The Role of Beneficiary-Centered Assignment for Medicare Part D

A study conducted by staff from Georgetown University and from NORC at the University of Chicago for the Medicare Payment Advisory Commission

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Final Report

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Executive Summary

Under the Medicare Part D benefit, dually eligible beneficiaries and others who qualify for the low-income subsidy are assigned to a plan while maintaining the option of choosing one on their own. Under a policy of random assignment, beneficiaries are not steered to any particular plan and qualifying plans receive an equal share of beneficiaries. This report considers the potential impact on beneficiaries and the federal government of using random assignment, as compared to "intelligent random assignment" or "beneficiary-centered assignment." The study was based on interviews with state officials who have experience with beneficiary-centered assignment and on an analysis of how Medicare drug plans cover 100 drugs commonly used by Medicaid beneficiaries.

Findings

- Beneficiary-centered assignment is feasible for Medicaid and state pharmacy assistance program populations. States have found that it is not costly and has not had a disruptive effect on the markets in their states.
- State officials believe that beneficiaries have better access to the drugs they are used to taking under this approach to assignment. They also see the potential for savings, although the extent of savings depends in part on how the programs wrap around Part D.
- A substantial number of studied drugs were off formulary for at least one Part D plan in each of the regions used in this study. In addition, about one-third of covered drugs require either prior authorization or step therapy for at least one plan we studied. Both situations potentially cause access problems for beneficiaries but generally do not incur added costs for the federal government.
- In each region, about half of studied drugs are covered on non-preferred tiers for at least one of the plans we studied. As a result, monthly cost sharing varies across plans in each region. We found that cost sharing for each drug is nearly always at least $5 per month higher in at least one plan, compared to the plan with the lowest cost sharing for that drug, and is at least $50 higher for one-tenth of the drugs in this study. These higher costs are not incurred by beneficiaries, but are paid to the plans by the federal government.
- Beneficiary-centered assignment could be designed to avoid some of the situations where beneficiaries have prescriptions for drugs that are off formulary or face some type of utilization management. It could also be designed to reduce program costs for federal and state governments. Policymakers would need to decide how to balance these goals, as well as how to account for differences in plan premiums and deductibles.
- In designing a new system of assigning beneficiaries, policymakers would also need to balance other factors, including the cost and disruption of revisiting plan assignments annually and implications for risk selection and payment fairness.
- The analysis for this report was done on a drug-by-drug basis and does not take into account the complexity posed by beneficiaries taking multiple drugs. MedPAC's

ability to estimate the potential for savings if a mechanism other than random assignment were used.

The Role of Beneficiary-Centered Assignment for Medicare Part D

Medicare's new drug benefit was designed around a market-based model in which beneficiaries choose among private plans competing to enroll beneficiaries in their communities. By exploiting market incentives, the design is expected to help curb drug cost growth while providing the coverage packages that beneficiaries desire. In particular, beneficiaries face different financial incentives, in the form of premiums, deductibles, and copayment amounts, for plan benefits that differ in terms of covered drugs (formularies) and use of utilization management tools. As consumers, beneficiaries are encouraged to examine the plans available to them and pick that whose costs and benefits most closely relate to their expected drug needs.

The new benefit also includes provisions designed to provide financial support to low-income beneficiaries, including the dually eligible beneficiaries who formerly received coverage for prescription drugs from state Medicaid programs. In contrast to the individual-level choice model described above, most of the beneficiaries eligible for this low-income subsidy (LIS) were randomly assigned to plans, although they are free to switch from their assigned plan. As described below, the use of random assignment helped ensure equity across participating plans, among other things. In this report, we examine the question of how well random assignment and alternatives such as a system of beneficiary-centered assignment address the needs of LIS beneficiaries and how they affect the costs to Medicare of subsidizing the drug spending for these beneficiaries.

Background: The Rules

In creating the Medicare Part D benefit, the Congress chose to shift all dually eligible beneficiaries from receiving drug coverage from their state Medicaid programs to being enrolled in a Medicare Part D private plan. In order to ensure that all dual eligibles were enrolled in a plan in time for the January 1, 2006, start of the program, CMS chose to assign them to a plan. In most cases beneficiaries were assigned to standalone prescription drug plans (PDPs). Those already enrolled in a Medicare Advantage plan were assigned to that plan's drug plan (MAPD). Beneficiaries always retained the option of rejecting that assignment and choosing a different plan. In fact, dual eligibles are the only beneficiaries that retain the option of switching plans throughout the year.

In assigning these beneficiaries to plans, CMS was guided by two principles. One was to avoid steering beneficiaries into any particular plan. CMS viewed this as a core element in the choice-based design established by the law's authors. A second goal was to assist in the establishment of a stable market for Part D plans by guaranteeing qualifying plans an equal share of beneficiaries – unless beneficiaries themselves made their own choices to favor certain plans.

Assigning beneficiaries randomly and in equal numbers was part of a larger strategy to encourage health plans to participate in the new Medicare benefit and to ensure that the new market envisioned in the Medicare Modernization Act (MMA) would be successfully created. Health plans regularly used the number of dual eligibles they expected to enroll in statements to investors to demonstrate the value of their participation and investment in Part D.

Random assignment ensured to some extent that plans' assigned enrollees would not on average have higher drug utilization than those assigned to competing plans. These results were considered important for obtaining plan participation and a degree of predictability for plans in the program's first year. It also was seen as relieving some of the pressure on the risk adjustment system.

For a plan to qualify for a share of randomly assigned beneficiaries, it must meet both design and cost requirements. First, only plans that are designed as a standard benefit, or actuarially equivalent to the standard benefit, are eligible for assignment of LIS beneficiaries. Second, plans must have a premium below a benchmark premium level in their region. By law, premium benchmarks are supposed to be based on an enrollment-weighted average of the PDPs and MAPDs for a particular region. For the program's first year, an unweighted average was used since there was no enrollment. As described below, CMS has continued use of an unweighted average for at least one additional year.

Any beneficiary qualifying for the low-income subsidy (including all full dual eligibles) will pay no premium for a plan with a premium below the benchmark. Each of the organizations offering below-bnchmark plans received an equal share of the low-income beneficiaries who were randomly assigned. Beneficiaries qualifying for the low-income subsidy can choose to enroll in plans with higher premiums, but must pay the difference between the plan's premium and the benchmark.

About 30 percent of all plans had premiums below their regional benchmarks in 2006. The number of qualifying plans varied considerably by region. Regions with a higher penetration of Medicare Advantage plans tended to have lower benchmarks and fewer qualifying PDPs.[1]

Implementation of random assignment for dual eligibles occurred early in the first open season (the fall of 2005), with the intention of ensuring that beneficiaries were enrolled in plans by January 1, 2006. Beneficiaries other than dual eligibles who qualified for the low-income subsidy were given the opportunity to enroll in a plan on their own. Those not doing so after a period of time were given facilitated enrollment whereby they were assigned randomly to a qualifying plan.

