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Issue Brief

Medicare Part D: How Do Vulnerable Beneficiaries Fare?

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ABSTRACT: Health insurance coverage for Medicare beneficiaries has been broadened by the addition of a prescription drug benefit—Medicare Part D. For some beneficiaries, however, particularly those who must make the transition from Medicaid to Medicare prescription coverage, the new program can be confusing or disruptive and result in delays in getting drugs or in adverse health outcomes. In the fall of 2006, well after Part D was implemented, counselors, attorneys, program managers, health professionals, and others who have direct knowledge of beneficiaries' experiences identified a continuing need for accurate, easy-to-use information about private drug plan options and procedures associated with using the plans. This issue brief details counselors' responses to researchers' questions and suggests that certain policy and procedural changes could enhance program performance.

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BACKGROUND

The Medicare Part D program, in its third year of operation in 2008, offers prescription drug coverage to 44 million Medicare beneficiaries. Unlike other benefits available under traditional Medicare, Part D is administered through more than 1,800 stand-alone prescription drug plans (PDPs), as well as through numerous private Medicare Advantage plans (MA-PDs).[1]

The process of enrolling in the Part D program, choosing a drug plan under the program, and using the plan pose challenges for some beneficiaries, particularly those whose participation in the Part D program may be complicated by additional factors. Prescription drug coverage for Medicaid beneficiaries, for example, changes to Part D coverage when they become eligible for Medicare. This shift is accompanied by new co-payment requirements as well as changes in the drugs covered and in the pharmacies beneficiaries can use.

Those who qualify for the Part D Low-Income Subsidy (LIS)—a valuable benefit that provides substantial help with premiums and cost-sharing—must

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complete a separate subsidy application and then separately enroll in a Part D program plan. Because Part D plans are permitted to have restricted formularies—lists of prescription drugs they cover—beneficiaries who take multiple medications may have particular difficulty finding plans that meet all their needs.

The great majority of Medicare beneficiaries—more than 39 million—have enrolled or have been enrolled in the Part D program or have "creditable" coverage that is at least equivalent to that provided under Part D. Millions of Medicare beneficiaries, beneficiaries with low incomes still do not have drug coverage, however.

Anecdotal reports indicate that some beneficiaries face enrollment delays, and enrollment in a plan may be insufficient to guarantee access to needed drugs. In an effort to more systematically assess how Medicare beneficiaries are faring, beneficiary counselors, attorneys, program managers, and others who have direct knowledge of beneficiaries' needs and concerns were asked to report on their perceptions and make recommendations for program improvements. A total of 660 beneficiary contacts responded to a set of questions about a three-month period—the period beginning after the Part D program had been operational for six months and before beneficiaries faced choices about coverage options for the coming 2007 plan year. (See "About This Study" on p. 10 for further details.)

By virtue of their positions, respondents were likely to hear from beneficiaries primarily when they had questions or problems. Consequently, the results reported here do not represent the experiences of all Medicare beneficiaries. By basing their reports on issues that are most problematic, however, respondents were able to make recommendations for changes that could have a positive impact on the program for the most vulnerable Medicare beneficiaries.

FINDINGS

Respondents were asked to comment on issues related to the auto-enrollment process to assign low-income beneficiaries to drug plans, the availability of drugs for individuals enrolled in drug plans, and the impact of LIS. Their answers provide a sense of the challenges facing beneficiaries and those who assist them and of program policies and procedures that are working well.

Auto-Enrollment

To participate in the Part D program, beneficiaries must enroll in a stand-alone PDP or through a MA-PD.[2] In an effort to promote uninterrupted coverage for dual-eligible beneficiaries (those enrolled in both Medicare and Medicaid), the Centers for Medicare and Medicaid Services (CMS) automatically enrolls them into Part D plans. In addition, beneficiaries enrolled in Medicare Savings Programs—under which Medicaid pays for their Part B premiums and, for some, part of their Medicare out-of-pocket costs—are automatically enrolled into Part D plans.

