Medicare Rights Center

# Part D 2007: Addressing Access Problems for Low Income People with Medicare

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## Abstract

On January 1, 2007, a quarter of a million impoverished people with Medicare in 40 states potentially face new restrictions on their drug coverage when they are randomly assigned a new Part D prescription drug plan without regard to the medicines they take. The random reassignment is happening to people with Medicare who receive the low-income subsidy (LIS, or "Extra Help") and were automatically enrolled in 2006 in a Part D prescription drug plan (PDP) that next year no longer qualifies for a full premium subsidy. This annual reshuffling of poor people with Medicare among the Part D plans is inevitable because of Congress' failure to provide a stable drug coverage option under Original Medicare. Congress should fix the law to provide drug coverage administered under Original Medicare. Although the Centers for Medicare & Medicaid Services (CMS) has taken steps to minimize the number of people subject to random reassignment, the drug benefit design is such that there is no way for CMS to avoid having some people fall through the cracks. CMS must take additional steps to minimize the inevitable disruption in coverage of the drug regimens of this vulnerable population. CMS has also failed to require continuity of coverage for an even greater number of low-income people with Medicare who will be switched to new plans offered by the same company. This brief recommends that CMS take individuals' drug regimen into account when conducting reassignment and establish additional protections that would minimize the disruptions of drug regimens.

**CMS should**

1. **exercise its legal authority to use formulary criteria to guide the reassignment process, so-called "intelligent" reassignment, much as the state pharmaceutical assistant programs (SPAPs) have done**;
2. **require that Part D plans exempt from formulary restrictions any drug regimens covered under the plan that was assigned for 2006;**
3. **necessitate Part D plans to carry over into 2007 all exceptions and prior authorization requests granted in 2006, whether granted by them or by another Part D plan;**
4. **extend a Special Enrollment Period to all people with Extra Help, whether or not they will be reassigned to a new plan in 2007, or end the private plan lock-in instituted in 2006;**
5. **guarantee that it will reimburse states that use the Medicaid program as a fall-back option for dual eligibles when coverage is unavailable through the Part D plan.**

## Introduction

On January 1, 2006, six million people with Medicare and Medicaid—the poorest older adults and people with disabilities—were abruptly switched from Medicaid coverage to coverage by a randomly selected Part D plan. Without a drug benefit under Original Medicare, this vulnerable population was parceled out among more than 600 plans nationwide, needlessly complicating an already challenging transition. With each plan using a

different formulary, employing different computer systems and following separate policies, disaster was inevitable. CMS ignored warnings from the Medicare Rights Center and others and refused to allow Medicaid coverage to continue as a backup. The result was widespread disruptions in coverage, prompting 37 states, on their own initiative, to step in to provide emergency back-up coverage through Medicaid.

The specific reasons for the chaos at the pharmacy counter included the

- mismatch between the drug regimens of people with Medicare and Medicaid and the formularies of the Part D plans to which they were randomly assigned;
- widespread failure of Part D plans to provide required transitional supplies and to establish fair and efficient appeals procedures that would enable coverage of medically necessary drugs;
- systems problems that left hundreds of thousands of individuals unenrolled from any Part D plans or unrecognized as enrolled in Extra Help and entitled to lower, affordable copayments.

Many of those problems remain unresolved as CMS implements reassignment for 2007, setting the stage for a repeat on a smaller scale of the chaos that accompanied the kick off of the Part D benefit last January.

Part D plans restrict coverage of medicines commonly used by low-income people with Medicare. The Office of Inspector General (OIG) of the Department of Health and Human Services found in 2006 that many of the 200 prescription drugs most commonly prescribed to people with Medicare and Medicaid were not covered by one or more Part D plan. The 2007 formularies will also restrict access to these medicines. A follow-up survey of the Part D plans that will be randomly assigned Extra Help recipients in New York State found the plans either denied coverage or imposed restrictions on nine of the 10 most popular single source brand-name drugs on the OIG list.

**People with Medicare are still not afforded protections that prevent interruptions of critical drug regimens.** In response to access problems witnessed in early 2006, CMS made it mandatory for plans to cover a 30-day supply of nonformulary or restricted drugs for new enrollees. As a result, plans are more likely to acknowledge their obligation to provide such transitional supplies. However, people with Medicare are still not notified in a timely fashion that they must file an appeal or change to a covered drug before their temporary supply is exhausted.[1] Coupled with persistent delays in the appeals process, this has meant that people with Medicare are often left without coverage for prescription drugs for weeks or months.