For 2007, new benchmarks were calculated in each region. The list of plans eligible for random assignment grew in 2007, in part because the overall number of plans participating in Part D was higher and in part because of steps taken by CMS to minimize disruption to beneficiaries. The agency used its demonstration authority to continue using an unweighted average of premiums, which allowed more plans to remain below the benchmark. In addition, CMS established a de minimis rule whereby plans could retain enrollees by waiving up to $2.00 in premium charges above the benchmark amount. The proportion qualifying based on the benchmark fell to a little over 25 percent without the de minimis policy, but was a little over 30 percent with that policy in force.

[1] The benchmarks are based on premium averages across both PDPs and MAPDs. In general, MAPD premiums are lower, in part because they can lower premiums using so-called rebate dollars (amounts by which its premium bid for Parts A and B services are below the plan's payment amount).

For 2007, CMS used random assignment for 1.1 million beneficiaries who had been randomly assigned to plans that no longer qualified under the benchmark (including the $2 de minimis waiver) in 2007. Random assignment is used on an ongoing basis when Medicaid beneficiaries become eligible for Medicare and their prescription drug coverage changes to Part D and for others who become newly eligible for Medicaid and Medicare.

Key Questions

The use of random assignment has raised two critical policy concerns. One is whether beneficiaries end up in plans that best serve their needs. A second is whether the federal government faces higher costs when beneficiaries are randomly assigned.

Beneficiaries eligible for the low-income subsidy (LIS beneficiaries) pay lower cost sharing than other beneficiaries enrolled in the same plans. For drugs on a plan's formulary, low-income copayments for each drug are between $1 and $5.35, depending on the type of drug, the beneficiary's income, and Medicaid status (Table 1). In addition, LIS beneficiaries do not face a deductible or coverage gap – they continue to pay between $1 and $5.35 during these periods, and they have no cost sharing once they reach catastrophic coverage. The federal government pays plans for these costs on behalf of the subsidized beneficiaries, covering any difference between what the LIS beneficiary pays and what a non-subsidized beneficiary would pay in the same plan.

Table 1. LIS Copayments in 2007

	Copayment
Full Dual Eligibles Under 100% of Poverty	
Generic drugs	$1.00
Brand name drugs	$3.10
Other LIS Beneficiaries	
Generic drugs	$2.00
Brand name drugs	$5.35

The government, however, does not cover any drugs that are off the plan's formulary or when the drug does not meet the plan's standards for prior authorization or other utilization management measures. In these cases, a beneficiary is faced with either paying the full cost of the drug, changing drugs, obtaining an exception, or going without the drug altogether.

In the context of these cost sharing rules, the use of random assignment, while helping provide stability for plans, does not guarantee that individual beneficiaries are assigned to a plan that covers all of their drugs without restrictions. A study in the fall of 2005 by the Office of the Inspector General found that drug plan formularies for the program's first year included between 76 percent and 100 percent of the commonly used drugs they reviewed.[2]

[2] In some cases, plans may omit these drugs from plan formularies because they cover therapeutic alternatives that are preferred either for clinical safety or effectiveness reasons or because they are able to negotiate lower prices.

The report further found that about half of the 178 commonly used drugs that they reviewed were included by all formularies.[3]

Although beneficiaries have the right to change plans to find a better fit, many have not done so (although data are not available on how many dually eligible beneficiaries actually made a switch from their randomly assigned plan). As described below, a few states stepped in to help their beneficiaries improve the match between their drug needs and the available plans using a process know as "intelligent random assignment" or "beneficiary-centered assignment." Most states did not.

The use of random assignment may increase costs incurred by the federal government because the federal government incurs costs for the difference between the minimal copayments paid by beneficiaries and the full copayments charged by plans. The government's costs increase significantly as the difference between the subsidized copayment and the plan's full copayment grows (Table 2).

Table 2. Copayment Subsidies in a Typical Four-Tier Plan

	Full Dual Eligible Beneficiary Copayment	Median Plan Copayment	Federal Government Share
Generic Drug	$1	$7	$6
Preferred Brand Drug	$3.10	$22	$18.90
Nonpreferred Brand Drug	$3.10	$55	$51.90
Specialty Drug ($500)	$3.10	$125	$121.90

NOTE: Median plan copayments are based on 2006 data, which probably have not changed appreciably for 2007; the LIS copayments are 2007 levels. Higher copayment amounts ($2 and $5.35) apply for those full duals over 100% of the federal poverty level and other LIS-eligible beneficiaries. For specialty drugs, we use the minimum cost level established by CMS in this illustration – and the typical 25 percent coinsurance.

Differential copayments provide other beneficiaries a significant incentive to switch to a preferred drug, provided they and their physicians agree that it represents an acceptable therapeutic alternative. But the low-income beneficiary faces no financial incentive to switch, or to request a tiering exception from the plan. Low-income subsidy beneficiaries do face a modest incentive to switch from a brand-name drug to a generic alternative – including therapeutic alternatives that are available in the same drug class as the sole-source drug they are currently taking. Although the dollar magnitude of the incentive is less than for other beneficiaries, the $2.10 difference may be as important to them as the larger difference is to beneficiaries with less modest means.

This report considers the potential impact on beneficiaries and the federal government of random assignment, as compared to "intelligent random assignment" or "beneficiary-centered assignment." First, we examine the ways that a few states have approached this problem, either in Medicaid or in state pharmacy assistance programs (SPAPs). We then examine the coverage of 100 commonly used drugs to show the differences among plans that received randomly assigned beneficiaries in three regions.

[3] Office of the Inspector General, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.

Current Experience with Beneficiary-Centered Assignment

Recognizing that random assignment might create challenges for beneficiaries as their drug coverage transitioned from Medicaid to Medicare or as their SPAP coverage changed, several states considered ways to help beneficiaries find a plan that fit their drug use.

State Medicaid Programs

Maine is the one state that has used beneficiary-centered assignment for dual eligibles. Legislation passed in 2005 gave the administration emergency rulemaking authority to reassign dually eligible beneficiaries who already had been randomly assigned to Part D plans by CMS. It also allows the state's Department of Health and Human Services to serve as an "authorized representative" for the purposes of enrollment into a Part D plan. Initially, three months of drug utilization data from MaineCare for all duals (excluding those in nursing homes) was compared to plan formularies for ten plans that contracted with the state (as with Maine's SPAP, described below, not all plans met the criteria for contracting with the state for this purpose). Individuals' drug needs were matched with formularies and pharmacy networks for the plans. In addition, potential out-of-pocket costs associated with the plans were considered for each beneficiary (Maine covers Part D copayments and pays for Part D excluded drugs that are covered by MaineCare). The state switched plans on behalf of beneficiaries who had been auto-assigned to plans that covered less than 85 percent of the drugs they take.[4] Each received a letter indicating that their drug plan had been changed and instructions with a number to call if they preferred not to be switched. Another group of beneficiaries received letters indicating that the plans to which they had been auto-assigned were adequate, but not the best fit. Alternate plans that provided better options were listed and beneficiaries were told to contact the state if they wanted help switching plans. Plan assignment for dually eligible beneficiaries in the SPAP was reassessed for 2007; the state has contracts with five plans for 2007. The state conducts monthly matches to reassign any randomly assigned beneficiaries who have just become eligible for Medicare Part D.

