

FACTORS TO CONSIDER WHEN RENEWING MEMBERSHIP IN A PART D 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
- 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, bypass 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

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 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.

- 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
 - 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.