**System problems have not been fixed.** Counselors at the Medicare Rights Center continue to receive complaints from individuals whose plans have been switched without their knowledge, overriding plan choices they have made previously. Others have

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[1] Most pharmacies do not provide notice of appeal rights at the pharmacy counter and instead post a flier with the information, often in locations that escape notice by customers. Part D plans do not consistently mail notices to plan members advising them that they received a transitional, temporary fill and must either schedule a doctor's appointment to change prescriptions or appeal for coverage.

erroneously been dropped from Extra Help rolls for 2007. CMS and the Social Security Administration have also been unable to fix incorrect premium withholds from Social Security checks months after the errors have been identified. Additionally, low-income people with Medicare have experienced problems when they switched plans; often their eligibility for Extra Help does not transfer to the new plan and they were overcharged at the pharmacy counter. With such a massive reassignment among plans, these persistent data exchange problems could mean that many individuals will face unaffordable copayments at the pharmacy counter in January.

The population subject to reassignment is particularly vulnerable if the process creates barriers to accessing their medications. The majority are dual eligibles—people who receive both Medicare and Medicaid—a group that suffers high rates of mental illness and cognitive impairment and low rates of health literacy.[2] These impairments make it difficult for individuals to negotiate coverage restrictions imposed by their assigned plan or to select a plan with a formulary that better matches their current needs.[3]

## The Scope of the Problem

CMS has taken numerous steps to minimize the number of low-income individuals who will be affected by reassignment. Using its demonstration authority, CMS changed the way the regional low-income benchmark was calculated for 2007.[4] The benchmark sets the upper limit for the premium subsidy Medicare will pay for Extra Help recipients and is based on the average Part D premium charged in each region. Under the demonstration, CMS gives less weight to low-premium plans with high enrollment than required by law, effectively raising the benchmark. This means that fewer plans have premiums above the 2007 benchmarks, reducing the number of people with Medicare facing random reassignment to a little over one million. The number of affected individuals was further reduced when CMS doubled the de minimis threshold to $2.[5] Plans with 2007 premiums less than $2 above the regional benchmark will not have their members reassigned to plans offered by other companies. CMS also opted not to reassign individuals who overrode their initial assignment by CMS and selected their own plan (or were reassigned by a state pharmaceutical assistance program). These individuals will face new premium charges in January, which will come as a surprise to those who did not read, or did not understand, a notification letter sent by their Part D plan. The number of individuals facing random reassignment is now put at 288,000[6] although earlier estimates were in the 400,000 to 500,000 range.[7]

Using its demonstration authority, CMS reduced the number of people with Medicare who will receive notices of their pending reassignment just weeks before a highly contested

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[2] "Dual Eligibles and Medicare Part D," Kaiser Commission on Medicaid and the Uninsured, May 2006.
[3] "The New Medicare Prescription Drug Law: Issues for Enrolling Dual Eligibles into Drug Plans," Richard Jensen, Kaiser Commission on Medicaid and the Uninsured, January 2005.
[4] "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries," Abby Block, Director, Center for Beneficiary Choices, CMS, June 8, 2006.
[5] "Modified De Minimis Premium Policy for Low-Income Subsidy Beneficiaries," Abby Block, Director, Center for Beneficiary Choices, CMS, August 30, 2006.
[6] Conversation with CMS official, November 2006.
[7] MedPAC public meeting transcript, October 5, 2006. Available online at www.medpac.gov/public_meetings/transcripts/10_06_MEDPAC_all.pdf.

Congressional election where the Part D benefit is a campaign issue. However, these are temporary measures and they do not eliminate the dynamic that will cause a yearly churning of the low-income population among the Part D plans. The dynamics of the Part D benefit require the plans to lowball bids in order to garner automatic market share through the reassignment and auto-enrollment process. At the same time, the calculation of the low-income benchmark, once it is done according to the terms of the law, creates a downward spiral that eventually will eliminate all but the most bare-bones, low-cost plans from eligibility for a full premium subsidy. The only way to ensure stability for the low-income population and everyone with Medicare as well as comprehensive coverage is for Congress to enact a drug benefit administered directly through Medicare.