New Jersey also planned to conduct beneficiary-centered assignment for dual eligibles by matching claims data for Medicaid beneficiaries with plan formularies, but ultimately did not receive permission from CMS. They did conduct manual reviews from one group of dually eligible beneficiaries, those in psychiatric hospitals and developmental centers, to identify optimal plans for those patients.

At least three other states took some steps to assist beneficiaries in evaluating their plan options, but did not attempt to assign dual beneficiaries to plans. For example, ***Florida's*** Medicaid program worked with an outside firm, *GoldStandard*, which matched historical prescription data for duals with data on plan formularies to produce personalized Medicare Part D reports for participants.[5] Beneficiaries then had the option to switch from their

[4] The initial match indicated that one of four duals had been randomly assigned to plans that covered less than 60 percent of the drugs they take.

[5] *GoldStandard* offered its software more generally to states without charge. It received grant funding from pharmaceutical manufacturers (without strings attached) to develop the software. Other states were

randomly assigned plan to another. ***Connecticut*** sent 65,000 dual eligibles vouchers to redeem at their local pharmacy for assistance in evaluating the plan to which they had been assigned or in selecting a plan that better suited their prescription drug needs. Pharmacies were paid a stipend by the state to perform this service. Some dual eligibles used this voucher, but most did not. In ***New York***, where the Medicaid program provided full wraparound benefits for the first year of the Part D program, pharmacists and counselors were urged to help seniors get into the plans that were best for them before January 2007, when the wrap was eliminated.

State Pharmacy Assistance Programs

Before the creation of Part D, several states had pharmacy assistance programs (SPAPs) that provided financial assistance to non-dual beneficiaries with their drug costs. SPAPs were created by over 20 states to subsidize prescription drug costs for over 1 million Medicare beneficiaries.[6] Prior to the passage of the MMA, SPAPs filled a significant gap in Medicare – its lack of outpatient prescription drug coverage – for certain low- and modest-income Medicare beneficiaries lacking supplemental drug coverage either from Medicaid or through retiree benefits.

Several SPAPs wanted to continue providing assistance to Part D enrollees after creation of the program. The MMA defined a "qualified SPAP" and indicated how these state-funded pharmacy assistance programs could operate relative to Part D. Payments made by a qualified SPAP on behalf of Part D beneficiaries for covered drugs count towards the beneficiaries' true out-of-pocket costs, shortening the time the beneficiary spends in the coverage gap or "donut hole." Qualified SPAPS also received transitional funds to educate beneficiaries about Medicare Part D.

In general, the SPAPs achieved savings through the use of wrap-around coverage, since Medicare Part D now covers some of the drugs costs previously paid by the state programs. By offering subsidies to help beneficiaries cover their cost sharing, the SPAPs are in a similar position as the federal government. They can save money by finding plans that charge lower copays. In addition, when SPAPs help cover the costs of off-formulary drugs, their interests align with the beneficiaries' interests to find plans that place all the drugs an individual is taking on their formulary.

One important point of discussion between SPAPs and CMS at the start of the Part D program concerned the extent to which SPAPs could assist their enrollees in choosing drug plans. SPAPs' main concerns were to assure continued access to prescription drugs for beneficiaries and to maintain their own abilities to manage their programs. Several states suggested and continue to suggest that their beneficiaries should be enrolled in a limited number of plans. CMS voiced concerns about the possibility that programs might steer their enrollees into one plan or a limited number of plans and thus restrict choice.

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considering use of the software, but a lawsuit (eventually settled), together with the limited time available, apparently convinced other states to abandon this approach.

[6] The largest enrollment is in five SPAPs – Illinois, Massachusetts, New Jersey, New York, and Pennsylvania.

As of early 2006, six SPAPs – Connecticut, Maine, New Jersey, New York, Nevada, and Pennsylvania – had made decisions to provide assistance in choosing plans by using beneficiary-centered assignment for some of their enrollees. Beneficiary-centered assignment was conducted in all six states for large groups of beneficiaries for the 2006 plan year.[7] ***Maine*** and ***Pennsylvania*** repeated the process for 2007 as did ***New York*** for a smaller group of SPAP enrollees. We interviewed representatives from each program to learn more details about the process in each state. The programs are listed in Table 3 with information about the type of Part D wraparound benefits the SPAPs provide.

Table 3. SPAP Provisions for Wrap-Around Coverage for Part D, Selected States

Program		Part D enroll-ment required	Program provides assistance with:					
			Premiums	Deductible	Cost sharing	Coverage gap	Non-formulary coverage	Excluded drugs
CT	Connecticut Pharmaceutical Assistance Program to the Elderly and the Disabled (ConnPACE)	Y	Y	Y	Y	Y	Y (1)	Y
ME	Low Cost Drugs for the Elderly and Disabled Program (DEL)	Y	Y	Y	Y	Y	N	Y
NJ	Pharmaceutical Assistance for Aged and Disabled (PAAD)	Y	Y	Y	Y	Y	Y	Y
NY	Elderly Pharmaceutical Insurance Coverage (EPIC)	N (2)	N	N	Y	Y	Y	Y
NV	Senior Rx	Y	Y	N	N	Y	N	N
PA	Pharmaceutical Assistance Contract for the Elderly (PACE)	N	Y	Y	Y	Y	Y	Y

NOTE: Based on state decisions available as of early 2006. Unpublished paper of Hoadley, O'Brien, et al.
(1) Non-formulary drugs that ConnPACe covered before Part D
(2) Legislation pending

Issues SPAPs had to consider in developing the process for beneficiary-centered assignment

The design of SPAPs and circumstances in states differ considerably. Therefore, each state used a different approach to beneficiary-centered assignment. All of the states had to consider similar issues, however.

Do SPAPs Have the Authority to Make Assignments on Behalf of Beneficiaries?

Legislatures in ***Connecticut***, ***Maine***, and ***Pennsylvania*** granted authority to their SPAPs to act as authorized representatives so the programs could make determinations about the best plan assignment, and could switch plans on behalf of beneficiaries. In ***Nevada***, where the

[7] Pennsylvania's PACE program did not finalize its decisions until the latter part of 2006 and implemented its beneficiary-centered assignment process as of September 2006.

legislature was not in session, the SPAP sent letters to all of its members asking them to complete and return an authorization form if they wanted assistance choosing a plan.

