



## Cutting through Confusion in Part D

By Joseph Antos

*Seniors are struggling to decide whether to enroll in the Medicare prescription drug benefit that began January 1, 2006. The program has more than 3,000 plans of all descriptions, and most seniors have at least forty plan options. This mind-boggling array of choices arose out of unique circumstances—multibillion-dollar subsidies, a one-time opportunity to market to 42 million beneficiaries, and no previous track record to assess what types of plans would be most in demand. Despite press coverage to the contrary, most seniors can easily select the best plan by simply knowing the drugs they now take. As this is the first national test of competition and consumer choice in Medicare, success or failure here will determine the direction of future reforms.*

Faced with a bewildering array of options, millions of older Americans seem paralyzed by the prospect of selecting a plan offering the new Medicare prescription drug benefit.<sup>1</sup> According to the Centers for Medicare and Medicaid Services (CMS), there is an average of forty to fifty Part D plans in each region of the country.<sup>2</sup> That figure does not include drug benefits offered by private health plans in Medicare Advantage (MA),<sup>3</sup> which could mean a dozen or more *additional* options for many seniors.<sup>4</sup> Moreover, the details—deductibles, co-payments, coverage in the infamous doughnut hole,<sup>5</sup> and drugs covered by the plan—are complex and vary greatly across plans. Choice is good, but does there have to be so much of it?

Although seniors have a large number of drug plan options from which to choose, most of those options are easily discarded by following the first rule of smart shopping—choose the lowest cost option that meets your needs. Rather than worrying about whether a plan requires a deductible or attempting to plumb the intricacies of multi-tiered formularies, people should look at the

bottom line cost they would incur over the course of the year. Paying more than the lowest cost makes no more sense in this market than it does in other markets.

The Medicare drug benefit can be a good deal for millions of seniors if they choose the right plans. The program offers substantial subsidies for all enrollees in an approved drug plan, with additional help for low-income beneficiaries. Vigorous competition has driven down premiums for many of the plans.<sup>6</sup> The average monthly premium is \$32.20, about 13 percent below what had been expected, and most beneficiaries can enroll in plans with premiums under \$20.

Medicare Advantage plans may be even more attractive, offering drug benefits plus comprehensive coverage at lower cost to beneficiaries than the cost of traditional Medicare with a stand-alone drug plan and Medigap insurance. Enrollment in such plans might increase only modestly this year, however, since the decision to shift from traditional Medicare is more complicated than the choice of a drug-only plan. Several Medicare Advantage sponsors are marketing drug-only plans with the hope of converting some of those beneficiaries to that company's MA option in future years.

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Despite these signs of progress, the future of the drug benefit is precarious. Enrollment is likely to be much lower than expected this year, which could drive next year's premiums skyward—a development that would be announced just before the 2006 election.<sup>7</sup> The program has already been criticized for not reducing drug prices below what could be obtained at major retailers, which will increase political pressure for direct government price setting.<sup>8</sup> Long-term program costs remain in the trillions of dollars—a sore point for conservatives—despite 2006 outlays that are likely to be lower than initially projected by the administration and the Congressional Budget Office (CBO).

White House pressure kept the Medicare drug benefit off the legislative agenda in 2005, but the program is squarely in Congress's crosshairs this year. Even unavoidable failures will be met with harsh criticism and the threat of precipitous action. If the drug benefit fails to meet political expectations, Congress is likely to tighten regulatory controls and impose across-the-board budget cuts that could mean the end of the competition strategy for all of Medicare.

## So Many Options, So Little Time

When the Medicare Modernization Act (MMA) of 2003 was signed into law, critics complained that the new drug benefit was too complicated. The “doughnut hole” was singled out for the sharpest criticism. Seniors would not understand a benefit that had a gap in coverage after the beneficiary had already spent several thousand dollars on their prescriptions.<sup>9</sup> Giving seniors a choice of competing private drug plans was also criticized as needlessly complex. Critics argued that Medicare should not deviate from its traditional approach of a single nationally uniform benefit.