Despite CMS' efforts, low-income people with Medicare in 35 states ranging from Florida to Montana will still face random reassignment to new Part D plans (see Appendix). In 26 states, people with low income who were automatically enrolled in the Part D plan offered by Medco, a national pharmacy benefit manager, will be randomly reassigned to plans offered by its competitors.

In New York, about 40,000 people with low income who were auto-enrolled in the SilverScript plan will be randomly assigned among 13 below-benchmark plans. Although the formularies in the receiving plans vary widely, no account is being taken of drug regimens in making the assignment. Further, individuals subject to reassignment receive no protections that would continue coverage provided by their existing plan even if it is the result of a successful appeal for coverage.

The potential for access problems for the reassigned population is demonstrated by a survey of the formularies offered by the 13 plans[8] in New York that will receive random assignment. Looking at the 10 single source brand-name drugs most commonly prescribed to people with Medicare and Medicaid—drugs that have no generic substitutes—reveals wide disparities in coverage among these plans. Only Depakote, which is used to treat epileptic seizures, was covered by all the plans without restrictions. The survey shows that a number of drugs, including antipsychotics, blood thinners and blood pressure medicines, for which interruptions in drug regimens can trigger serious illness or death, are among those subject to restrictions by these plans. The survey found the following:

- **All plans covered the antipsychotics Risperdal, Seroquel and Zyprexa, as required by CMS, although two plans required prior authorization for Zyprexa.** Patients already stabilized on these drugs are supposed to be exempted from prior authorization requirements, but it remains unclear if plans will be able to make that distinction, as they are required to by CMS, without the benefit of the drug history of its reassigned members. The most common restriction imposed are quantity limits, which will impact the drug regimens of those who receive higher doses after failing to respond adequately to lower dosages. Five plans impose such quantity limits on all three antipsychotics, while one plan exempts Seroquel and another exempts Zyprexa. Six plans allow coverage without restriction. SilverScript imposes no quantity limits on these medicines and other critical mental health drugs.

[8] Information on Simply Prescriptions was not available on the medicare.gov formulary finder.

- **Four plans required prior authorization for Aricept,** a medicine that slows the progression of Alzheimer's disease, which affects 10 percent of people with Medicare and Medicaid.[9]
- **Three of the plans do not cover Lipitor,** and one plan required step therapy.[10]
- **Three plans excluded Nexium and Prevacid, which are used to treat gastrointestinal reflux disease, from their formularies.** One plan required prior authorization on both of the drugs, while two required step therapy for both. One plan covered Prevacid, restricting only the quantity prescribed, while a second plan denied coverage for Prevacid but would cover Nexium if step therapy was completed. Even if a patient meets clinical criteria that allow access to this class of drugs, random assignment could place her in the plan that happens not to cover the drug she takes. Four plans covered both drugs, including two that imposed quantity restrictions on at least one of the medicines.
- **Two of the plans do not cover Norvasc,** a medication used to treat high blood pressure.
- **Two plans required prior authorization and one required step therapy for Plavix,** a medication used to prevent a heart attack or stroke.

## Recommendations

The wide disparity in formulary coverage among these plans makes it inevitable that random reassignment will result in low-income people with Medicare facing new restrictions affecting their drug regimens on January 1, 2007. The best way to ensure continuity of coverage on a year-to-year basis is to provide prescription drug coverage directly through Medicare. If Congress were to enact this fundamental reform to Part D, low-income people with Medicare would be guaranteed an affordable, comprehensive plan every year, rather than being subject to changing formularies and plans each January.

The mismatch between formularies and drug regimens is the reason some state pharmaceutical assistance programs (SPAPs) have used formulary criteria to enroll their members, including many Extra Help recipients, in the most suitable Part D plan available.[11] With the exception of Maine's assignment process for both 2006 and 2007,[12] however, these state efforts do not include people who receive both Medicare and Medicaid, the dual eligibles who make up the vast majority of those impacted by random reassignment.

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[9] "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," Kaiser Commission on Medicaid and the Uninsured, July 2005.
[10] Under step therapy, plan members are required to first try an alternative medication. If that drug proves ineffective or has side effects, then coverage is granted for the drug originally prescribed.
[11] "The Pharmacy Coverage Safety Net: Variations in State Responses to Supplement Medicare Part D," Kimberly Fox and Linda Schofield, University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy February 2006.
[12] Maine has the legal authority to serve as an authorized representative status for its dual eligible population as well as members of its SPAP.