What are the Processes Used for Beneficiary-Centered Assignment?

For the initial beneficiary centered assignment, ***Maine***, ***New Jersey***, and ***Pennsylvania*** each relied on the pharmacy benefit administrator they contract with to develop computer programs and conduct the matches. ***New York*** worked with an outside group – *GoldStandard* – that had developed a program for matching. ***Connecticut*** and ***Nevada*** conducted matches using the CMS *Plan Finder*. They had some extra help. Pharmacy students from the University of Connecticut and members of the Pharmacy Association assisted the process in ***Connecticut***. Additional staff supported by the SPAP transition grant helped in ***Nevada***.

In the program's second year, ***Maine*** and ***Pennsylvania*** used essentially the same approach. ***New York*** developed its own program, based on the one provided by *GoldStandard* and used it for a small number of enrollees, those who have the full low-income subsidy. ***New Jersey*** recommended that beneficiaries stay in their plans. Re-assignment did not occur in ***Connecticut*** or ***Nevada***.

On an ongoing basis, ***New Jersey***'s SPAP asks new enrollees to send a current drug use profile with the name and location of the pharmacy they use. The program then uses the CMS *Plan Finder* to recommend a plan. Officials note that with the *Plan Finder* they can consider tiers as well as formulary restrictions, especially for higher priced items.
The current ConnPACE application asks, "Do you have a Medicare part D prescription drug plan? If NO, would you like ConnPACE to select a Medicare part D PDP for you?" In ***Maine***, plan assignments are reviewed as individuals with Medicaid coverage become eligible for Medicare Part D, as they qualify for the LIS, or as they apply for the SPAP.

What Criteria are Used in Making Assignments?

All six SPAPs matched data on individuals' current drug use with data on each plan's formulary. ***New York*** did not include generic drugs in the match – they assumed that generics would be available – but they did consider whether plans had prior authorization rules for drugs (The state's EPIC program is a secondary payer for drugs that are not available to beneficiaries). ***Pennsylvania***'s assessment looks first at specialty drugs, then other drugs, and looks at whether there are tier designations for drugs. (Pennsylvania's PACE pays all cost-sharing for beneficiaries). The focus in ***New Jersey*** was on maintenance medications. All of the states considered whether plans' pharmacy networks included the pharmacies that beneficiaries had been using. In a few of the states, marital status is taken into account and couples are treated as a unit when plan assignments were made.

In most states, information about prescription drug and pharmacy use was available from historical program data. ***Maine*** and ***New York*** examined three months and ***Pennsylvania*** looked at 12 months of data. In ***Nevada***, where computerized records were not available, enrollees received a letter that asked them to provide this information if they wanted help choosing a plan.

Officials mentioned some technical challenges related to the matching process. In ***New Jersey*** and ***New York***, for example, matching drugs from prescription records at the NDC code level with plan formulary files was difficult, especially before the introduction by CMS of a system of reference NDC codes.[8] One problem that ***Maine*** encountered is that their historical data for SPAP enrollees is incomplete because the program covers only drugs for certain health conditions. Therefore, in some cases, they could not make optimal matches with the new plans.

Decisions about which criteria to use depend in part on program design and other circumstances in the state. An SPAP that covers cost sharing, for example, will have more interest in examining whether certain drugs are on formulary tiers than does a program that provides coverage only when beneficiaries are in the coverage gap. More precise matches occur when more criteria are used, but the process also becomes more complicated.

For Whom Should Assignments be Made?

The number of SPAP beneficiaries for whom some sort of beneficiary-centered assignment was done ranged from fewer than 1,000 in ***Nevada*** (where only about 10 percent of beneficiaries returned the form to ask for assistance) to about 150,000 in ***Pennsylvania***. Maine made assignments for about 10,000 SPAP and 12,000 Medicaid beneficiaries. Differences among states in the number of people assigned reflect not only the size of the state populations and the numbers of people participating in the SPAPs, but also the proportion of enrollees that the program assigned. ***New York***, for example, noted that they were late in making assignments the first year and therefore assigned only about 12 percent of program participants. About three-quarters of SPAP members received assistance in ***Connecticut***.

Beneficiary-centered assignment has not been used for certain groups of SPAP enrollees. Initially, none of the states assigned individuals with Medicare Advantage coverage because they did not want to interrupt these individuals' broader health insurance coverage. (***Pennsylvania*** is beginning to look at assignments for beneficiaries who have Medicare Advantage). SPAP members who have retiree or other types of coverage that preclude their use of Part D are not included in the pool to be assigned.[9] ***Pennsylvania*** also excludes those with no drug utilization in the previous year. And ***Nevada*** worked only with members who returned the initial letter the program sent offering to help with beneficiary-centered assignment.

Can Beneficiaries Opt Out? Is Beneficiary-Centered Assignment Disruptive?

All of the SPAPs give beneficiaries opportunities to opt out of their assignment. In ***New York***, for example, the EPIC program sent a letter to certain enrollees, which specified the

[8] For 2007 plan formulary submissions, CMS introduced a system of reference NDC codes so that all plan formularies refer to the same code to indicate that a particular drug is covered. This system, for example, allows states to match generic drugs from different manufacturers to plan formulary listings.

[9] SPAPs did encounter some difficulties when they conducted matches for these beneficiaries because the information they received from CMS did not indicate that the beneficiaries already had other coverage.

best plan choice and indicated that the beneficiary would automatically be enrolled in the plan unless they informed the plan that they wanted to opt out. Very few – less than two percent – asked not to be assigned. In ***Pennsylvania***, beneficiaries receive a letter informing them that they are being assigned to a particular plan and that they have ten days to notify the SPAP if they are not in agreement with that assignment. They can call and ask for another plan, or ask not to be assigned at all. The vast majority of members assigned stay in their assigned plans. The experience in ***Maine*** has been similar.

Officials in both ***Maine*** and ***Pennsylvania*** note that while some disruption occurs at re-assignment it is minimal. Also, enrollees became much more comfortable with the process when it was used the second time. In ***Pennsylvania***, for example, the SPAP received almost 80,000 calls when re-assignment occurred for 2006, but only 27,500 for 2007. In both years, the three main reasons for the calls were that enrollees wanted to know what was happening, they wanted to be sure they were not losing their SPAP coverage, or they wanted to check to be sure they did not have to take any additional action. The Maine and Pennsylvania SPAPs are well established programs that are generally trusted by enrollees and in Maine, additional trust was fostered by the members of a Part D Stakeholders Group, which was established in response to a legislative directive and participated not only in making policy but also in helping to explain it. Both states have provided beneficiaries with explanations about the re-assignment process and with assurances that they would not see changes or would see improvements in their coverage.

Are Assignments Made to All Plans?