At the start of the Part D program, when more than six million beneficiaries were transitioned from Medicaid to Medicare drug coverage, CMS auto-enrolled all dual eligibles into drug plans with premiums at or below the average for their area (benchmark plans) using a random assignment process. Other beneficiaries were randomly assigned to plans through what CMS termed "facilitated enrollment."[3]

Dual eligibles and other beneficiaries with incomes below 150 percent of the federal poverty level and assets below a specified value (up to $11,990 for an individual in 2008) are eligible for LIS under Part D, which covers their premiums and cost-sharing requirements except for a nominal amount per prescription. In 2006, LIS enrollees accounted for 52 percent of PDP and 15 percent of MA-PD enrollment.[4]

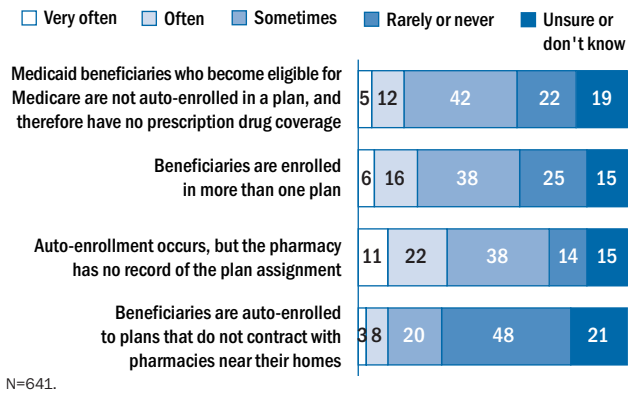
The auto-enrollment process is used for individuals who have Medicaid coverage when they become eligible for Medicare and for those who have Medicare coverage when they become eligible for Medicaid. Enrollment is facilitated for individuals who are found eligible for LIS through the Social Security Administration (SSA) or Medicaid. In addition to auto- or facilitated enrollment of beneficiaries when they first become eligible for LIS, CMS also engages in reassignment of certain LIS beneficiaries to new plans. Specifically, CMS reports that at the end of

2007, some 2.1 million beneficiaries receiving LIS were reassigned to new plans because the premiums for their prior plans had increased to a level above the benchmark for subsidized premiums.[5] All beneficiaries enrolled in plans through the auto-enrollment or a facilitated process have the option of switching plans at least once during the plan year; beneficiaries who receive assistance from their state Medicaid program (full Medicaid or a Medicare Savings Program) can change plans monthly.[6]

Auto-Enrollment and Data Exchange

Auto-enrollment requires electronic communication among SSA, CMS, drug plans, and pharmacies. Respondents indicated that even after six months of program operation, some beneficiaries were experiencing difficulties related to the auto-enrollment process. Sixty to 70 percent of respondents reported that, at least sometimes, plan assignment may not have occurred, the pharmacy may not have had a record of the assignment, or beneficiaries may have been assigned to more than one plan. Less frequently, according to respondents, beneficiaries had been auto-enrolled in plans that did not contract with pharmacies near their homes (see Figure 1).

Figure 1. Issues Related to Auto-Enrollment
(Percent of Respondents Reporting How Often Issues Occur)



N=641.
Source: Georgetown University Health Policy Institute Survey, *Part D and Vulnerable Medicare Beneficiaries*, Nov. 2006.

Beneficiaries who receive LIS and are enrolled in drug plans have experienced other difficulties related to the exchange of electronic information, including being charged the wrong co-payments or being billed for premiums they are not required to pay. Nearly 70 percent of respondents reported that these incorrect charges had been assessed at least sometimes; more than 25 percent reported that this had occurred often or very often.

Respondents also reported that dual-eligible beneficiaries had been passively enrolled in Medicare Advantage Special Needs Plans but are not aware that their Medicare coverage—including coverage for drugs—had changed. Twenty percent of respondents said this had happened very often or often. An additional 18 percent reported that it had sometimes occurred.

Solving Auto-Enrollment Problems

In some cases, problems were easily resolved, but in a substantial portion of the cases, the resolution took a month or more or the problems may have remained unresolved. Fewer than half of respondents (46%) reported, for example, that when beneficiaries were enrolled in more than one plan the problem was resolved in less than one month.

Assistance from States

Some states have taken steps to help with difficulties related to auto-enrollment. In the fall of 2006, respondents from 43 states reported that state funds had been used to provide counseling, assistance, or information about the Part D program to beneficiaries. Respondents from 24 states said that State Pharmacy Assistance Programs (SPAPs) had helped beneficiaries enroll in appropriate drug plans. Respondents from 19 states reported that state funds were used to pay for drugs while auto-enrollment issues were resolved.