**1. CMS should exercise its legal authority to use formulary criteria to guide the reassignment process, so-called "intelligent" reassignment, much as the SPAPs have done**.

As required by the statute, CMS regulations stipulate that the initial auto-assignment into a Part D plan for a full-benefit dual eligible who has failed to enroll be done on a random basis among plans that are below the regional low-income benchmark.[13] However, the law makes no requirement for "random" reassignment during the annual coordinated election period. In fact, CMS regulations[14] notably make no mention of the random nature of the process, stating that "during the annual coordinated election period, CMS may enroll a full-benefit dual eligible individual in another PDP if CMS determines that the further enrollment is warranted."

The precedent set by Maine's "intelligent" assignment of its dual eligible population in 2006 shows the potential benefits of intelligent reassignment. Under the random assignment planned by CMS for 2006, one quarter of Maine's dual eligible population were slated for auto-enrollment in plans that covered less than 60 percent of their medicines. By matching formularies with drug regimens, Maine was able to ensure that all its dual eligibles were enrolled in plans that covered between 90 and 100 percent of their drugs.[15]

In addition, the reassignment process for Extra Help recipients who are not full benefit dual eligibles is conducted under CMS' authority to "facilitate" enrollment. There is no statutory requirement that "facilitated" enrollment be conducted on a random basis.

Finally, the determination of the low-income benchmarks for 2007—and therefore the selection of the Part D plans eligible to receive reassignment—is being conducted under demonstration authority. As evidenced by CMS' use of a nonstatutory formula to calculate the benchmark, this demonstration authority gives the agency broad latitude to set the criteria for reassignment **and** the requirements on Part D plans receiving reassignment.

Whether or not CMS acts to implement intelligent reassignment in the months remaining before the start of 2007, the agency **needs to** take a series of steps that would ensure continuity of coverage for the low-income population in January. These additional protections should apply to individuals who are being reassigned to plans offered by separate companies, those reassigned to plans offered by the same parent company, as well as those remaining in the same plan in both 2006 and 2007. Companies that are able to keep market share through the benchmarks and reassignment procedures established by CMS under its demonstration authority should be obligated to extend these minimum protections to low-income people with Medicare.

**2. CMS should require that Part D plans exempt from formulary restrictions any drug regimens covered under the plan that was assigned for 2006.**

Absent intelligent reassignment, this is the best way to guarantee continuity of coverage from 2006 to 2007. At a minimum, grandfathering should apply to all individuals who are

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[13] 42 USC § 1395w-101(b)(1)(C) and 42 C.F.R. § 423.34(d).
[14] 42 C.F.R. § 423.34(c).
[15] Conversation with Jude Walsh, special assistant to Maine Governor John Baldacci, November 2006

reassigned to another plan offered by the same company, a protection afforded by at least one major Part D sponsor.[16] Low-income people with Medicare should not be denied a level of prescription drug coverage a Part D sponsor deems medically appropriate for individuals who can afford a plan with a premium that is above the regional benchmark.

**3. CMS should necessitate Part D plans to carry over into 2007 all exceptions and prior authorization requests granted in 2006, whether granted by them or by another Part D plan.**

There is no clinical rationale for ending coverage of drugs determined to be medically necessary at the end of the year. In fact, only a narrow subset of prior authorization requests—those for time-limited therapies—should have any sunset provisions. People with Medicare have a reasonable expectation that all exceptions and prior authorization requests should be determined on clinical grounds; requests granted by any company or through an independent review are equally valid and should be carried over irrespective of which plan receives enrollment. Although the roll over of exceptions should apply to all people with Medicare, it is particularly important for low-income individuals who tend to have more limited access to doctors and more difficulties negotiating the appeals process.

**4. CMS should extend a Special Enrollment Period to all people with Extra Help, whether or not they will be reassigned to a new plan in 2007, or end the private plan lock-in instituted in 2006.[17]**

Although people with Medicare and Medicaid are able to change Part D plans on a monthly basis, there is no Special Enrollment Period for people who applied for Extra Help. Those who will **not** be reassigned to a new drug plan because they affirmatively enrolled themselves into a Part D plan may also face new difficulties this coming January. Plans are required to send everyone enrolled in the plan an Annual Notice of Change (ANOC) explaining what changes will take place in the plan for the next year, including that people with Extra Help will have to pay premiums starting in 2007.[18] However, many people with Extra Help will get lost in the technical language of these letters, which are not personalized to the exact circumstances of the individual, or they will miss the notice entirely. For those who still qualify for Extra Help, having to pay even a small monthly premium could mean a financial hardship. Many will not understand until January or later that they face new premium costs.