The fears of the critics may have been realized. There is widespread confusion among seniors about the details of the drug benefit, and initial enrollment levels are low.<sup>10</sup> CMS has provided detailed information about deductibles, co-payments, drugs included on plan formularies, and retail pharmacies that participate in each drug plan's network, but that information seems to add to the confusion.

No one has ever had as many different health plan choices as there are under the new Medicare drug benefit. In Brooklyn, for example, there are ninety-one drug plan options, including forty-six stand-alone drug plans and forty-five Medicare Advantage plans offering a drug

benefit.<sup>11</sup> Such a large number of options might be expected in a highly populated area like New York City. However, there are numerous prescription drug plans available in sparsely populated areas as well. Billings, Montana, has fifty-two plan options even with a population one-twenty-fifth the size of Brooklyn's.

An army of people has been mobilized to help seniors with their drug plan choices. Organizations including the Access to Benefits Coalition (whose members are senior and patient advocacy groups, including AARP), business groups, and state and local government agencies have joined CMS in the effort to help seniors enroll in the new program. Some of those efforts were quickly overwhelmed by the demand for assistance and the difficulty of providing it.<sup>12</sup>

Confusion was inevitable, even if there had been fewer plan options and greater uniformity in benefit design. Few people at any age purchase health insurance with full knowledge of how their coverage would apply to their own individual circumstances. Seniors are no exception. Medigap policies are popular with beneficiaries to a large extent because such supplementary coverage eliminates the need to keep track of traditional Medicare's complicated rules about what services are covered and what the beneficiary must pay. Initial enrollment in Medicare during the mid-1960s was also filled with confusion, misinformation, and procrastination, but eventually most people signed up.

Fortunately, most seniors do not have to become insurance experts to choose the drug plan that offers them the best deal. Instead of focusing on the details of every option, seniors should limit their investigation to the plans that offer the lowest total cost (including the plan's premium) for their prescriptions over the year. That information is readily available from CMS through a website or an 800 number.<sup>13</sup> Seniors should not spend much time worrying about most of the other details of the benefit since the total annual cost summarizes that information in a way that is readily comparable across plans with different structures. A plan that requires a deductible, or does not have coverage in the doughnut hole, or charges a higher premium may well be the best choice for some patients with particular drug needs.

Depending on the prescriptions that a person uses, many different plan designs could yield the best deal for a Medicare beneficiary. For example, Sally Jones, a woman in her early seventies living in Cleveland with several chronic conditions common to seniors, has stand-alone drug plan options whose total annual cost

ranges from \$3,790 to \$6,083.<sup>14</sup> Her lowest cost option is a plan with a \$250 deductible, no coverage in the doughnut hole, and a monthly premium of \$14.43. She has two other plan options that are within \$40 of that plan. One of those options has no deductible, no doughnut hole, and a monthly premium of \$63.91. The other option has a \$250 deductible, no coverage in the doughnut hole, and a \$34.82 monthly premium.

By providing a generous subsidy, Congress virtually guaranteed that the new drug benefit would be a good deal for Medicare beneficiaries. Mrs. Jones would save about \$1,830 by enrolling in the lowest-cost Medicare drug plan rather than purchasing her prescriptions using the AARP retail discount. There are thirty-four Medicare drug plans that offer Mrs. Jones some savings compared to the AARP discounted price. If she used a Medicare mail order service, she could save another \$430 annually.<sup>15</sup>

Many seniors want to select a Medicare drug plan that not only offers the lowest cost for the pharmaceutical needs they currently have, but also for the needs they might potentially have in the future. Although that is an understandable impulse, few people are in a position to speculate accurately about future drug therapies that might be prescribed for them.<sup>16</sup> In addition, beneficiaries have limited financial exposure because they can change drug plans every year. Those who guess wrong about their future treatment will likely pay more than they had to for drug coverage.