Consequences for Beneficiaries

For some auto-enrolled beneficiaries, the great majority of whom had coverage for all needed drugs prior to Part D, the change to Part D coverage has been problematic. Some 46 percent of respondents reported that because of difficulties related to auto-enrollment, beneficiaries very often or often had experienced delays getting needed drugs. An additional third (36%) said

this sometimes occurred. Another one-third of respondents said that very often or often beneficiaries had been unable to get the drugs they needed. Seventy percent reported that beneficiaries' health or well-being had been negatively affected at least some of the time because of problems associated with auto-enrollment. An additional one-third said these consequences had sometimes occurred.

ACCESS TO PRESCRIPTION DRUGS

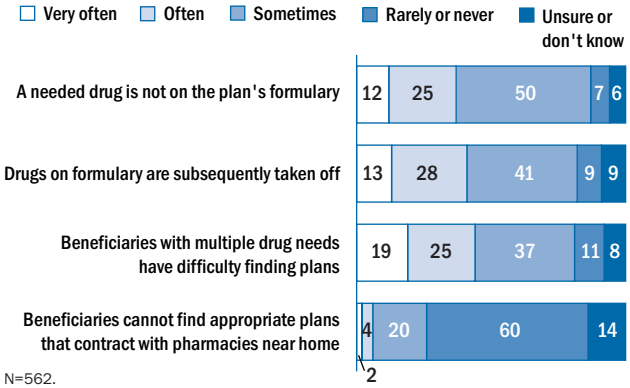
One of the primary considerations for beneficiaries in choosing drug plans is whether their plan's formulary covers the drugs they take. All prescription drug plans use formularies and utilization management tools. These tools commonly used by Medicare Part D plans include "tiered pricing" to distinguish among preferred drugs, non-preferred drugs, generic drugs, and specialty drugs; limits on the number of pills or dosage amounts; requirements for prior authorization for covered prescription drugs; and "step therapy," or requirements to try particular medications included in the plan's formulary before those prescribed by the physician.

Formularies and Utilization Management Tools

Part D formularies and utilization management tools have the potential to keep program costs down, but they also may hinder access to needed drugs by being too restrictive. More than one-third of respondents reported, for example, that very often or often needed drugs were not on their clients' formularies and that beneficiaries who took multiple drugs had difficulty finding plans to meet their needs (see Figure 2).

Low-income beneficiaries who were auto-enrolled into plans were more likely than others to have difficulties related to plan formularies and utilization management rules. One reason is that many were not aware that new restrictions had been applied to their coverage. Two-thirds of respondents—67 percent—said that few or no dual-eligible beneficiaries were aware that their Medicaid drug coverage had been changed when they became eligible for Medicare.

Figure 2. Difficulties Related to Obtaining Needed Drugs
(Percent of Respondents Reporting How Often Issues Occur)

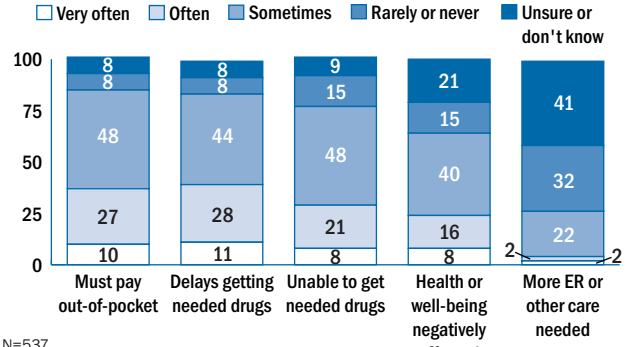


N=562.
Source: Georgetown University Health Policy Institute Survey, *Part D and Vulnerable Medicare Beneficiaries,* Nov. 2006.

In addition, low-income beneficiaries had been assigned randomly to plans that offered coverage unsuited to their current drug regimens. Some 51 percent of respondents reported that very often or often beneficiaries had been auto-enrolled into plans that did not cover a drug they took or that imposed prior authorization, step therapy, or other utilization management tools. A 2006 survey of 16,072 seniors reports that one of five dual eligibles said they needed special permission to get a prescription filled—double the rate reported by seniors with incomes above 200 percent of poverty.[7]

Respondents reported other adverse consequences associated with access for low-income beneficiaries. More than 80 percent, for example, reported that beneficiaries had faced delays in getting needed drugs at least some of the time (see Figure 3).