**5. CMS should guarantee that it will reimburse states that use the Medicaid program as a fall-back option for dual eligibles when coverage is unavailable through the Part D plan.**

This will encourage states like New York and California to maintain their "Medicaid wrap" programs into 2007 and allow additional states to reinstate safety net programs for a transition period in 2007.

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[16] Conversation with representatives of UnitedHealthcare.
[17] "Elimination of HMO Lock-In: A Vital Consumer Protection," the Medicare Rights Center, June 2006.
[18] "Reassignment of LIS-Eligible PDP Members Effective January 1, 2007," Abby Block, Director, Center for Beneficiary Choices, CMS, September 22, 2006.

**Appendix: 2006-2007 Benchmark PDP Comparison in the 50 States and D.C.**[1]

| State | Number of Plans | | Companies With Plans That Will No Longer Be Benchmark In 2007 | Companies With Benchmark or De Minimis Plans In 2007 |
|---|---|---|---|---|
| | 2006 | 2007 | | |
| **Alabama** | 9 | 14 | Medco,[3] United (United plan)[4] | Windsor Rx,[5] CIGNA, RxAmerica (x2), Pennsylvania Life Insurance Company, MemberHealth,* Aetna, Health Net, WellCare, First Health,[6] HealthSpring, United, UniCare, AmeriHealth[7] |
| **Alaska** | 8 | 15 | PacifiCare | Humana, Health Spring, Health Net (x2), Aetna, United, RxAmerica, NMHC Group Solutions, Sterling, WellCare, UniCare, United (x2), SilverScript, CIGNA, MemberHealth |
| **Arizona** | 6 | 8 | Health Net | WellCare (x2), CIGNA, Humana, Health Net, UniCare, SierraRx, United (AARP) |
| **Arkansas** | 13 | 18 | United (United) | WellCare, Windsor, RxAmerica (x2), First Health, Health Spring, Health Net, Aetna, FOX, Humana, UniCare, United, SilverScript, WellCare, Arkansas BCBS, Pennsylvania Life, CIGNA, United American, MemberHealth, Medco |
| **California** | 10 | 9 | PacifiCare, United (United), Health Net | WellCare, RxAmerica, CIGNA, Humana, Health Net, WellCare, Blue Cross of California, UniCare, United, SierraRx |
| **Colorado** | 10 | 15 | PacifiCare | WellCare, United (AARP), Health Net (x2), HealthSpring, Aetna, Humana, SierraRx, Blue Cross Blue Shield of Colorado, UniCare, SilverScript, WellCare, MemberHealth, Pennsylvania Life |
| **Connecticut** | 11 | 15 | PacifiCare, Health Net, United (United) | WellCare, United (AARP), CIGNA, RxAmerica, HealthSpring, Sterling, MemberHealth, Humana, UniCare, Health Net, WellCare, United, SilverScript, Pennsylvania Life, Anthem Blue Cross and Blue Shield |
| **Delaware** | 15 | 16 | PacifiCare, AmeriHealth,* Medco | CIGNA, WellCare, Health Net (x2), HealthSpring, United (AARP), Humana, WellCare, First Health, United (x2), SilverScript, Elder Health, Pennsylvania Life, RxAmerica, Aetna, UniCare, MemberHealth* |
| **Florida** | 6 | 5 | PacifiCare, AmeriHealth, Universal Health Care, Inc.[8] | WellCare, Health Net, Humana, WellCare, United, UniCare |
| **Georgia** | 14 | 16 | Blue Cross Blue Shield, AmeriHealth,* United (United | CIGNA, WellCare, United (AARP), Health Net (x2), HealthSpring, First Health, RxAmerica, United American, Humana, WellCare, United, MemberHealth,* RxAmerica, Aetna, Pennsylvania |