Some beneficiaries are willing to pay more for convenience or other perceived benefits of more expensive plans. A significant number of seniors prefer to visit their local pharmacy, despite savings that could reach 12 percent or higher through mail order.<sup>17</sup> Others prefer a plan without the doughnut hole, perhaps because their monthly spending would be fairly constant over the year. That convenience can come at a high price. A *Washington Post* staff writer reported that her mother, who regularly uses fourteen pharmaceuticals, is willing to spend nearly \$330 more a year for what is effectively a level-payment drug plan.<sup>18</sup>

The choice of drug plan is more complicated if a senior wants to consider shifting from traditional Medicare to Medicare Advantage. In many cases, an MA plan offering drug coverage has better total health insurance coverage at a lower cost than that of traditional Medicare with a stand-alone drug plan plus a Medigap policy. However, MA plans such as preferred provider organizations (PPOs) or health maintenance

organizations (HMOs) typically have a limited panel of participating providers. Going to an out-of-network provider typically means higher costs for the patient. Because of that complexity, it is likely that most beneficiaries currently in traditional Medicare will remain there in 2006.

## For Some, an Easy Decision

A substantial proportion of Medicare beneficiaries have little reason to pore over their drug plan options. Those with employer-sponsored retiree drug coverage—about 8.2 million people—almost certainly should remain in their current plan.<sup>19</sup> In most cases, the retiree plan is at least as good as the Medicare benefit is.<sup>20</sup> Some firms also strongly discourage their Medicare-eligible retiree from enrolling in a Medicare drug plan. In a recent survey, a substantial number of large employers have indicated that retirees who sign up for the Medicare drug benefit would lose either the company's drug coverage or all retiree health coverage.<sup>21</sup> There are a variety of reasons for such a policy, including administrative difficulties if some retirees are on the employer plan and others are in a Medicare plan, as well as the potential loss of a federal subsidy for those retirees who opt out of the employer plan.<sup>22</sup> The retiree might not be the only person affected by this, however. If the retiree has a family policy, the spouse (including someone who was not eligible for Medicare) could also be automatically disenrolled from part or all of the firm's health plan.

About 6.4 million low-income beneficiaries were eligible for drug coverage under Medicaid until this year. They were automatically shifted to a Medicare drug plan at the beginning of the year. They bear very little of the cost of the new benefit, paying no premiums or prescription costs other than a \$1 or \$3 co-payment for each prescription. Such beneficiaries need not concern themselves with the benefit structure of their plan, but they should verify that their drugs are on the plan's formulary and that they may purchase their prescriptions at their neighborhood pharmacy.

Most of the remaining 27 million Medicare beneficiaries have some homework to do before they enroll in a drug plan. Those who are eligible for the full low-income subsidy (but were not automatically enrolled in a plan) would save money by selecting a plan that will not charge them an additional premium. That information is readily available from CMS. Higher-income beneficiaries should consider all the options, but the best stand-alone

drug plan for most people will be the one with the lowest annual cost.

Some beneficiaries face exceptional difficulties selecting a drug plan. People living in nursing homes, for example, have special needs because of the group living arrangement and must select from among a set of specialized drug plans. Many of those individuals, as well as others living at home, are impaired and cannot be expected to make such a decision. They are dependent on the judgment of relatives, friends, or perhaps social workers or other professionals who interact with them. The law did not provide for a default enrollment process for beneficiaries unable to make their own decisions.

## Information and Adverse Selection

CMS has provided unprecedented access to cost information under the drug benefit. No other insurance program allows prospective customers to determine in advance how much individual drugs would cost them under each of the plan options. Such information encourages adverse selection, attracting people who would gain the most from the coverage and discouraging those with the least to gain.

Critics argue that adverse selection could cause a “death spiral” when consumers have a choice of plans. Under that scenario, the most comprehensive drug plans would attract the sickest patients, driving up premiums and forcing out less expensive enrollees who can find a less comprehensive benefit for a much lower price elsewhere. Ultimately, comprehensive plans would go out of business. One recent analysis demonstrated the potential impact on premiums of adverse selection coupled with low enrollment in Part D.<sup>23</sup> If only the poorest and sickest 20 percent of the Medicare population enrolled in the drug benefit, the average premium could be as much as 42 percent higher than if all beneficiaries enrolled.

