

SRA/RFA MEDICARE PART D SURVEY

In the fall of 2006, the USC Staff Retirement Association and the Retired Faculty Association conducted a survey to see how members of our Retirement Community had fared under the new Medicare prescription drug plan. We received 95 responses, 64 from respondents who were on a Medicare Part D plan and 31 who were on an HMO or PPO plan.

The results show only the experiences of those who participated in the survey. There was and is no intent to indicate that USC retirees should make their selection of a Medicare Part D provider based on the data below. In fact, the survey showed us that it is very difficult to select a plan, and everyone's unique and special needs must drive the decision-making process. These data are available with the names of those who did have Medicare Part D coverage in 2006 and were willing to discuss their experiences. We hope that you can benefit from these discussions.

We would also encourage you to attend future programs on Medicare and Medicare Part D to keep up-to-date with what is happening, including changes that may be made in these plans.

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REPORT
First Year Experiences in the Medicare-D Prescription Drug Plan Survey
USC Retiree Community

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Highlights of the Report

- ***95 USC Retirees participated in this survey** (64 in Medicare-D plans, 31 in non-Medicare-D plans);
- *The 64 Medicare-D participants enrolled in 10 different plans, but **two thirds participated in only two plans – AARP (23) and Humana (20)**.
- ***Only four plans had more than two participants**, so summary information is presented on those four: (AARP 23, Humana 20, Aetna 8, and RxAmerica 5).
- *On a five point scale, moderate satisfaction was reported in AARP (3.2), Aetna (3.4) and RxAmerica (3.6), **but high satisfaction was reported in Humana (4.7)**.
- *Asked about whether you intended to stay with the same plan next year, Aetna was 71%, RxAmerica was 75%, Humana was 79%, **but AARP was only 43%**.
- *As a group, **42% of all 64 Medicare-D respondents experienced surprise** with their plans (while only **15% of the 31 in the non-Medicare-D sample did so**)
- *52 of the 64 Medicare-D respondents indicated **a willingness to be contacted by a USC person exploring using that plan** (to answer more direct individual questions).
- *Many Medicare-D respondents did not understand how quickly they would fall into the “donut hole,” nor how hard it would be to get out.
- *Many Medicare-D respondents tended to continue to be confused and uncertain about the available alternatives and how best to proceed during the open enrollment period.

Background

Beginning on January 1, 2006 the Medicare-D Prescription Drug Plan became available for those who had Medicare A (hospital coverage) and B (physicians coverage) – 62 being the first age of eligibility for A, and 65 for B. **Most members of the USC retiree community had no need to participate in this Medicare-D prescription drug program since they already had Medigap coverage with a prescription drug benefit established through their present employer (or a spouse's employment), or the HMO or PPD plan they had elected earlier.** That is, most of the 2,100 faculty and staff USC retirees with no primary health insurance other than Medicare had already initiated a Medigap policy (such as Kaiser, Pacific Care, Health Net, Blue Cross, etc.) which continued to provide a prescription drug benefit).

But for those USC retirees **not** otherwise covered, the Medicare-D plan became the only way to get help with their prescription drug costs. This was basically the case with the 400 or so USC retirees that participate in the USC Senior Care Plan which had provided such prescription coverage in the past. But when Medicare D became available the University decided that USC Senior Care would no longer provide a prescription drug benefit (and the USC Senior Care price was simultaneously adjusted downward). We know of no other Medigap plan (in our area) that made that choice.

The process of learning about the 47 available Medicare-D plans offered by 18 private insurers in California proved formidable and harrowing. Information was late and uneven in quality. Details of the formularies of plans in which you thought you might have interest were complex and changing. Prices were uncertain and changing. Details of the plans were complex. In the final analysis, knowing what the “right” program for any given person might prove to be was beyond calculation (e.g. not knowing how your own health situation might change during the year made estimating costs only a not-very-informed-guess). Actual behavior by the various plans was impossible to anticipate with any level of confidence. Potential changes in drug availability , behavior on the part of plans on appeals and price were simply unknowable. And few could get their minds around the uncertainties of the “donut hole” where any coverage at all would be foregone.