Figure 3. Consequences of Difficulties Related to Procedures to Obtain Drugs
(Percent of Respondents Reporting How Often Consequences Occur)



N=537.
Source: Georgetown University Health Policy Institute Survey, *Part D and Vulnerable Medicare Beneficiaries,* Nov. 2006.

More than half of respondents indicated that by the fall of 2006 they had some experience helping beneficiaries resolve issues related to formularies and utilization management. Their responses suggest that for some beneficiaries, utilization management procedures had an impact on timely access to the drugs they needed. Only about half of respondents, for example, said that on average difficulties related to utilization management rules are resolved is less than one month. In addition, 43 percent of respondents reported that very often or often, utilization management requirements for physicians to submit supporting evidence caused delays in obtaining medications. Altogether, nearly three-quarters of all respondents identified this problem as occurring at least sometimes.

Exceptions and Appeals

All Part D drug plan sponsors must establish a coverage determination process through which a plan enrollee may challenge formulary restrictions or other decisions about drug coverage made by the Part D plan. An exception request—a common type of coverage determination—is the initial step used to ask the plan to cover a drug not on the formulary or to request exceptions to rules associated with utilization management. A beneficiary may also appeal an unfavorable coverage decision. Yet 89 percent of respondents said that few or none of the beneficiaries with whom they work knew what to do when a drug was not covered by their Part D plan. More specifically, 87 percent of respondents said few or no beneficiaries realized they could request an exception for coverage of a non-formulary drug. In addition, 85 percent said that few or no beneficiaries knew they could appeal an exception coverage decision. Among respondents who had experience filing exception requests, about half said the requests were resolved in less than two weeks, an additional 18 percent said problems were resolved in two weeks to one month, and 33 percent reported that the process took more than one month or the issue remained unresolved.

CMS has taken some steps to improve the coverage determination process, but with fewer than half of respondents characterizing these efforts as very helpful, helpful, or somewhat helpful, the data suggest that more must be done. Recognizing that plans were not always adhering to required timeframes, for example, CMS has repeatedly issued clarifying guidance to plans. Only about one-third of respondents—36 percent—said this guidance was very helpful, helpful, or somewhat helpful.

CMS supported efforts of medical and consumer organizations and a health plan trade association to develop a model form for requesting coverage determinations. Plans may now use the form on a voluntary basis. Some 43 percent of respondents said that having the form available was very helpful, helpful, or somewhat helpful. In addition, drug plans are now required to ensure that pharmacies post or distribute notices of beneficiaries' rights to contact the plan to seek an exception. Only about 30 percent of respondents said that the notices are very helpful, helpful, or somewhat helpful.

Plan Switching

The ability to switch plans at any time is another alternative for dual-eligible beneficiaries who are auto-enrolled in plans that do not cover the drugs they take. Three-quarters of respondents—76 percent—said that few or none of the dual-eligible Medicare beneficiaries they see were aware they had the right to switch plans at any time. The process may be difficult for some: about one-third of respondents—34 percent—said that very often or often beneficiaries who were auto-enrolled had difficulty switching plans. An additional 31 percent said this difficulty sometimes occurred. When asked what they were most likely to do when dual-eligible beneficiaries needed drugs that were not available through the plans to which they are auto-assigned, about half of those who responded said they would help their clients switch plans without filing for an exception, and half said they would help their clients file an exception request.

Obtaining Prescription Drugs

Respondents indicated that six months into the program, some of the Part D protections intended to assure timely

access to needed drugs were not implemented in an optimal manner. Respondents reported, for example, that coverage determinations were not always handled in a timely manner. Plans are required to respond within 72 hours for a standard and 24 hours for an expedited coverage determination, but only 11 percent of respondents reported that this always, almost always, or often occurs. In addition beneficiaries were not always able to obtain drugs in six "protected classes." Plans are required to cover all or substantially all drugs in these classes but may use prior authorization or other utilization management tools.[8] Only 13 percent of respondents said that beneficiaries are always, almost always, or often able to obtain drugs in the six protected classes in a timely manner.