Although beneficiaries with higher drug costs have stronger incentives to enroll in Part D than those with lower costs, such extreme adverse selection seems unlikely even in a year with low enrollment. Beneficiaries with very high drug expenses in one year may not have such high costs in a subsequent year (or the reverse). Because the onset of serious illness is often unpredictable, some beneficiaries with low current drug costs will enroll in the Medicare drug benefit to protect themselves from what could be a large financial risk.

Moreover, the benefit was designed with safeguards against adverse selection. Perhaps the most important

contribution to program stability is the generous premium subsidy, which lowers the cost of coverage well below its actual cost. Low-income beneficiaries will pay no premium, and higher-income beneficiaries will pay only 25 percent of the cost of the benefit. Sizeable premium subsidies have been shown to promote broad participation and stability in the Federal Employees Health Benefit Program, which offers a choice of plan options to federal employees and retirees.<sup>24</sup>

The premium subsidy, combined with the widespread availability of low-premium plans, is likely to attract a diverse population in terms of expected drug spending. All states but Alaska have at least one stand-alone drug plan with a monthly premium of less than \$20, and a number of states have plans with premiums below \$10 a month.<sup>25</sup> About 70 percent of Medicare beneficiaries will have access to zero-premium Medicare Advantage plans offering drug benefits. For seniors with low drug expenses who are uncertain about their best option, a low-premium Part D plan could be attractive insurance against making a potentially costly mistake. However, even that choice requires the beneficiary to make a concrete decision about enrolling in Part D.

Other policies reinforce the incentives to enroll in the drug benefit. The MMA halted new sales of Medigap plans offering a drug benefit. Although beneficiaries who already had such coverage were grandfathered in, they will almost certainly find better value in Part D. In addition, Medicare imposes a late enrollment penalty on those who fail to enroll in an approved drug plan when they are first eligible.<sup>26</sup> That penalty may not be well understood by seniors who have not yet enrolled in Part D, however, and may provide very little extra motivation for them to make their plan decision. Public outreach and education campaigns to explain the advantages of enrollment are likely to be far more important in motivating people than the negative incentive of the late enrollment penalty will be. In particular, many people still do not seem to appreciate the need to sign up for a plan to buy protection against future bills.

## Why So Many Plans?

There are sixty-five sponsors of stand-alone Medicare drug plans offering an astonishing total of 1,413 plans across the country.<sup>27</sup> In addition, there are 1,649 Medicare Advantage plans offering drug benefits in thousands of local markets. Those numbers are even more astounding if one remembers the fear that many of the proponents of

the Medicare drug benefit had in 2003 that there might be few plans willing to participate in the program. In the phrase of Tom Scully, who was CMS administrator at the time, stand-alone drug plans do not exist in nature.<sup>28</sup> For that reason, the legislation includes a provision for “fall-back” plans that were supposed to emerge if there were fewer than two plan options in a geographic region.

Mr. Scully was correct. Stand-alone drug plans have never been offered before by private insurers because of the near-certainty that such plans would face severe adverse selection. Instead, most comprehensive insurance programs are structured like Medicare Advantage plans, offering the drug benefit as part of broader coverage for hospital and outpatient services.

The influx of thousands of Medicare drug plans is a reminder of just how much power Congress has over nature, at least when it comes to controlling market activities. Congress had resisted establishing a drug benefit in Medicare largely because of concerns over the cost of the program, even though private insurers responded to consumer demand by including prescription drugs as part of their standard coverage decades ago.<sup>29</sup> That changed with the MMA, which provided hundreds of billions of taxpayer dollars to assure that there would be strong demand for the new drug benefit.