Finally, most USC retirees who had to make a choice did so using whatever information or intuition they could generate. The one saving grace in all of this was the knowledge that the effect of your decision was limited to the one year – 2006. Each future year was to have an open enrollment period (from November 15 through December 31) at which time a new decision can be made – either to continue with the plan you chose earlier, or shift to a new plan as of January 1. We had thought there might be some inter-year stability among the plans, but that now seems unlikely, since all seem to be making changes based on their changes in their first year. So, choices in this first open enrollment period seem likely to be very similar to the ones made at this time last year -- i.e., chancy and uncertain.

Nonetheless, the Boards of the Staff Retirement Association (SRA) and the Retired Faculty Association (RFA) determined that it might prove useful to schedule a meeting for our joint membership at which information about this Open Enrollment period could be made available. In addition, it seemed useful to see if we could collect a bit of data about the experiences of our members with the various plans elected for 2006.

We had no knowledge of which of our approximately 2,100 joint membership had elected a Medicare-D plan, and it would have cost well over \$1,000 to mail a questionnaire to everyone (we knew that most of our members had not needed to participate in Medicare D). Therefore, we decided to develop a very simple questionnaire (12 items) and distribute it by email to those of our members who happen to have email (about 500) and live with the responses of those who participated in Medicare D provided by email or by fax. This provided a way to generate a bit of performance and experience data that was available to no one when the first year decisions had to be made at this time last year.

Carole Gustin and Bob Biller took the laboring oar on this project – including framing the questions, recording and summarizing the data that came back and preparing this report. This section summarizes some of the observations, reflections, and insights generated by the data. All errors of fact and interpretation are ours alone. We welcome suggestions or alternative readings and would be happy to receive them at either of the authors' email addresses

The results of the survey are neither rigorous nor scientific – they simply represent a larger range of experience than any of us have generated individually. The results of the survey can be read as an answer to the question: **“What have we learned in the year about the operation of the Medicare-D plan we have chosen, and what difference might that make in whether we stay with that plan or elect another?”**

Some Overall Findings

95 survey responses were completed (64 from those who had enrolled in a Medicare-D plan – and 31 who had continued with some HMO/PPO or other plan which provided prescription drug coverage). The latter proved useful for comparison purposes. There were something like 400 USC Retirees known to have been affected by the Medicare-D decision (of whom perhaps 40% could be reached by email). So, we believe that the 64 responses represent a small but useful sample – with an approximate response rate of about 40%.

While there were 47 plans available from which we could choose, only ten plans were selected by the USC retirees in this sample. Two of those plans captured two thirds of us in this first year (AARP with 23 and Humana with 21). Only two other plans had more than one or two participants (Aetna with 8 and RxAmerica with 5), and therefore no comparisons proved easily possible other than among those four most frequently chosen plans.

It was striking how, on the satisfaction we felt with the plan that we had chosen, that three of the four most frequently chosen plans had roughly similar levels of satisfaction (AARP with 3.2, Aetna with 3.4, and RxAmerica with 3.6). But it was even more striking how much more satisfied those participants were who had enrolled in a Humana plan – with an average score of 4.7. The average for the Medicare-D sample as a whole was 3.8 (but it is striking that those who had **not** participated in Medicare D reported a higher average level of satisfaction with the prescription drug arrangements of the various plans in which they were participating – at 4.2).

Further, when respondents reported whether they presently intended to stay with their present plan for next year, three of the plans were seen to be roughly similar with Aetna at 71%, RxAmerica at 75%, and Humana at 79%, but this time AARP, at 43%, lagged substantially.

So, on balance, among the four plans that most of us elected, those who elected Humana seemed to be feeling best about their choice, while those who elected AARP were feeling most uncertain about their choice.

It was also striking how much more frequently those in the Medicare-D sample reported themselves as being surprised by one or more aspects of their plan in this first year (42%), while those who continued with a prior Medigap arrangement reported themselves as being substantially less frequently surprised (15%). Most surprises seem not to have been positive ones.