Beneficiaries had sometimes received other types of assistance when drugs were not available through the Part D program. In the fall of 2006, for example, 48 percent of respondents reported that very often, often, or sometimes pharmacists provided drugs without assurance of reimbursement when difficulties related to auto-enrollment occurred. In addition, 57 percent of respondents said that very often, often, or sometimes beneficiaries got the drugs they needed through state-financed or other assistance programs.

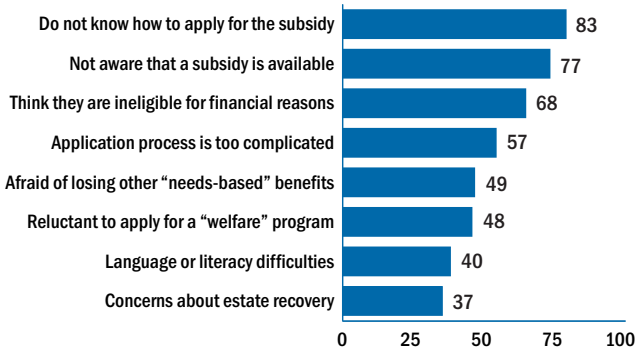
LOW-INCOME SUBSIDY ENROLLMENT

The Part D LIS is available to Medicare beneficiaries with incomes below 150 percent of the federal poverty line and limited assets. In January 2008, CMS reported that 12.5 million beneficiaries are eligible for LIS, a figure adjusted from the previous year when 13.2 million were reported eligible for the LIS. Of the 12.5 million, 7.9 are deemed eligible by virtue of their participation in other means-tested programs (Supplementary Security Income or Medicaid), and an additional 460,000 have other creditable coverage. The remaining 4.1 million must apply for LIS. At the beginning of 2008, some 37 percent of these beneficiaries were receiving the subsidy and were enrolled in a plan, but 63 percent were not.[9]

Reasons for Low Enrollment

According to respondents, the most common reasons for low enrollment in LIS are that beneficiaries do not know how to apply for the subsidy or do not know the subsidy is available. Results from the 2006 survey of 16,072 seniors indicate that among those who had incomes of 150 percent of poverty or less and were not receiving LIS benefits, only half were aware of the program.[10] Another common reason that beneficiaries did not apply for LIS was they thought they were ineligible for financial reasons. More than half of respondents said the complicated application process posed a barrier to enrollment (see Figure 4).

Figure 4. Reasons Beneficiaries Do Not Apply for the Low-Income Subsidy
(Percent of Respondents Reporting that Reasons Are Very Common or Common)



Note: Other respondents indicated that these reasons were not too common or not at all common or said they were unsure or didn't know.
N=508.
Source: Georgetown University Health Policy Institute Survey, *Part D and Vulnerable Medicare Beneficiaries,* Nov. 2006.

Apparently, established LIS application procedures are not well understood. More than three-quarters of respondents indicated that few or none of their clients were aware they could apply for LIS either through SSA or Medicaid (76%), or they could appeal a decision about LIS eligibility (84%). Few or none knew whether they should contact SSA, Medicaid, CMS, or their drug plan if they had problems related to LIS (79%).

Program rules require that eligibility for LIS be reevaluated at the end of the first year. CMS has established a redeeming process, and SSA uses a redetermination process. In the fall of 2006, however, when

reevaluation was occurring, respondents indicated that few or none of the beneficiaries they saw knew their eligibility for LIS must be reevaluated (77%) or knew what they were required to do with regard to the redeeming or redetermination processes (79%).

About two of five respondents said that very often or often beneficiaries had questions about letters they received from SSA or CMS explaining the process (46% and 44%, respectively). An additional 24 percent said that beneficiaries sometimes had questions.

Facilitating LIS Enrollment

Certain policies and practices can help beneficiaries qualify for or obtain LIS, but respondents indicated they were not widespread. Medicaid agencies are required to process LIS applications, but respondents from only six states said this process had occurred. SPAPs were facilitating LIS enrollment in 17 states.

Many of the Medicare beneficiaries who were eligible for LIS knew they were also eligible for benefits provided through Medicare Savings Programs. Respondents from just eight states, however, indicated that enrollment in Medicare Savings Programs was occurring. States have the option of increasing income eligibility standards for these programs so that more people can receive benefits and, consequently, may be deemed eligible for Part D LIS.