| | | | plan) | Life, InStil (by BCBS), Medco, UniCare** |
|---|---|---|---|---|
| **Hawaii** | 8 | 13 | PacifiCare, Medco | Humana, RxAmerica, Health Net, CIGNA, HealthSpring, SilverScript, United (AARP), UniCare, WellCare, United (x2), MemberHealth, RxAmerica |
| **Idaho** | 14 | 18 | PacifiCare, Regence, RxAmerica | United (AARP), WellCare, Health Net (x2), HealthSpring, Aetna, SierraRx, Humana, SierraRx, UniCare, MemberHealth, RxAmerica, SilverScript, United (x2), Pennsylvania Life, CIGNA, WellCare |
| **Illinois** | 15 | 17 | PacifiCare, United (United), Medco | WellCare, Elder Health (x2), CIGNA, Health Net (x2), United (AARP), First Health, RxAmerica, Humana, WellCare, United (x2), HealthSpring, SilverScript, Pennsylvania Life, Aetna, UniCare, HISC—BCBS (x2), MemberHealth |
| **Indiana** | 13 | 17 | United (United), PacifiCare, Medco | WellCare, United (AARP), Health Net (x2), Health Spring, CIGNA, Aetna, RxAmerica, Humana, Anthem BCBS, UniCare, WellCare, First Health, United, MemberHealth,* SilverScript, Pennsylvania Life, AmeriHealth |
| **Iowa** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, Humana, Wellmark BCBS of Iowa, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |
| **Kansas** | 11 | 16 | PacifiCare, United (United), Medco | WellCare, Health Net (x2), CIGNA, HealthSpring, First Health, United (AARP), RxAmerica, Aetna, Humana, Blue Medicare Rx, WellCare, SilverScript, United, Pennsylvania Life, MemberHealth |
| **Kentucky** | 13 | 17 | United (United), PacifiCare, Medco | WellCare, United (AARP), Health Net, HealthSpring, CIGNA, Aetna, RxAmerica, Humana, Anthem BCBS, UniCare, WellCare, First Health, United, MemberHealth,* SilverScript, Pennsylvania Life, AmeriHealth |
| **Louisiana** | 11 | 8 | AmeriHealth,* United (United), SilverScript, PacifiCare, Medco | WellCare, CIGNA, HealthSpring, Health Net, Humana, WellCare, United, Pennsylvania Life, MemberHealth*, UniCare** |
| **Maine** | 14 | 18 | PacifiCare, RxAmerica, Medco | Humana, WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, UniCare, WellCare, United (x2), SilverScript, First Health, Pennsylvania, RxAmerica, Anthem BCBS, CIGNA, MemberHealth |
| **Maryland** | 15 | 16 | PacifiCare, AmeriHealth,* Medco | CIGNA, WellCare, Health Net (x2), HealthSpring, United (AARP), Humana, WellCare, First Health, United (x2), SilverScript, Elder Health, Pennsylvania Life, RxAmerica, Aetna, UniCare, MemberHealth* |
| **Massachusetts** | 11 | 15 | PacifiCare, | WellCare, CIGNA, RxAmerica, HealthSpring, |

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|---|---|---|---|---|
| | | | Health Net, United (United) | United (AARP), Sterling, MemberHealth, Humana, UniCare, Health Net, WellCare, United, SilverScript, Pennsylvania Life, BCBS of Massachusetts |
| **Michigan** | 14 | 15 | PacifiCare, United (United) | WellCare, Elder Health, CIGNA, Health Net (x2), HealthSpring, United (AARP), Humana, WellCare, United, SilverScript, Pennsylvania Life, RxAmerica, Priority Medicare Rx, BCBS of Michigan, First Health, UniCare, MemberHealth, Medco** |
| **Minnesota** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, Humana, BCBS of Minnesota, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |
| **Mississippi** | 12 | 15 | United (United), PacifiCare, | Windsor Rx, WellCare, RxAmerica (x2), Health Net (x2), Aetna, United (AARP), Humana, HealthSpring, United, WellCare, SilverScript, Pennsylvania Life, CIGNA, UniCare, MemberHealth, Medco |
| **Missouri** | 10 | 10 | PacifiCare, United (United) | WellCare, Health Net, MemberHealth, HealthSpring, Humana, BCBS of Missouri, UniCare, WellCare, United, Pennsylvania Life, First Health, SilverScript |
| **Montana** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, BCBS of Montana, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |
| **Nebraska** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, Humana, BCBS of Nebraska, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |
| **Nevada** | 7 | 7 | First Health, PacifiCare | WellCare, United (AARP), Health Net, Humana, WellCare, BCBS of Nevada, UniCare, SierraRx |
| **New Hampshire** | 14 | 18 | PacifiCare, RxAmerica, Medco | Humana, WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, UniCare, WellCare, United (x2), SilverScript, First Health, Pennsylvania Life, RxAmerica, Anthem BCBS, CIGNA, MemberHealth |
| **New Jersey** | 14 | 19 | PacifiCare (x2), Horizon BCBS | WellCare, United (AARP), CIGNA, Elder Health (x2), HealthSpring, Sterling, RxAmerica, Aetna, Humana, WellCare, Health Net (x2), UniCare, United (x2), First Health, Pennsylvania Life, Horizon BCBS, SilverScript |
| **New Mexico** | 8 | 9 | SierraRx | RxAmerica, Health Net, Humana, UniCare, Presbyterian Prescription Drug Plan, SilverScript, Pennsylvania Life, United, WellCare |
| **New York** | 15 | 13 | GHI, PacifiCare (x2), Health | HIP, WellCare, CIGNA, Elder Health, RxAmerica, Sterling, HealthSpring, Humana, WellCare, UniCare, |