After initial concern about the difficulties of offering a drug-only benefit, the health insurance industry recognized the opportunity that had been created. Much like the 1889 Oklahoma land rush, there would not be a second chance for plans to stake a claim to 42 million brand new customers. In future years, only those individuals newly entering Medicare by turning age sixty-five or becoming eligible through disability—perhaps 1 to 3 million people annually—plus a fraction of previous enrollees would actively consider their choice of Medicare drug plan. Despite great uncertainties regarding how the program would be managed by CMS and the pattern of drug spending under the new benefit, potential drug plan sponsors could be left in the dust if they did not offer a plan for 2006.

Entering a new and untested market holds considerable risks for any potential plan sponsor. Detailed information on the prescription drug usage of the Medicare population is not available, and utilization will likely change in response to the new subsidy (which stimulates use) and plan design (which can be structured to modify drug utilization). Sponsors also have little basis for estimating probable enrollment, which depends on how the sponsor’s plan stacks up against the competition. Some

sponsors, including pharmacy benefits managers, had little experience marketing directly to individuals rather than to employee groups.

To encourage sponsor participation, the MMA limits financial exposure of the plans by paying a high proportion of the cost for enrollees who have exceptionally large drug needs. The federal government also shares in any large aggregate losses (or gains) that a plan might experience, with the greatest financial protection in 2006 and 2007. In addition, the MMA provided incentives for comprehensive health plans to participate in Medicare Advantage: payments to MA plans are based on their own bids rather than being tied to costs in the traditional Medicare program; payment levels were increased; and a stabilization fund was established to encourage health plans to offer benefits to all beneficiaries in broad geographic regions.

Drug plan sponsors hedged their bets by offering multiple plan options, hoping to attract groups of beneficiaries in a variety of medical and financial circumstances. A number of sponsors, seeing the automatic assignment of dual eligibles to Medicare drug plans as a low-cost way to gain members, structured at least one of their plan offerings to have premiums below the national average. One sponsor, Humana, aggressively sought higher-income beneficiaries who have low drug use by offering plans with extremely low premiums.<sup>30</sup> The widely touted \$1.87 premium plan offered in six states in the upper Midwest is offered by Humana.

About half of all stand-alone drug plans offer the standard benefit or one that is actuarially equivalent; the remaining plans offer enhanced benefits.<sup>31</sup> Only about a third of plans require a \$250 deductible; some of the others require a smaller deductible, but most have no deductible. Several sponsors co-brand their plans with well-known organizations. For example, UnitedHealth Group has partnered with AARP, and Humana is affiliated with Wal-Mart.

Not all of the drug benefit sponsors will survive the intense competition for enrollees, and the sponsors that continue to offer plans will pare their offerings to those that attract the best response from beneficiaries. Moreover, the plans that are most successful at enrolling members will be in a stronger bargaining position with drug manufacturers and should be able to offer better deals next year.

Although consolidation is inevitable, we may not see much change for 2007. Most sponsors will be focused on the challenges of starting up the new drug plans, and

they will also have to meet a tight CMS schedule to participate in the program next year. In addition, plans will have only a few months of operating information with which to refine their offerings.

The pace of other activities is likely to defer serious discussions between sponsors about possible mergers or acquisitions, and any consolidations that did occur must be reviewed by CMS. Consequently, Medicare beneficiaries are likely to have about as many plan options for 2007 as they had for this year. Fortunately, by then most beneficiaries will have become more familiar with the drug benefit and the process for choosing a plan, which should ease the open enrollment process next fall.

## Outlook for Medicare Competition

The Medicare drug benefit is the first nationwide test of competitive market reform in Medicare. Every beneficiary has been offered a choice of drug plans and access to information about the cost and benefits provided by each plan.<sup>32</sup> Start-up problems are to be expected, and low enrollment rates this year are likely because of the newness of the decision. What matters most is what happens next.

There are a number of political flashpoints. Sharp increases in program costs, changes in plan formularies that reduce the availability of some drugs, or continued low enrollment for 2007 could prompt Congress to tighten regulatory controls on the program. Concerns about the overall budget deficit could lead to a repeat of the 1997 Medicare reform legislation, whose across-the-board payment reductions contributed to the exodus of private plans from Medicare+Choice (since renamed Medicare Advantage).