Historically, Medicare Savings Programs have had low enrollment. Combining screening for LIS with screening for these programs could improve enrollment in both; the drug benefit subsidy might act as a lure to encourage beneficiaries to inquire about other assistance. From the survey responses, however, this prompt is not happening to a great extent.

State Medicaid programs are required to screen and enroll LIS applicants for Medicaid and Medicare Savings Programs eligibility, but respondents from just 11 states reported that this process was occurring. SSA offices are not required to screen for Medicaid eligibility, but in nine states identified by respondents, beneficiaries could apply for the Medicare Savings Programs in at least some SSA offices. In 10 states, respondents said that some offices had developed methods to share information with Medicaid if permitted by the applicant.

Respondents indicated they were most likely to recommend that beneficiaries apply for LIS through SSA (52%) rather than through the Medicaid office (7%), though some made recommendations on a case-by-case basis (28%) or did not make recommendations about where to apply (13%).

PROGRAM CHALLENGES AND HELPFUL PRACTICES

In response to an open-ended inquiry, individuals who assist Medicare beneficiaries said the greatest challenge they faced was that beneficiaries do not understand the Part D program (see Figure 5). They noted a need for clearer information about the program at the onset, reporting that beneficiaries and counselors often cannot get information when they ask for it from plans, pharmacists, or CMS, or, at times, they had received inaccurate information. Respondents commonly characterized Part D as a complex program with too many plan choices. Other challenges frequently cited involved computer system problems, coverage restrictions, affordability, and enrollment difficulties.

Figure 5. Challenges Associated with the Part D Program
(Open-ended responses: "Based on your experience, what are the two biggest challenges in assuring that Part D works well for beneficiaries?")

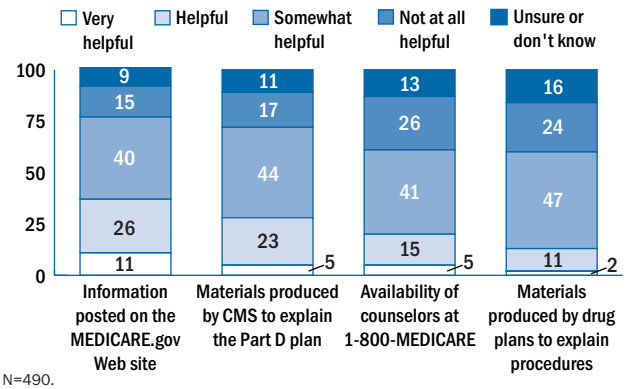
Challenges	Percent of responses
Difficult to get and understand information	23%
Program complexity	17%
Computer system problems	13%
Coverage restrictions	13%
Affordability	11%
Enrollment difficulties	9%
Other*	14%

Note: Respondents could specify up to two challenges.
* "Other" includes various challenges, each representing 4% or less of responses.
N=717.
Source: Georgetown University Health Policy Institute Survey, *Part D and Vulnerable Medicare Beneficiaries,* Nov. 2006.

The availability of one-on-one counseling, including help from State Health Insurance Program (SHIP) counselors, was cited most commonly in

response to an open-ended question regarding aspects of the program that have been particularly helpful for Part D beneficiaries. The on-line "Plan Finder" tool developed by CMS was identified as particularly helpful for beneficiaries and their counselors. LIS was also mentioned frequently as an important component for Part D effectiveness. Other successful policies or procedures mentioned were point-of-service assistance at pharmacies; involvement of community-based organizations in helping to publicize the program and enroll beneficiaries; and help from CMS regional offices. In response to questions about particular methods to help beneficiaries, the MEDICARE.gov Web site received the most positive ratings (see Figure 6).

Figure 6. Activities to Help Beneficiaries
(Percent of Respondents Reporting How Helpful Activities Are)



N=490.
Source: Georgetown University Health Policy Institute Survey, *Part D and Vulnerable Medicare Beneficiaries,* Nov. 2006.

When asked to consider specific program changes or enhancements, respondents were most enthusiastic about expanding the point-of-service system and extending enrollment periods. Two-thirds of respondents noted a need to make more materials available for beneficiaries with limited English proficiency.