| | | | | |
|---|---|---|---|---|
| | | | Net, United (United) (x2), SilverScript | American Progressive, United, Simply Prescriptions, Health Net, First Health |
| **North Carolina** | 13 | 14 | United (United), PacifiCare, Medco | WellCare, United (AARP), HealthSpring, First Health, Health Net (x2), Aetna, Humana, WellCare, United, SilverScript, Pennsylvania Life, RxAmerica, CIGNA, UniCare, MemberHealth |
| **North Dakota** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, Humana, BCBS of North Dakota, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |
| **Ohio** | 10 | 13 | AmeriHealth,* PacifiCare, United (United) | WellCare, Elder Health, Health Net, Pennsylvania Life, MemberHealth,* Aetna, HealthSpring, Humana, WellCare, Anthem BCBS, UniCare, United, Coventry, SilverScript |
| **Oklahoma** | 12 | 14 | United (United), PacifiCare, Medco | WellCare, RxAmerica (x2), First Health, HealthSpring, Health Net, CIGNA, United (AARP), Aetna, Humana, United, WellCare, SilverScript, Pennsylvania Life, UniCare, BCBS (x2), MemberHealth |
| **Oregon** | 15 | 16 | PacifiCare, Asuris Northwest, RxAmerica | United (AARP), HealthSpring, Aetna, CIGNA, Humana, Health Net (x2), SierraRx, UniCare, United (x2), SilverScript, Pennsylvania Life, MemberHealth, RxAmerica, WellCare |
| **Pennsylvania** | 15 | 20 | PacifiCare, United (United), Medco | CIGNA, WellCare, Avalon, United (AARP), Geisinger (x2), Highmark, UPMC, Elder Health, Health Net (x2), HealthSpring, Humana, WellCare, UniCare, United, Highmark Senior Resources, Pennsylvania Life, MemberHealth, RxAmerica, AmeriHealth, First Health, SilverScript, Aetna |
| **Rhode Island** | 11 | 15 | PacifiCare, Health Net, United (United) | WellCare, CIGNA, RxAmerica, HealthSpring, United (AARP), Sterling, MemberHealth, Humana, UniCare Health Net, WellCare, United, SilverScript, Pennsylvania Life, BCBS of Rhode Island |
| **South Carolina** | 16 | 16 | AmeriHealth,* PacifiCare | WellCare, CIGNA, HealthSpring, Health Net (x2), United (AARP), Aetna, United American, Humana, First Health, WellCare, United (x2), RxAmerica (x2), Pennsylvania Life, InStil (by BCBS), BCBS, UniCare, Medco, MemberHealth,* SilverScript |
| **South Dakota** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (2), HealthSpring, FOX, Aetna, Humana, Wellmark BCBS of South Dakota, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |
| **Tennessee** | 9 | 14 | Medco, United (United) | Windsor, CIGNA, RxAmerica, Pennsylvania Life, MemberHealth,* Health Net, Aetna, RxAmerica, Humana, First Health, HealthSpring, WellCare, |