Within our USC retiree community there is a clear sense that we are in this together and want to be helpful to each other. An astonishing 52 of the 64 respondents in the Medicare-D sample (over 80%) indicated a willingness to be contacted if another USC person wants to consult with them about some aspect of the plan that the one had used for the last year and the other was considering using for the next year. Our own lives might have gotten much more difficult, unsettled and chancy, but we do want to be helpful to each other.

Reviewing the responses from our retirees participating in Medicare D in 2006 seems to indicate that the complexities of the various plans, the lack of clear answers to important questions, the apparent consistent absence of any incentive to constrain costs, leaves most of us with a feeling of unrest and uncertainty as to what to expect next or how best to grapple with this difficult problem. We are, as a community, roughly as much at sea in October 2006 as we were in 2005 – with little apparent prospect that things are about to get better. Here are some representative findings:

Some Specific Findings

1. **Plans chosen:** 89% of the sample (54 of the 61 Medicare-D enrollees) chose **only four insurers** (AARP 23, Humana 20, Aetna 8, and RX America Advantage 5). The other 8 persons selected Blue Cross (2), MemberHealth/Community Care Rx (2), Blue Shield (1), Coventry Advantra Rx (1), Medco Health Solutions (1), and United American (1). No one chose any of the other 23 plans offered by the 8 other carriers. **Three quarters of this USC Medicare-D sample (43 out of 64) chose the AARP and Humana plans.**
2. **Satisfaction level:** Among the four most frequently chosen plans, the weakest satisfaction level (on the 5 point scale where 5 = highest) was attained by AARP at 3.2 (only 1 out of 10 persons gave it a “5.” Aetna was stronger at 3.4 (with 1 out of 5 persons giving it a “5”). RX America at 3.6 was stronger still (with 2 out of 5 giving it a “5”). **Humana at 4.7 was the strongest in satisfaction level (more than 1 out of 2 giving it a “5”).**
3. **Plan configurations:** Three of the four most frequently chosen insurers achieved roughly similar satisfaction levels and offered multiple plans (Aetna 3, RX America 2, and Humana 3). AARP elected to offer only one plan configuration. This may suggest that being able to select from among plans with similar overall structure but specific differences on some features (such as price, deductibles, donut hole coverage, etc.) is likely to be associated with higher satisfaction.
4. **Appealing the availability of a drug:** Among the four most frequently chosen insurers, each had a least one person who had to appeal the availability of a drug. RX America had three of their five persons in the sample who needed to appeal – one was known to have been denied and one was approved. AARP had one of its 21 persons who found it necessary to appeal and that appeal was

denied. Aetna had one of its 8 persons who found it necessary to appeal and that appeal was granted. Humana had one of its 18 persons who found it necessary to appeal and that appeal was granted.

5. **Willingness to help another USC colleague:** 81% of the USC Medicare-D sample (52 out of 64) indicated a willingness to answer questions about the plan they have used this year if that would be helpful to another USC retiree. A list of those folks (by plan taken) is shown on the last page of this report. If contact information on any of these persons is needed, any USC person may contact Carole Gustin or Bob Biller, and we will pass it along.

6. **Prescription drugs really do cost a lot:** Many respondents noted their surprise at the overall high cost of the medications they take – much higher than they expected or had been aware of previously.

7. **No insurers seem to have established any credibility on their pricing policies.** The fact that many prescriptions can be purchased for substantially less than the “our cost” amount cited by the plan insurer -- through a discounter such as Costco -- and that the “our cost” figures are so substantially different among plans, leaves many puzzled and angry – especially since the scale of “over pricing” immediately hurts the plan subscriber who slips into the donut hole much quicker than expected.

8. **Falling into the “donut hole” for many has come much sooner than expected:** Many were surprised that they would reach the donut hole faster than they expected (because the overall cost of the medications proved to be immensely larger than the co-payments they were being charged previously).