For the most part, beneficiary-centered assignments are made to plans with premiums at or below the benchmark, or within the de minimis amount beyond the benchmark. Initially, the ***Nevada*** SPAP ran a report on the top 100 drugs used by their members and entered the data into the Medicare website to identify the plans that covered most of the drugs. The intent was to enroll all members in one of the plans by January 1 and then, because their members could switch, to conduct individual analyses. CMS did not approve that plan, however, contending that it did not fit the definition of "random." Therefore, ***Nevada*** simply used the *Plan Finder* to make assignments. ***Connecticut*** used a similar approach.

New Jersey "co-brands" with a particular plan and ***Pennsylvania*** has "partner plans" chosen because they have broad formularies suited to many of their enrollees, good pharmacy networks, and are willing to work with the SPAPs to effect smooth transitions. For example, they have agreements to honor prior authorization agreements that already had been established for SPAP members. ***Maine*** has contracts with a limited number of plans that accept assigned MaineCare and SPAP enrollees. The state sent an RFP to all plans, but only signed contracts with plans that met certain criteria. Ten participated the first year and five have contracts in the second year.[10]

[10] The Draft 2008 Call Letter issued by CMS to drug plans on March 22, 2007, makes explicit the CMS non-discrimination policy for SPAPs, stating that SPAPs with authorized representative status may facilitate enrollment of their beneficiaries into plans that agree to state-specific coordination criteria approved by CMS. In addition, SPAPs must allow beneficiaries to enroll in Part D plans that do not meet the coordinating criteria if they wish to do so and must provide these beneficiaries the same wraparound benefits or assistance.

Findings and Implications Based on SPAP Practices

The review of SPAP operations in six states suggests that beneficiary-centered assignment is a process that could be used on a national basis.

- Beneficiary-centered assignment is feasible for Medicaid and SPAP populations. Larger programs that contract already with pharmacy benefit administrators report that the process is not costly; it falls within the scope of their current contracts.

- The practice has not had a major market impact. Officials report that there is some clustering among certain plans when beneficiary-centered assignment is used. In ***Pennsylvania***, for example, about 70 percent of assigned beneficiaries were enrolled in three plans. But several officials note that the enrollment patterns among those they assign correspond with the patterns for other Part D enrollees in the state and nationally, with the larger better known plans having more members.

- Significant changes in premiums did not occur between 2006 and 2007 for the plans to which beneficiaries were more commonly assigned, though three states reported that one plan no longer met benchmark requirements and so reassignment was necessary or beneficiaries switched plans. Formulary changes were even less frequent. The ***Pennsylvania*** SPAP reported that one of the more popular plans expanded its formulary.

- State officials believe that beneficiaries have better access to needed drugs with beneficiary-centered assignment. They say that if the assignment is right the first time fewer beneficiaries will have to either file for exceptions or appeals or switch plans. And they note that it can take 17 days to get to the first level of appeal and can take two to three months to switch plans. Officials report that the process of assigning beneficiaries to a certain group of plans fosters cooperation between the SPAP and the plans so that before exception requests or appeals are filed, designated individuals at the plans can resolve coverage issues with SPAP staff on behalf of beneficiaries. When beneficiary-centered assignment is used, the level of appeals that SPAPs have filed on behalf of beneficiaries is lower than had been anticipated originally.

- States see the potential for savings associated with beneficiary-centered assignment. The savings that SPAPs realize depends in part on what the programs cover. States have not systematically determined whether program savings are associated with beneficiary-centered assignment, but there are some indications of savings. For example, New Jersey reports that the wrap-around costs for non-formulary drugs were lower than had been anticipated prior to beneficiary-centered assignment.[11] Several officials – from states that

[11] Initially the state budgeted $50 million, but spent only about $3 million for wraparound costs associated with non-formulary drugs. Several factors account for the difference: the need to make an early estimate based on incomplete information about plan formularies; the willingness of pharmacists and physicians to work with patients to switch to formulary drugs; beneficiary-centered assignment.

have more generous wraparound benefits – noted that research in this area would be helpful.

- Accurate real-time electronic information systems are needed to make beneficiary assignment efficient and effective on a larger scale. Some states report difficulties because they did not have accurate information about beneficiaries' current coverage. As a result, they were not able to initiate the beneficiary-centered assignment process at the optimal time. Some made plan assignments for individuals who already had chosen plans because data on their current status was not available. Better data systems would help in this regard.

Different Assignment Methods: Potential Costs for Beneficiaries and the Government

The state experience suggests that a system of beneficiary-centered assignment is feasible. This section considers the implications of different approaches to assignment by studying the placement of commonly used drugs on plan formularies and the degree to which cost sharing varies among the plans to which beneficiaries may be assigned. As outlined earlier in the report, the structure of the low-income subsidy means that beneficiaries are shielded from most of the cost-sharing differences, but that the federal government is responsible for paying the remaining costs.

Methodology for Looking at Plan Formularies

Data on drug coverage and prices were collected from the Medicare Plan Finder website. We selected three PDP regions in different parts of the country: Region 3 (New York), Region 20 (Mississippi), and Region 25 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming). In each region, we identified the plans eligible for LIS auto-enrollment (see Table A-1 in the appendix). The result was a list of 29 plans, of which 16 are LIS eligible in New York, 21 are LIS eligible in Mississippi, and 20 are LIS eligible in Region 25. However, Simply Prescriptions (eligible only in New York) was excluded from the study because data were not available on the Medicare Plan Finder website at the time we collected the data.

From a list of the 200 drugs most commonly used by Medicaid beneficiaries published by the Office of the Inspector General, we selected the first 100 covered by Part D for which data were available on the Plan Finder website (see Table A-2 in the appendix).[12] In general, we used the most common form, strength, and monthly dose offered by the Plan Finder as the amount for which we collected price information. Among the 100 drugs in our study, 47 are single-source brand-name drugs, while the remaining 53 are available in generic form.

The next several sections consider first situations where plans omit drugs from their formularies or require measures such as prior authorization before they pay for a drug. These are circumstances that affect the beneficiary's access to specific drugs, but not the federal government's cost in subsidizing drug purchases. Second, we consider situations

[12] Office of the Inspector General, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.

where drugs have higher cost-sharing levels because of tier placement or the structure of their cost sharing. In these cases, beneficiary access to drugs is normally not affected, but the government's costs may be higher. In any of these situations, it is important to remember that plans often have clinical reasons for how particular drugs are treated on their formularies and that some patients' drug regimens may benefit from being reviewed by their physicians.

How Often Are Commonly Used Drugs Off Formulary for LIS Plans?