POLICY IMPLICATIONS AND RECOMMENDATIONS

Respondents across the country who assist Medicare beneficiaries generally agree that certain enhancements or changes could increase the efficacy of the program for vulnerable beneficiaries.

Improve Communication Systems

The development of a system for "real-time" electronic exchange of information among all of the organizations involved with the administration of the Part D program would help eliminate or resolve difficulties associated with auto-enrollment for beneficiaries, health plans, and pharmacists. In particular, this electronic exchange could help low-income beneficiaries when they are not assigned to plans, are assigned to more than one plan, or are charged premiums or the wrong amount for co-payments.

Reconsider Random Assignment

Medicare beneficiaries who do not receive LIS are encouraged to match their drug needs with plan offerings when choosing a plan. A system that considers prescription drug needs when low-income beneficiaries are assigned to drug plans could alleviate many of the difficulties associated with auto-enrollment. A precedent for this is a method some state pharmacy assistance programs use to match information on hand when assigning enrollees to plans.

Expand Point-of-Service Assistance

The point-of-service system CMS established so that pharmacists may fill prescriptions for dual-eligible beneficiaries even if they have no record of their plan was cited by respondents as being particularly helpful. A great majority said that an expansion of such systems to help resolve more types of problems at the pharmacy would be helpful.

Simplify LIS Enrollment

Program changes could help increase the number of Medicare beneficiaries receiving LIS and Part D prescription drug coverage.

Eliminate the asset test. The asset test significantly complicates the LIS application process. The need to provide information not readily available, such as the cash surrender value of life insurance policies, stymies applicants; the need to verify this type of information also creates an extra burden for Social Security or Medicaid offices. If the asset test is not eliminated,

the limit should be increased and the test amended to simplify the way assets are counted and documented.

Require greater participation by state Medicaid offices. The law gives applicants a choice of applying for LIS through Medicaid or SSA, but, in practice, few applications come through Medicaid. Medicaid offices are important pathways for some LIS applicants, and because Medicaid programs are state-based, they have more capacity to exchange information with other state-based programs. Thus, they can identify individuals who may be eligible for LIS or, with permission, obtain information needed to determine financial eligibility.

Medicaid offices should also be involved when beneficiaries lose LIS because of changes in their eligibility status for the underlying program through which they were deemed. As the Part D program entered its third year in 2008, almost half a million beneficiaries lost their deemed status for LIS.[11] If Medicaid programs were required to reevaluate subsidy eligibility for those who lose deemed status, either by using information on hand or requesting information from beneficiaries, and coverage continued during the re-evaluation period, coverage gaps would likely be reduced.

Do not count LIS as income. About half of respondents indicated that fear of losing other benefits is a reason that beneficiaries do not apply for LIS. A legislative change to ensure that LIS assistance is not counted as income when determining eligibility for other needs-based programs would likely increase program enrollment. Many precedents for this exist in federal public benefits; the most recent is the Prescription Drug Discount Program that preceded Medicare Part D.

Target outreach. Respondents said the primary reasons Medicare beneficiaries do not apply for LIS are they are not aware a subsidy is available or do not know how to apply for it. This lack of knowledge suggests a need in to conduct more targeted outreach efforts.

Improve Program Monitoring

The Part D program was designed with important protections for beneficiaries. Respondents indicated, however, that difficulties often are not resolved in a timely manner or not at all. Findings such as these argue for more aggressive monitoring of drug plan operations on the part of CMS to promote program quality.

The development and required use of standard notices and procedures for functions such as coverage determinations, exceptions requests, and appeals would allow those who assist beneficiaries—including counselors, pharmacists, and physicians—to provide help more quickly and efficiently. CMS's ability to monitor plan operations would also be enhanced.

Support More One-On-One Counseling

Even if more and better information were available and steps taken to simplify LIS application and plan enrollment procedures, the need persists for one-on-one counseling such as that provided by community-based organizations. Respondents indicated that meeting this need is a particularly important factor in helping to assure that beneficiaries understand how to use the Part D program effectively.