9. **The over \$3,600 relief at 95% coverage is much tougher to reach than was expected:** Many respondents were surprised the “donut hole” can’t be escaped until their own personal payments reach the \$3,600 level. Many had thought that the \$3,600 threshold was reached in the same way as the \$2,250 threshold, i.e., by the sum of one’s personal co-payments and the plan’s payments basic payments. That is wrong. The \$3,600 counts **none** of the plan’s payments **nor** any of the participant’s monthly plan fees.

10. **The total cost of drugs has not routinely been recognized:** Most respondents had not focused on the total cost of the drugs they required (focusing instead on the co-payment amount) and therefore were not easily able to calculate any price increase that occurred during the first nine months of the year. Only two respondents seem to have recorded a 1/1/06 starting price (or kept track thereafter) -- which would have allowed a calculation on the price increase for the year so far. Most of us have only considered a “cost” what we have paid as our “co-pay” on drug costs – not the total cost reported by these insurers.

11. **Many expect to do an overall assessment AFTER this first year’s experience:** So an open enrollment period before the year has ended may be less useful than expected.

12. **Non-Medicare-D respondents:** Some persons who had continuing prescription drug coverage under other plans responded to the survey anyway (i.e. persons with no Medicare-D prescription drug plan). Their responses to several of the questions are included for comparison purposes. These are persons who **continue with prescription drug coverage under other plans by which they are already covered or by Medigap insurance they have purchased which includes prescription drug support.**

Note: Such non-Medicare-D participants generally have **greater satisfaction** with their arrangements than those who elected a Medicare-D plan. They are surprised less (15% vs. 42) and their satisfaction (as measured on a 5-point scale) averages 4.3, while the satisfaction of those who enrolled in a Medicare-D plan was 3.8.

Some Comments of Survey Respondents

A full set of respondent comments on all plans is available on request. A copy of the “Responses” summary from which this report has been prepared can be received by contacting Carole Gustin or Bob Biller. Here are some selected observations associated with the 4 most frequently chosen plans whose participants generated the particular comment.

AARP

Mail order prescriptions take longer to process than they did with USC Senior Care.

I’m still not saving a significant amount of money.

There is not enough coverage in terms of the amount before the “donut hole” is reached.

The prescriptions are bought at a high price now because I reached the “donut hole” in May.

That was not only a surprise but a shock.

For the drugs I take, there appears to be little difference from my previous plan.

I have not gotten anything from this plan; do not like to be forced to have it.

The high quoted cost of medications – no evidence of savings from bulk buying.

Almost all of the drugs I order are brand name - with a high cost per drug.

The “donut hole” is too big and I had to get an MD’s justification for a rather common drug.

The new plan is much more costly than the old USC Senior Care plan and more difficult to use. Without the Part D drug plan, by having M.D.s prescribe generics, I would save by purchasing a Costco and not paying monthly premiums plus exorbitant costs. Where’s the benefit?

When I faxed my doctor’s prescription order, one prescription was not original (it had been faxed to me by my doctor). The plan insisted the doctor fax them the prescription directly. While this was going on I ran out of pills and the pharmacy charged me \$76 for 10 pills (until the 90-day supply arrived). The plan sent me a special form to fill out, but in spite of monthly phone calls for three months now, I still have not received the \$70 refund which I am owed. All other transactions have been processed quickly and efficiently.

I am in a worse situation this year than I was last year before the Medicare-D program was forced on me. My prescription bill is doubled this year if not more. I have had to discontinue really expensive meds like Advair inhaler because the cost is too high, approximately \$225 per month.

I was able to include all our present drugs, there was no deductible, and the lower cost.

So far, the paperwork has been fine.

I receive a monthly printout of my drug costs/balances.

I expect AARP to help lead good coverage and service.

Very prompt service.

The plan sounded “good” but the USC Senior Care plan was “very good.”

The program is weak.

I suspect my physicians were not as cost conscious before as they are now with Medicare Plan D.

(AARP cont.)