To examine the effects of random assignment on beneficiaries, we asked how often our sample drugs are omitted from the formularies of any of the LIS-eligible plans. Off-formulary drugs do not directly lead to any added costs for the federal government, because the subsidy does not apply to these drugs. Beneficiaries in these cases may choose to pay for the drug out of pocket if they can afford to do so, or they may seek other assistance in obtaining these drugs. Such assistance in some cases is available wrap-around coverage by Medicaid programs such as *MaineCare* or some SPAPs, through manufacturer-run prescription assistance programs, or from other safety-net programs. Alternatively, beneficiaries may work with their physicians to find an alternative therapy that is covered by their plan or to make a formal request to the plan for a formulary exception, or they may switch to another plan. Beneficiaries unaware of or unsuccessful with these other options may choose to stop taking the particular drug (with or without the concurrence of the prescribing physician).

In each of the three regions we studied, we found that a substantial subset of drugs were off formulary for at least one plan (Table 4). In the New York region, over half (60 drugs) are covered by all plans, while just under half are covered by all plans in the other two regions. Some additional drugs are listed on formulary by all but a single plan (this might be due in some cases to errors on the CMS website). But there is a small set of specific drugs that are more systematically left off of plan formularies. For example, nine of our 100 sample drugs fail to appear on the formularies of at least five of the New York region's LIS-eligible plans.

Table 4. Coverage of Selected Drugs on Plan Formularies for LIS-Eligible Plans, By Region, 2007.

	Region 3 (New York)	Region 20 (Mississippi)	Region 25 (Iowa and others)
How many of 100 drugs are ever not covered by a plan?	40	56	55
How many of 100 drugs are not covered by 1/3 or more plans?	9	8	7

NOTE: Based on 100 drugs commonly used by dual eligibles.

In general, the drugs covered by all formularies are more likely to be generics. About half the generics (27 drugs) are always covered in each state, and about a third of brands (16 drugs) are always covered in each state. In most cases, the drugs most commonly left off formularies are drugs for which the status has changed since the original list was created by the OIG. For example, Zithromax (an antibiotic) and Amaryl (a drug used to treat diabetes) both became available generically in late 2005, and Miralax is a laxative formerly available by prescription only that was approved for over-the-counter sale in 2006.

The differences seen in patterns of formulary coverage vary systematically by plan. Some plans have made decisions to cover all drugs, while others are much more selective in which drugs they list on their formulary. In the three regions we studied, the least generous plan formulary covers between 72 and 77 of the 100 drugs in our sample, while the median plan covers just over 90 drugs.

Overall, these results are consistent with those reported by the Office of the Inspector General for 2006. As in our analysis, that study found that about half the drugs studied were covered by all plans. That study reported that plans on average covered 92 percent of studied drugs and that the smallest formulary covered 76 percent of the drugs – results quite similar to our study.[13]

How Often Do Utilization Management Restrictions Apply to Commonly Used Drugs?

From the beneficiary's perspective, the fact that a drug is listed on the formulary does not guarantee that the drug is covered for his or her specific circumstances. Certain drugs may be subject to utilization management requirements – tools used by plans to help manage drug use and total costs. Plans use these tools to steer beneficiaries to specific drugs as well as to control the use of certain drugs. Under prior authorization, plans may ask for assurance that a particular drug is medically necessary before granting permission to fill the prescription. Step therapy requirements (sometimes referred to as "fail first" policies) restrict coverage of a particular drug unless and until certain other drug therapies have been tried first. With quantity limits, a plan may limit the number of drugs covered over a certain time period, such as limiting a prescription to a 30-day supply or to just 7 migraine pills per month.

Plan enrollees and the physicians who prescribe their drugs may find these requirements an obstacle that blocks or delays the ability to get a prescription filled. If a patient is unable to obtain authorization from the plan to fill a prescription, their options are similar to those when a drug is off formulary. The federal government is at risk for costs only if the requirements are fulfilled and the plan agrees to pay for the prescription. Thus from a pure cost perspective this is not an important factor to the Medicare program.

For those SPAPs that provide coverage of non-formulary drugs as part of their wrap-around coverage, the failure to get prior authorization for a drug means that the state will pay for it as not covered on the formulary. In most cases, states did not take the presence of utilization management flags into account in their procedure for assigning beneficiaries, but some indicated that it might have been helpful to do so. Some state officials also indicated that they sometimes got involved helping beneficiaries get the necessary approval to receive these drugs, so the presence of these flags was a potential drain on state staffing resources as well.

Our data show that about one-fourth of drugs in each region have a prior authorization requirement for at least one of the LIS-eligible plans (Table 5). Similarly, about one-fifth of

[13] Office of the Inspector General, *Dual Eligibles' Transition: Part D Formularies' Inclusion of Commonly Used Drugs*, OEI-05-06-00090, January 2006.

drugs in each region have a step therapy requirement for at least one plan. There is some overlap in the application of these two requirements, so up to one-third of the 100 studied drugs have one of these two requirements imposed by at least one plan. Quantity limits are applied considerably more often. Based on other research, we have found that certain plans apply quantity limits on a large proportion of all drugs – apparently because they use this requirement to apply routine limits such as limiting prescriptions to a 30-day supply.

Plans typically choose to impose utilization management requirements on a small subset of drugs. For example, no plan in this study applies prior authorization or step therapy to more than 15 drugs. The overlap among plans is even smaller: only a handful of drugs have prior authorization or step therapy in as many as one-third of LIS-eligible plans in Regions 3 and 25 – with none reaching that level in Mississippi's region.

Table 5. Presence of Utilization Management Restrictions for Selected Drugs on Plan Formularies for LIS-Eligible Plans, By Region, 2007.

	Region 3 (New York)	Region 20 (Mississippi)	Region 25 (Iowa and others)
How many of 100 drugs have a prior authorization requirement in at least one plan?	23	26	24
How many of 100 drugs have a step therapy requirement in at least one plan?	22	20	20
How many of 100 drugs have either a PA or ST requirement in at least one plan?	33	31	29
How many of 100 drugs have a quantity limit in at least one plan?	65	69	64
How many of 100 drugs have any UM requirement in at least one plan?	68	74	68
How many of 100 drugs have either PA or ST in 1/3 of plans?	5	0	3

NOTE: Based on 100 drugs commonly used by dual eligibles.

Some of the drugs that are most likely to require prior authorization are Prevacid and Nexium (proton pump inhibitors used to treat gastrointestinal conditions and for which there are less-expensive alternative treatments), Celebrex (a Cox-2 pain medication where there are significant questions about appropriate usage), and Aricept (the most commonly used drug for Alzheimer's disease). Step therapy is most commonly required for some of these same drugs as well as Singulair (an asthma medication) and Diovan (a drug for high blood pressure). Both of the latter represent drugs where it is not unusual to start patients on less costly alternative treatments.

How Often Are Commonly Prescribed Drugs on Plans' Non-Preferred or Specialty Tiers?