Such actions would fundamentally change the operation of the drug benefit before the program has a chance to mature. Interference by Congress could destabilize the new program and would reinforce the government's reputation as a poor business partner. Failure in this program also would reinforce doubts about the role of markets in Medicare and in health care generally. Congress should restrain its natural impulse to micromanage the program and give competition a chance to work.

## Notes

1. See, for example, Associated Press, "Seniors Express Medicare Confusion," November 28, 2005; and Susan Levine, "Seniors Find Medicare Plan Options Bewildering," *Washington Post*, November 19, 2005.

2. Bureau of National Affairs, "Regional PPOs Available in Most States; Ten Firms to Offer Nationwide Coverage," *BNA's Health Policy Report* (October 3, 2005): 1257.

3. Seniors and disabled persons may enroll in either traditional Medicare or in Medicare Advantage. Traditional Medicare offers a nationally uniform set of benefits with complex rules about what services are covered and how much beneficiaries must pay out of pocket. MA plans cover all Medicare services, but the plans are able to offer less complicated and more generous coverage. MA plans typically have a more limited network of health providers than traditional Medicare has, but the total cost of care to the beneficiary is often substantially lower than it is under traditional Medicare.

4. See Medicare Prescription Drug Coverage, "Landscape of Local Plans State-by-State Breakdown," available at <http://www.medicare.gov/medicarereform/map.asp> (accessed December 27, 2005).

5. Insurance with a doughnut hole provides some initial coverage of health costs and protection against very high costs, but no coverage in the middle. The standard Medicare drug benefit has no coverage for drug spending that exceeds \$2,250 but is less than \$5,100 in a year. Those limits will be adjusted for inflation after 2006.

6. U.S. Department of Health and Human Services, "Medicare Takes Major Step toward 2006 Drug Benefit," press release, September 23, 2005.

7. One factor that could force premiums up in 2007 is low enrollment largely confined to high-cost patients; see Jonathan Blum et al., *The Impact of Enrollment in the Medicare Prescription Drug Benefit on Premiums*, Kaiser Family Foundation report, October 2005.

8. House Committee on Government Reform—Minority Staff, *New Medicare Drug Plans Fail to Provide Meaningful Drug Price Discounts*, 109th Congress, 1st sess., November 2005. Note that this report primarily compares prices offered by ten Medicare drug plans at thousands of retail outlets with mail order sources, Canada, or the Department of Veterans Affairs (which has a limited number of distribution sites). In addition, the report does not account for cost-saving methods that encourage the use of generics and lower-cost brand drugs.

9. The standard benefit defined in MMA requires enrollees to pay the first \$250 in prescription drug spending as a deductible, and 25 percent of the cost of their drugs between \$250 and \$2,250. Enrollees spending more than that amount would pay the full cost until they had paid \$3,600 out of pocket, which is equivalent to \$5,100 in total spending for prescriptions. The benefit would pay all but 5 percent of the cost of their prescriptions above \$5,100.

10. Nearly 21 million Medicare beneficiaries (out of a total of 42 million) had enrolled in some drug benefit during the first month (November 15–December 13, 2005) of the open enrollment period. However, only about 1 million of those people signed up for a stand-alone Medicare drug plan—about 5 percent of beneficiaries for whom the enrollment decision would require careful study of the costs of alternative plan options (a point discussed later in this paper). About 6 million “dual eligibles”—people who were enrolled in both Medicare and Medicaid—were automatically enrolled in a Medicare drug plan. Another 9 million people remained covered by retiree drug benefits and 4.4 million people were enrolled in Medicare Advantage plans offering drug coverage. See U.S. Department of Health and Human Services, “More Than 21 Million Medicare Beneficiaries to Be Covered for Prescription Drugs as of January 1, 2006,” press release, December 14, 2005.