The “donut hole” calculation is different for **entry** than it is for **exit**. For entry, you get to the \$2,250 “donut hole” by the sum of the high total prices quoted by the plan and your co-pays – which causes you to get to the “donut hole” faster than you might have expected. The **exit** (getting out of the “donut hole” at the \$3,600 level where 95% of your costs will be covered is driven only by what you have paid personally (the sum of your earlier co-pays and the entire quoted prices you pay while you are in the “donut hole.” Your monthly plan fees do not count. So, you can get out of the “donut hole” (to the safety of the “plan pays 95% level” much more slowly than you might have expected). It does make the “bulk buying” model of Canada clearly more attractive (which passes the savings directly to the consumer), and I do not wonder at how fiercely the pharmaceutical industry fought for this plan over one more akin to Canada’s.

Aetna

The objective of Aetna is NOT to provide drugs if at all possible and the establishment of procedures not communicated to the subscriber which prevent obtaining drugs in a timely fashion.

Aetna makes it difficult to obtain the drugs. The rigidity and non-responsiveness to communications – most of the time not responding at all.

95% of brand name drugs are covered.

This plan provides very good coverage on generics and level 2 brands, but very little savings on level 3 brands. Many medications do not have generic equivalents. Since it is the total cost of the medication (out of pocket plus what the plan pays, getting to the “donut hole” may be surprisingly fast.

The Medicare-D program is overly complex, inconsistent from plan to plan, and a money maker for the drug makers and for the insurers who accept the government and subscriber payments and then do everything possible to avoid providing a cost-effective product.

Humana

It’s better than I anticipated.

Its ease of use is better than I expected.

That I have actually saved money.

How expensive my prior plan was by comparison.

The plan’s stated cost of a particular drug is/was often overstated. For example, in one case they said the drug cost to them was \$100, when I got the same drug from Drugstore.com for \$12. This has been toned down, but it persists.

Mail order does not seem to offer any advantage – my former plan had a much more cost-effective mail order system.

It’s difficult to get prompt answers and reasonable explanations about why a prescription is not covered.

There was a change of mail-order pharmacy made without my knowledge in the beginning (the publicized pharmacy could not handle the volume), but the new arrangements are satisfactory.

You have to be careful when getting prescriptions.

Humana has been courteous and helpful in all my contacts with them.

It is inexpensive.

There is no charge or co-pay for generic drugs; the number of pharmacies is broad and we have a new CVS close to us, so we are satisfied with our choice. I have USC Senior Care which used to cost me \$270 per month (and that included a drug plan but no dental or

(Humana cont.)

optical insurance). Now, my USC Senior Care costs me \$175 per month and it gives me dental and optical insurance. That saves me \$95 per month and \$95 for my husband as he has the same USC Senior Care. That combined \$190 per month more than covers the co-payments for the drugs we need to buy each month.

The coverage is satisfactory.

Good customer service; low monthly premiums; completeness of the formulary (at least for me); excellent web site; prompt mail order service; quarterly summary of drug costs; complete documentation on the plan; availability of three plans that span the possibilities of need better than any others I looked at.

Low monthly premium, very simple enrollment process.

I have had no problems.

So far, so good.

For my three drugs I found other drug plans at least twice as expensive and my monthly payment is only \$5.40.

Rx America

The lack of help in getting issues resolved.

One drug that was included in the formulary prior to January 1 was not included when the plan began. The generic versions of the drugs I take cost about the same with Medicare D as I can buy them over the internet from Canada.

Unwillingness to offer support or to fill physician's orders.

Difficult getting our doctor and plan to communicate on a prescription for Celebrex.

I'm not sure it saves any cost over buying drugs from low cost sources without the plan.

For now, I'm still subscribing from an insurance standpoint that in the future my wife or I may need an expensive drug. I believe the net effect of the Medicare-D program may be to allow the pharmaceutical companies to keep prices higher than they would if we had a Canadian style bulk buying plan.

The plan covers a large fraction of the cost of my prescriptions and I have no work to do; the pharmacy does all the work. The plan sends me a summary of the costs each month.