CONCLUSION

Counselors and others who work directly with vulnerable Medicare beneficiaries have identified difficulties associated with the random, automatic assignment of low-income beneficiaries to drug plans. A large majority reported that beneficiaries they see commonly have difficulty obtaining prescription drugs because of plans' utilization management rules, and that consequently, health or well-being is affected. Counselors noted that program complexity poses a challenge for the beneficiaries they assist, and that simple, accurate program information is needed. Respondents recommend, for example, that one-on-one counseling be supported and that efforts to simplify the Medicare Part D LIS application process be undertaken.

Notes

[1] Medicare Advantage plans provide Part A (hospital insurance) and Part B (supplementary medical insurance) as well as Part D coverage through managed care organizations. Stand-alone prescription drug plans provide only pharmacy benefits.

[2] Beneficiaries may also keep their existing coverage through employer-based or other credible insurance at least equivalent to Part D.

[3] The term "auto-enrollment" refers to both "auto" and "facilitated" enrollment in this report.

[4] Medicare Payment Advisory Commission, Public Meeting Transcript, Oct. 5, 2006, available at http://www.medpac.gov/public_meetings/transcripts/10_06_MEDPAC_all.pdf.

[5] Centers for Medicare and Medicaid Services, "Medicare Prescription Benefit's Projected Costs Continue to Drop," Jan. 31, 2008, press release.

[6] CMS guidance now gives all LIS beneficiaries the right to change plans monthly.

[7] P. Neuman, M. K. Strollo, S. Guterman et al., "Medicare Prescription Drug Benefit Progress Report: Findings from a 2006 National Survey of Seniors," *Health Affairs* Web Exclusive (Aug. 21, 2007):w630–w643.

[8] The protected classes of drugs include cancer drugs, anti-HIV/AIDS drugs, immunosuppressants, anti-psychotics, anti-depressants, and anti-convulsants.

[9] CMS, "Medicare Prescription Benefit's," 2008.

[10] Neuman, Strollo, Guterman et al., "Medicare Prescription Drug Progress Report," 2007.

[11] Centers for Medicare and Medicaid Services, "Year 2007 Re-Deeming Data—Losing Deemed Status," available at http://www.cms.hhs.gov/limitedincomeandresources/.

About This Study

Researchers from Georgetown University's Health Policy Institute, the National Senior Citizens Law Center, and the Center for Medicare Advocacy compiled a list of 1,707 individuals who assist Medicare beneficiaries. Each potential respondent received an e-mail from the Health Policy Institute with an electronic link to a set of questions. Some 397 individuals responded, a rate of 23 percent. An additional 121 people responded after individuals from the original list forwarded them the link to the questions. At the Health Policy Institute's request, several other organizations sent the link to appropriate individuals on their own e-mail lists. As a result, 142 additional responses were received, for a total of 660. Because the set of questions was lengthy, response rates were somewhat higher for the first groups of questions, since some respondents did not answer all of the questions.

All respondents either directly counsel Medicare beneficiaries or serve in a supervisory capacity and are knowledgeable about counseling in their organizations. Although the effort was not designed to be nationally representative, individuals from 49 states (all but Alaska) and the District of Columbia responded: 35 percent were from the Midwest, 25 percent from the South, 21 percent from the West, and 19 percent from the Northeast. The majority of respondents (54%) described their primary professional activity as beneficiary counselors. Eight percent were attorneys. Individuals who manage or direct organizations that assist beneficiaries comprised 30 percent of respondents. The remaining respondents were health care providers or other interested parties.

Respondents were well-versed in Part D issues: 54 percent reported they spend half or more of their time on Part D. When asked to describe their own knowledge of Part D, 82 percent of respondents said they are very proficient or proficient and 14 percent rated their knowledge as somewhat proficient. Respondents primarily assisted subgroups of Medicare beneficiaries: 57 percent indicated that one-third or more of the beneficiaries they assist were dual eligibles, while some 43 percent said that one-third or more were rural residents. Eighteen percent reported that one-third or more of the beneficiaries they assist were younger than 65, and 6 percent of respondents said that one-third or more of the Medicare beneficiaries they helped were non- or limited-English speakers.

Note: A companion Powerpoint chartpack is available for download at http://www.commonwealthfund.org/usr_doc/Summer_McarePartDsupplchartpack.pdf?section=4039. It contains all figures included in this issue brief as well as additional figures excluded because of space limitations.

About the Authors

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