When a drug is not listed on a plan's formulary or when it has utilization management restrictions, access to that drug for beneficiaries may be limited. But these situations do not lead to higher costs to the federal government. By contrast, when a brand-name drug has higher cost sharing as a result of its tier placement, subsidized low-income beneficiaries are not affected since their cost sharing amounts are the same regardless of the drug's tier assignment. The federal government, however, incurs these higher costs because it pays the

difference between the plan's normal cost sharing amount and the amount paid by the beneficiary.

To assess the potential for the government to be in this situation, we considered how often our 100 drugs are on formulary but on non-preferred tiers or specialty tiers for the LIS-eligible plans. In each region, about half the drugs appear on a non-preferred tier for at least one plan (Table 6). Since the generic drugs are unlikely ever to appear on a non-preferred tier, this means that nearly every brand-name drug in our sample appears on the non-preferred tier of at least one plan. A small handful of drugs appear occasionally on specialty tiers as well.

Table 6. Tier Placement of Selected Drugs on Plan Formularies for LIS-Eligible Plans, By Region, 2007.

	Region 3 (New York)	Region 20 (Mississippi)	Region 25 (Iowa and others)
How many of 100 drugs are ever on a plan's non-preferred tier?	45	51	48
How many of 100 drugs are ever on a plan's specialty tier?	2	4	4

NOTE: Based on 100 drugs commonly used by dual eligibles.

In addition to creating the likelihood of higher costs to the federal government, plans may also be affected when they are assigned beneficiaries who use drugs on nonpreferred tiers. Plans place drugs on these tiers because they seek to create a financial incentive to shift utilization to other drugs in the same drug class. These utilization shifts in turn create the leverage plans use to negotiate for higher rebates from pharmaceutical manufacturers. Because low-income beneficiaries are shielded from these financial incentives, plans may see smaller shifts in utilization, and receive lower-than-expected rebates.

Some of the drugs that appear frequently on a nonpreferred tier include Celebrex (Cox-2 inhibitor for pain management), Lexapro (antidepressant), Detrol (overactive bladder), Cozaar (hypertension), Altace (hypertension), and Abilify (bipolar disorder and schizophrenia). All these drugs are relatively expensive brand-name drugs for which there are alternative medications available.

In each region, there is one LIS plan that covers all 100 studied drugs on one tier with standard 25 percent coinsurance (Table 7). Although all drugs in these plans are considered "preferred," cost sharing will be more expensive for those drugs with a higher negotiated price. There are other plans that cover all drugs but place some of them on nonpreferred tiers.

Table 7. Number of Covered Drugs on a Generic or Preferred Tier, by Plans, 2007.

Number of drugs on a generic or preferred tier for:	Region 3 (New York)	Region 20 (Mississippi)	Region 25 (Iowa and others)
Plan with the least drugs on these tiers	71	68	68
Plan with the median number of drugs on these tiers	86	87	88
Plan with the most drugs on these tiers	100	100	100

NOTE: Based on 100 drugs commonly used by dual eligibles.

At the other extreme, each region has multiple plans with fewer than three-fourths of the drugs on a generic or preferred tier (2 plans in Region 3, and 4 plans in Regions 20 and 25). These plans create the potential for overall higher cost sharing. We explore this dynamic further in the following section.

How Often Do Commonly Prescribed Drugs Have Higher Cost Sharing?

The appearance of a drug on a nonpreferred or specialty tier, for the purposes of this analysis, is a crude indicator of the potential added costs to the federal government for paying the additional portion of the normal plan cost sharing. In this section, we look directly at cost sharing differences. In each region, we calculated the minimum monthly cost sharing level for each drug among all the eligible plans that cover the drug. We then compared the monthly cost sharing in each plan to this minimum amount. In showing these costs, we are considering only the cost sharing during the initial coverage period, that is, after any applicable deductible and before the coverage gap. In addition, we are considering each drug individually and not taking into account the overall set of drugs obtained by any one beneficiary. Dual eligibles often take a large number of drugs. Any one person thus might have a mix of preferred, nonpreferred drugs, and uncovered drugs. Depending on the mix, there may or not be an ideal plan assignment for that beneficiary.[14] In this section, we consider the difference in prices only when drugs are covered, as an attempt to describe the costs that would be paid by the federal government when subsidizing beneficiary copays.

For nearly every one of the 100 drugs in our sample, there is at least one plan where cost sharing is at least $5 per month above that in the plan with the lowest cost sharing (Table 8). For about half the drugs, there is at least one plan where cost sharing is at least $25 above the minimum in the region. Even larger differences of $50 or more above the minimum monthly cost sharing occur for about a tenth of the drugs.

Table 8. Cost Sharing for Selected Drugs on Plan Formularies for LIS-Eligible Plans, By Region, 2007.

How many of 100 drugs ever have cost sharing (when covered) more than this amount above the plan with the lowest cost sharing?	Region 3 (New York)	Region 20 (Mississippi)	Region 25 (Iowa and others)
$5 per month above the minimum	95	98	95
$10 per month above the minimum	60	61	61
$25 per month above the minimum	50	43	43
$50 per month above the minimum	13	8	7

NOTE: Based on 100 drugs commonly used by dual eligibles.

Four drugs are by far the most likely to have cost sharing differences of $50 or more per month among the eligible plans, and the differences are sometimes much more than $50 (Table 9). Seroquel and Abilify are treatments for bipolar disorder and schizophrenia, Levaquin is a quinolone antibiotic, and Topamax is a migraine medication. For these drugs,

[14] This situation is directly comparable to any beneficiary who uses the Part D Plan Finder and learns that different drugs currently being taken are covered by different plans. One of the plans will have the lowest overall costs, but not necessarily as low as the hypothetical plan that has all of his or her drugs on a preferred tier.

the cost variation may be driven both by tier placement (i.e., placement on a higher cost, nonpreferred tier) and by the underlying high cost of the drug (which raises cost sharing particularly in plans that use coinsurance).

Table 9. Four Drugs Most Likely to Have Cost Sharing $50 Over the Minimum, and Maximum Difference in Cost Sharing, 2007.

Drug	Region 3 (New York)		Region 20 (Mississippi)		Region 25 (Iowa and others)	
	Plans $50 above the minimum	Difference between highest and lowest copay	Plans $50 above the minimum	Difference between highest and lowest copay	Plans $50 above the minimum	Difference between highest and lowest copay
Seroquel	8	$108.07	5	$74.79	5	$74.79
Abilify	9	$98.15	6	$242.46	5	$68.51
Topamax	8	$144.21	5	$152.21	5	$152.21
Levaquin	8	$127.85	6	$86.58	6	$86.58

For beneficiaries who use these drugs and other drugs with high cost sharing, random assignment into the more expensive plans will generate significantly higher costs for the federal government. In the worst case scenario in Table 9, all other things being equal, a beneficiary taking Abilify and randomly assigned to the highest-cost plan for that drug would cost the federal government $242 per month more than if they were randomly assigned to the plan with the lowest copay for that drug.

