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Medicare open enrollment and choosing a plan

It is Medicare Open Enrollment time again, through December 7, 2012. During this time, it is possible to choose a Medicare Part C or Advantage plan, either for the first time or to choose a new plan to replace an existing one. It is also the time to change the Part D or prescription drug plan, to match what is best for each beneficiary. The Center for Medicare Advocacy (CMA) urges Medicare beneficiaries to choose carefully, based upon new quality ratings available. (www.medicareadvocacy.org/2012/10/18/picking-a-plan-during-the-annual-enrollment-period-choose-carefully/).

The Centers for Medicare and Medicaid Services (CMS) released plan quality rating information for Part C and Part D plans for the 2013 plan year. (A Part C plan is a private Medicare Plan which often includes a prescription drug benefit, but is not the same as a Medigap plan for traditional Medicare). All plans were awarded a single star rating from one to five, with 5 being the highest. This method attempts to summarize the plan's performance across a number of quality and performance measures. There are very few 5 star plans available across the country, and Pennsylvania is not one of the states listed as having any 5 star plans as yet. However, this methodology allows beneficiaries to see which plans are consistently low performing plans, i.e. those that receive fewer than 3 stars for at least three consecutive years. Reportedly CMS is sending letters to 500,000 to 525,000 Medicare beneficiaries to tell them that they are in consistently low performing plans and suggesting that they switch plans. There will be a Special Enrollment Period (SEP) designated to allow beneficiaries to switch plans after the normal December 7 deadline. A recent search for local Medicare Part C plans available in this area shows the new rating scale for available plans (www.medicare.gov).

There are significant obstacles to choosing the best Part D plan for prescription drug coverage according to an article in *Health Affairs* by Chao Zhou and Yuting Zhang of the University of Pittsburgh (October 2012 vol. 31 no. 10 2259-2265). An abstract of the article can be found at http://content.healthaffairs.org/content/31/10/2259#aff-2. A major concern of some policy makers when the Medicare prescription drug benefit was proposed and then implemented in 2006 was whether seniors would be able to make smart choices from among so many competing plans. The authors found, using 2009 data, that *only 5.2 percent of beneficiaries chose the cheapest plan*. On average, nationwide, beneficiaries spent $368 more annually than they would have if they chose the cheapest plan available, and considering their medication needs. More than a fifth spent at least $500 more a year than was necessary. Generally, beneficiaries overprotected themselves by paying for plan features that they did not need, such as generic drug coverage in the "donut hole."

The authors postulate that finding the most cost effective plan for each beneficiary includes a preference for the status quo and avoidance of the "high cost of learning." It takes a great deal of effort to learn a new plan's rules and contracted providers (although these may change year to year anyhow). Zhou and Zhang recommend that CMS provide "customized communications to beneficiaries, recommending the three most appropriate Part D plans to them based on their medications history," or assign people to plans with an option to choose another.

Making choices about the most appropriate Part C and Part D plans remains difficult. Be sure to enlist the help of informed relatives and friends, and/or your local APPRISE counselor (found by calling your local Office of Aging). Choosing wisely can save you money.