| | | | | United, UniCare, AmeriHealth |
|---|---|---|---|---|
| **Texas** | 16 | 12 | HISC—BCBS, PacifiCare, SierraRx, SilverScript, United (United) | WellCare, CIGNA, Health Net, First Health, Humana, WellCare, Texas HealthSpring, United, Elder Health, MemberHealth, RxAmerica, Pennsylvania Life, UniCare, HISC—BCBS, Aetna |
| **Utah** | 14 | 18 | PacifiCare, Regence, RxAmerica | United (AARP), WellCare, Health Net (x2), HealthSpring, Aetna, SierraRx, Humana, SierraRx, UniCare, MemberHealth, RxAmerica, SilverScript, United (x2), Pennsylvania Life, CIGNA, WellCare |
| **Vermont** | 11 | 15 | PacifiCare, Health Net, United (United) | WellCare, CIGNA, RxAmerica, HealthSpring, United (AARP), Sterling, MemberHealth, Humana, UniCare, Health Net, WellCare, United, SilverScript, Pennsylvania Life, BCBS of Vermont |
| **Virginia** | 16 | 17 | PacifiCare, RxAmerica, Medco | WellCare, Health Net (x2), HealthSpring, United (AARP), Humana, WellCare, United (x2), RxAmerica, SilverScript, Pennsylvania Life, Aetna, UniCare, Anthem BCBS, First Health, CIGNA, MemberHealth |
| **Washington** | 15 | 16 | PacifiCare, Asuris Northwest, RxAmerica | HealthSpring, United (AARP), Aetna, CIGNA Humana, Health Net (x2), SierraRx, UniCare, United (x2), SilverScript, Pennsylvania Life, MemberHealth, WellCare, RxAmerica |
| **Washington, D.C.** | 15 | 16 | PacifiCare, AmeriHealth,* Medco | CIGNA, WellCare, Health Net (x2), HealthSpring, United (AARP), Humana, WellCare, First Health, United (x2), SilverScript, Elder Health, Pennsylvania Life, RxAmerica, Aetna, UniCare, MemberHealth* |
| **West Virginia** | 15 | 20 | PacifiCare, United (United), Medco | Highmark, CIGNA, WellCare, Avalon, United (AARP), Geisinger (x2), UPMC, Elder Health, Health Net (x2), HealthSpring, Humana, WellCare, UniCare, United, Highmark, Pennsylvania Life, MemberHealth, RxAmerica, AmeriHealth, First Health, SilverScript, Aetna |
| **Wisconsin** | 14 | 19 | WPS Health Insurance, PacifiCare, Medco | WellCare, United (AARP), Health Net (x2), HealthSpring, CIGNA, Aetna, NMHC, RxAmerica, Humana, Dean Health Insurance, BCBS of Wisconsin, UniCare, United (x2), SilverScript, WellCare, Pennsylvania Life, MemberHealth, United American |
| **Wyoming** | 14 | 16 | United (United) (x2), PacifiCare, Medco, RxAmerica | WellCare, United (AARP), Health Net (x2), HealthSpring, FOX, Aetna, Humana, BCBS of Wyoming, UniCare, SilverScript, WellCare, United, Pennsylvania Life, MemberHealth, RxAmerica |

[1] A distinction was not made between the plans themselves in most cases but only between the sponsors and the numbers of plans that they are offering.

[2] This column does not include any plans that were benchmark in 2006 but will be considered de minimis in 2007, since members of these plans will not be moved to a different plan.

[3] Companies in **black** are above the benchmark in 2007. Reassignment will be made randomly to below benchmark

plans (plans listed in **brown** or **violet**).

[4] Companies in **blue** are above the benchmark in 2007. Reassignment will be made to another plan offered by the same company that is below benchmark or below the $2 de minimis threshold.

[5] Companies in **brown** have newly benchmark plans in 2007.

[6] Companies in **violet** have plans that are benchmark in both 2006 and 2007.

[7] Companies in **green** have plans that were benchmark in 2006 and will still have premiums below the de minimis amount in 2007. Even though they are no longer benchmark plans, their auto-enrolled LIS-eligible members will stay in the same plan.

[8] This is was an above-benchmark plan in 2006 that will no longer exist in 2007. CMS has noted that any people in the plan with full LIS will be randomly reassigned to a below-benchmark plan in 2007.

* MemberHealth has purchased the Medicare Part D membership of Amerihealth in Alabama, Delaware, Georgia, Indiana, Kentucky, Louisiana, Maryland, Ohio, Tennessee, and Washington, D.C.

** According to CMS, there will not be any random transfers from Unicare in Georgia and Florida, or from Medco in Michigan, even though these plans' monthly premiums are a few cents above these states' de minimis amounts.