RxAmerica is owned by Longs Drugs and I will now not to business with Longs Drugs.

Summary

The responses of USC Retirees participating in Medicare D, indicate that with the complexities of the various plans, the lack of clear answers to important questions, the lack of confidence that this plan is beneficial to us (rather than principally to the pharmaceutical firms that seem to be its principal beneficiaries), leaves many of with feelings of disquiet and uncertainty.

Despite this uncertainty, it was clear that the 20 who enrolled in one of the three plan options offered by Humana were the most satisfied with their choice ---- 79% declared they would stick with their plan. On the other hand, only 43% of the 23 AARP participants stated they would definitely enroll in that plan for 2007. Could AARP fare better if they offered more levels of coverage akin to Humana's strategy rather than trying to make a one-size fits all model work?

Methodology

The methodology of this study was quick and dirty. We selected only twelve questions.

1. The person's name and contact info, so we could get the report back to them.
2. The name of the plan they had chosen for the year.
3. Whether anything surprised them about that plan?
4. Whether they would agree to answer questions for others about that plan?
5. Whether any of their prescriptions had been dropped by their plan in the year?
6. Whether they had to appeal the availability of a drug – and the outcome?
7. Whether they had experienced a price increase on their prescriptions?
8. If so, at what level?
9. How satisfied they were with their plan?
10. The major strengths and weakness of their plan?
11. Whether they intended to stay with the plan they had chosen?
12. Whether they had any other comments they wished to make?

The survey was distributed on September 13 with a deadline of October 6 so we could compile the results prior to the open meeting on October 24 from 10:00 to 11:30 a.m. in the Gerontology Building Auditorium. A copy of this report is being provided to each person that provided the data upon which the report is based, to persons who attend the October 24 meeting, and to anyone else at USC who might have interest.

We were not able to pre-test the instrument in any serious way. We were not able to do any secondary follow-up to see if we could increase the sample size. The sample size was small enough that only the most basic arithmetic statistics made sense. We did not know the precise size of the USC retiree group that elected a Medicare-D plan. We did not have the time or the money to do a mail survey to try to reach a larger group – but settled simply for those we could reach by email. Not everyone identified their plan very precisely (e.g., to which of the three Humana programs was reference being made). That is why we merged data into the bundles of plans offered by a single carrier. Not everyone answered every question. All errors of fact and interpretation are the authors alone.

This survey (in addition to its information of the first year's experience with Medicare D) demonstrates how the USC retiree community can mobilize and learn from the experience we collect individually, when that proves useful.

Personal Informational Resources

The following USC persons (enrolled in a Medicare-D plan this year) have indicated a willingness to answer questions about their personal experiences if another USC person is considering that plan and would like to get a more direct and personal assessment of that plan. Please contact Carole or Bob if you need a contact address.

AARP

Ginny Ainsworth	Lois Friss	Alex McEachern	Samuel Taylor
Peter Berton	Max Gaspar	Jack Nilles	Joe Titone
Bob Biller	Bob Harris	Mary Randall	Ken & Sally Williams
Roy Choudhury	Elaine Lawson	Gil Siegel	William J. Williams
Frances Feldman	Maxine Marmor	Robert Smith	

Aetna

Daniel and Josette Antonelli	Burton Marcus	Rex Soutar
Clarke and Janelle Howatt	Howard Saperston	Robert Stanton

Blue Cross

Clive Grafton	Gordon Cohn
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Community Care Rx

Louise Ball	Herb & Beatrice Farmer
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Coventry Advantra Rx

Hans Kuehl

Humana

Connie Ahrons	Joan Ewing	Sadye Lawson	David B. D. Smith
Donna Kay Boettcher	Joan Hill	Glenda Mourer	Elaine Steward
Alvin Cooperband	Ken Hill	Elizabeth Redmon	Ruberta Weaver
Jim Eddy	Richard Kaplan	Robert Shpall	Lynn Williams

Rx America

Jeanne & Bob Church	Bill Petak	George Bekey
David McConaughy	Bob Scales	

United American

Carole Gustin