysis for Connecticut Health Foundation, December 2005. Based on 11 prescription drug plans (PDPs) in Connecticut with no premium for dual eligibles; does not include Medicare Advantage health plans.

For example, for the person with HIV/AIDS, the highest cost plan in Connecticut was nearly 16 times (15.91 times) more expensive than the lowest cost plan. Driven largely by the plan's failure to cover pain medications used by the prototype, it would cost the state close to $5,000 if such a person remained in this high cost plan and was unable to switch medications or to secure coverage through an "exceptions" process for non-formulary medications.

In light of its substantial financial exposure for dual eligibles' out-of-pocket expenses, the state will try to help them switch to better plans. It will distribute vouchers to dual eligibles that they can use to pay their pharmacists for an individualized counseling session on selecting a Part D plan. However, questions remain about the voucher program. Dual eligibles may erroneously believe that the federal government already considered their individual circumstances when assigning them to a benchmark plan, making them less likely to use it. Also, given the complexity of issues involved, it is unclear whether all pharmacists will have the expertise and objectivity (given their stake in ensuring that individuals enroll in a plan in which they are in the network) to play this role.

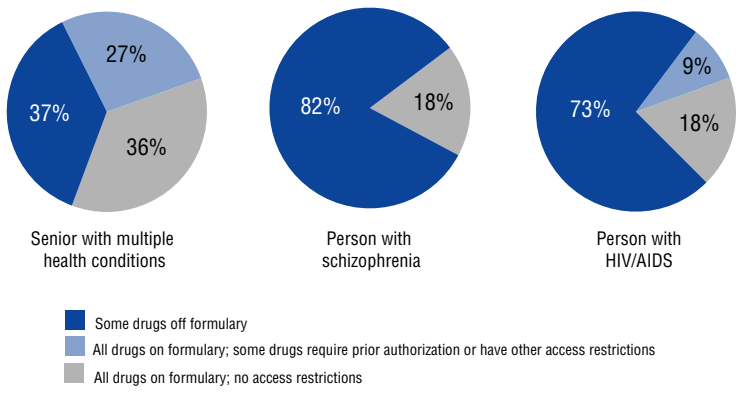
DUAL ELIGIBLES WITH EXTENSIVE MEDICATION NEEDS MAY FACE "ACCESS RESTRICTIONS" TO MEDICATIONS UNDER CONNECTICUT'S PART D PLANS

Dual eligibles in Connecticut may find that many of their medications are subject to "access restrictions," such as medications not being included on formulary and prior authorization requirements (Figure 3). For example, for a Connecticut dual eligible with HIV/AIDS, the majority of plans to which the federal government will randomly assign such a person report not covering at least one of their drugs (8 of 11 plans). In some instances, these "benchmark" plans even reported not covering antiretrovirals, which presumably reflects erroneous information as plans are supposed to cover all currently available antiretrovirals. It is important to note, however, that the highest cost plan for the person with HIV/AIDS covered all antiretrovirals, so the high cost reflects a lack of coverage for other drugs.

Although the state will cover non-formulary medications, dual eligibles still could face access barriers, including prior authorization requirements, to medications that are covered by their Part D plans. In most cases, beneficiaries will have little or no information on the prior authorization requirements that they face under various plans until they actually seek to fill a prescription. In some instances, the state may find that to "hold harmless" dual eligibles, it might need to cover medications denied due to prior authorization requirements, as well as to cover non-formulary medications.

Figure 3

Limits on Access to Medications Among 11 Plans to Which Connecticut's Dual Eligibles Will be Randomly Assigned



Source: Georgetown Health Policy Institute analysis for Connecticut Health Foundation, December 2005. Based on 11 prescription drug plans (PDPs) in Connecticut with no premium for dual eligibles; does not include Medicare Advantage health plans.

CONCLUSION

An early review of Connecticut Part D plans indicates that the coverage they provide will fall short of what dual eligibles and ConnPACE beneficiaries have come to expect from the state. In recent weeks, the state has effectively decided to ensure that it, rather than individual ConnPACE and Medicaid beneficiaries, will bear much of the burden created by these shortcomings. Although some questions remain unanswered about the state's specific plans, its efforts are laudatory and will do much to ensure that ConnPACE beneficiaries and dual eligibles are held harmless as a result of implementation of Part D.

DRUG REGIMENS OF THREE PROTOTYPE CONNECTICUT MEDICARE BENEFICIARIES

Senior with multiple health conditions: This prototype is based on a senior who takes six medications to treat multiple conditions (osteoporosis, high blood pressure, high cholesterol, arthritis and GERD or Gastroesophageal Reflux Disease). The medications used to treat these conditions were taken from the list of the top ten medications covered by ConnPACE in 2004 and reviewed by an internist to avoid contraindications. They are: Fosamax (70 mg) for osteoporosis, Prevacid (30 mg) for GERD, Plavix (75 mg) as a blood thinner, Lipitor (10 mg) for cholesterol, Norvasc (5 mg) for high blood pressure, and Celebrex for pain. Since Celebrex has fallen in usage since 2004 due to litigation over a similar medication (Vioxx), we also ran the analysis with a substitute pain medication (Voltaren), but found it made little difference in outcomes.

Person with schizophrenia and diabetes: This prototype is based on a person with schizophrenia who also has developed diabetes, high blood pressure, and high cholesterol, common co-morbidities. The prototype takes nine medications, which include Clozapine and Risperdal to treat the symptoms of schizophrenia, including delusions and hallucination; an anti-convulsant (Valproate) to address side effects from the schizophrenia medications; and hydrochlorothiazide (HCTZ), Humalog, Lantus, Lipitor, Lisinopril, Norvasc to treat the person's other illnesses. The real person who serves as the original basis for the prototype also uses Ativan (benzodiazepine) and aspirin (over-the-counter), but these medications were not included in the analysis because they will not be covered by most Part D plans.

Person with HIV/AIDS: Based on a real person who takes 13 prescription drugs (4 of these are antiretroviral medications) that should be coverable by his Part D plan; this prototype reflects the drug regimen of an individual who has been disabled by AIDS for more than 10 years. Along with antiretrovirals, he takes several narcotics and other drugs to manage pain associated with HIV-related myelopathy and anabolic steroids used to treat AIDS wasting. This analysis did not include certain drugs that he takes, such as Xanax (benzodiazepine) and B-12 injections (vitamin), because they cannot be covered under a standard Part D plan (Connecticut, however, will cover these drugs for dual eligibles through Medicaid and under ConnPACE). The analysis also did not include testosterone injections, which would be covered under the Medicare Part B program. The specific drugs used in the analysis were Acyclovir (800mg: 2x per day), Baclofen (10mg: 5x per day), Emtriva (200mg: 1x per day), Gemfibrozil (600mg: 2x per day), Lexiva (700mg: 2x per day), Lidoderm (5% DIS: taken as needed), Marinol (5mg: 6x per day), Methadone HCl (10mg: 5x per day), Nandrolone Decanoate injection (200mg/ml: 2x per month), Norvir (100mg: 2x per day), Oxycodone HCl (5mg: 5x per day), Retrovir (100mg: 6x per day), Tizanidine HCl (4mg: 1x per day).

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