11. This includes both stand-alone drug plans and Medicare Advantage plans offering the drug benefit. See Medicare Prescription Drug Coverage, “Landscape of Local Plans.”

12. “Medicare Drug Plan Counseling a ‘Nightmare,’” *Syracuse Post Standard*, November 25, 2005.

13. The prescription drug plan finder is available online at [www.medicare.gov](http://www.medicare.gov) or by calling 1-800-Medicare.

14. This patient is assumed to have the following chronic conditions: allergies, osteoporosis, high cholesterol, high blood pressure, congestive heart failure, and gastric reflux disease. Her drugs are Allegra, Fosamax, Lipitor, Lasix, Zestril, metoprolol, and Prevacid. Plan information was collected on December 20, 2005, using Cleveland zip code 44145.

15. The plan offering the best mail order deal was not the same plan offering the best deal for retail purchases of prescriptions. Details available from the author.

16. Some people may know that a change in drug regimen is likely in the near future and could consult their physician to determine what new drugs may be prescribed.

17. Using the Cleveland example, we found that Sally Jones could save between 1.5 and 12.3 percent by purchasing her drugs through mail order, depending on the plan she selected. These estimates are based on the three least expensive drug plans identified by the Medicare plan finder.

18. Lisa B. Mann, “Filling the Doughnut Hole,” *Washington Post*, December 6, 2005.

19. Estimated number of beneficiaries taken from Congressional Budget Office, *A Detailed Description of CBO’s Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004.

20. Employers sent each of their Medicare-eligible retirees a notice indicating whether the retiree drug plan was at least as

good as Medicare’s standard benefit. Enrollees in such creditable retiree drug plans are not liable for the late enrollment penalty.

21. In a recent survey, 29 percent of employers who will maintain retiree drug benefits and accept the federal subsidy for their Medicare beneficiaries said that retirees would lose all employer health benefits if they enroll in a Medicare drug plan. See Frank McArdle et al., *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins*, Kaiser Family Foundation and Hewitt Associates report, December 2005.

22. Albert B. Crenshaw, “Read the Fine Print before Signing Up for Medicare’s Drug Benefit,” *Washington Post*, December 11, 2005.

23. Blum, *Impact of Enrollment in the Medicare Prescription Drug Benefit*.

24. Curtis S. Florence and Kenneth E. Thorpe, “How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?” *Health Affairs* 22, no. 2 (March/April 2003): 211–218.

25. Bureau of National Affairs, “CMS Issues Drug Benefit Details as Plans’ Marketing to Seniors Begins,” *BNA’s Health Policy Report* (October 10, 2005): 1293.

26. Beneficiaries who fail to enroll in a Medicare drug plan when they are first eligible, and those who initially enroll and later disenroll, are subject to the late enrollment penalty unless they have other creditable drug coverage. The penalty is 2 percent of the average Medicare drug plan premium for every month that the person is without creditable coverage.

27. The plan counts were reported by the Medicare Payment Advisory Commission; see Bureau of National Affairs, “Few PDPs Offering ‘Standard’ Rx Benefits; Most Offer Enhanced Coverage, MedPAC Says,” *BNA’s Health Policy Report* (November 21, 2005): 1488.

28. Robert Pear and Walt Bogdanich, “Some Successful Models Ignored as Congress Works on Drug Bill,” *New York Times*, September 4, 2003.

29. The single exception was a drug benefit enacted as part of the Medicare Catastrophic Coverage Act of 1988. That act was repealed in 1989, largely because the drug benefit was mandatory and the costs were fully borne by Medicare beneficiaries.

30. Michael McCaughan, “Playing Offense in Part D: Three Aggressive Medicare Strategies Demand Pharma Attention,” *The RPM Report* (December 2005): 23–31.

31. BNA, “Few PDPs Offering ‘Standard’ Rx Benefits.”

32. Dual eligibles who have been automatically assigned to drug plans may change plans at any time. All other beneficiaries are free to choose the plans in their area during the open enrollment period.