Because a beneficiary enrolls in a single plan and thus must get all his or her drugs through that plan, it is interesting to look at these data from a plan perspective. In this case, we present data from one of the three regions – but results would look similar for other regions (Table 10).

Table 10. Cost Sharing for Selected Drugs for Four LIS-Eligible Plans, Region 3 (New York), 2007.

	Plan A	Plan B	Plan C	Plan D
Number of drugs on formulary	100	100	94	90
Of 100 covered drugs, how many have cost sharing…				
At the minimum monthly amount	2	1	53	50
Within $5 per month of minimum	71	9	77	55
$5 per month above the minimum	29	91	17	35
$10 per month above the minimum	22	28	15	30
$25 per month above the minimum	12	11	8	1
$50 per month above the minimum	7	1	4	0
Maximum difference for a single drug from the minimum	$127.85	$50.67	$144.21	$32.00
Sum of monthly differences from minimum for all covered drugs	$1,280.49	$1,158.79	$654.85	$509.63
Sum as a percentage of the total cost for all 100 drugs	19%	17%	10%	8%

NOTE: Based on 100 drugs commonly used by dual eligibles.

At one extreme, one plan (plan B) has only 9 of the sample drugs with cost sharing within $5 of the minimum monthly cost sharing available in this region. Thus, for 91 of 100 drugs, that plan will cost the federal government more than another plan in the region. In fact, that

plan has a cumulatively higher cost sharing per month of just over $1,150 – or 17 percent of total costs for the 100 drugs in our sample. Another plan (plan A) is within $5 of the minimum copay more often, but has cumulatively slightly higher cost sharing at 19 percent of total costs. It appears that this particular plan has several drugs with very high cost sharing that drives up total costs.

At the other extreme, one plan (plan D) has only one drug as much as $25 per month above the minimum cost sharing in the region. In this plan, cost sharing higher than the minimum adds up to only 8 percent of total drug costs. Similarly, another plan (plan C) has higher cost sharing that adds up to just 10 percent of total drug costs – and keeps 77 of its drugs within $5 of the minimum cost sharing. These two plans set the minimum cost sharing for about half the drugs in our sample because they offer $0 copays for all covered generics.

Other Costs to the Federal Government

Choosing the least expensive plan for each beneficiary is further complicated by the consideration of the other costs that the federal government subsidizes. Even though subsidy-eligible beneficiaries do not face a premium or deductible, the federal government incurs these costs on the beneficiary's behalf. Thus, it may be fiscally advantageous to the government to see someone enrolled in a plan with higher cost sharing if it has a lower premium and charges no deductible. In fact, it may be cheaper to pay higher premiums for an enhanced plan if it results in lower cost sharing.[15] Similarly, depending on which parts of the benefit are covered in the wrap-around benefits provided by a state, there are potential savings to an SPAP depending on the plan in which a beneficiary is enrolled.

Looking at the same four plans as in the previous section, for example, the plans that tend to have higher cost sharing also have lower premiums (Table 11). Even though the premiums amounts are dwarfed by the cost sharing differences for all covered drugs in our sample, the added cost for one beneficiary's set of drugs may be less than the premium difference. All four of the plans selected for this example have the standard $265 deductible, but there are others in the same region with no deductible. A system designed to minimize federal costs for each beneficiary would also have to take these costs into account.

Table 11. Cost Sharing for Selected Drugs, Premiums, and Deductibles for Four LIS-Eligible Plans, Region 3 (New York), 2007.

	Plan A	Plan B	Plan C	Plan D
Number of drugs on formulary	100	100	94	90
Sum of monthly differences from minimum for all covered drugs	$1,280.49	$1,158.79	$654.85	$509.63
Sum as a percentage of the total cost for all 100 drugs	19%	17%	10%	8%
Monthly Premium	$9.50	$16.40	$24.80	$25.40
Annual Deductible	$265	$265	$265	$265

[15] Maine currently assigns beneficiaries to one of the enhanced plans.

Policy Implications

The formulary analysis in this report focuses on a set of drugs most commonly used by dually eligible beneficiaries. Our findings suggest that random assignment into plans can have a significant impact on three important stakeholders: beneficiaries, state programs that provide wrap-around coverage, and the federal government.

The findings from our examination of state experiences using different types of beneficiary-centered assignment suggest that such approaches are feasible for use on a national basis. State pharmacy assistance programs have used these approaches with little disruption to the market and without incurring large costs. Officials see the potential for savings and believe that beneficiaries have better access to drugs.

In general, the use of beneficiary-centered assignment has the potential to avoid situations where beneficiaries discover that the drugs they need are off formulary or face some type of utilization management. This also reduces the need to use exceptions and appeals processes to maintain the use of current medications and can potentially increase adherence to regimens that control beneficiaries' health conditions.

Beneficiary-centered assignment also has the potential to reduce program costs for the federal and state governments. Our data show that a few drugs can incur additional cost sharing of more than $50 per month, depending on plan assignment, and a majority of our sample drugs can lead to at least $10 higher monthly cost sharing when a plan other than the one with the lowest cost sharing for that drug is selected.

Plans may have appropriate reasons for the formulary placement of drugs, and in some cases beneficiaries may be better off clinically or financially by switching medications. But at the very least, a change in prescription drug use will require consultation with the beneficiary's physician and a disruption of current patterns of treatment.

There are differences in the design of approaches to beneficiary assignment between those that maximize the matching of plans to the beneficiary's needs (e.g., avoiding drugs that are off formulary or are subject to utilization management) and those plan assignments that minimize the government's costs. Either approach is easy to design, but will lead to different assignments for at least some beneficiaries. In addition, there could be differences between an approach that identifies certain plans that are better in general and finding the single plan that is best for each beneficiary. In addition, the implementation of any such system should take into account the beneficiary's preferred pharmacy.

The federal government might also want to consider a potential role for quality or performance measures in designing a system of beneficiary-centered assignment. If some plans have better records on important performance measures, it might be appropriate for them to receive higher numbers of assigned beneficiaries. Ideally, performance measures relevant to the needs of low-income beneficiaries would be used for this purpose.

It is important to remember that the concept of beneficiary-centered assignment was first considered and used when large numbers of beneficiaries had to transition from SPAP to Part D coverage and, in Maine, when the transition occurred for dual eligible beneficiaries.

There are many situations in which assignment still needs to occur on an ongoing basis. For example, when Medicaid beneficiaries first become eligible for Medicare, when individuals are newly approved for the low-income subsidy, and when individuals apply for SPAP benefits, they are making a transition that requires selecting a Part D plan. Beneficiary-centered assignment could also be used on an annual basis to re-assign beneficiaries if plans in which low-income beneficiaries are participating raise their premiums so that they are no longer below the benchmark.

One potential concern is that re-assigning beneficiaries who are already enrolled in a plan that is eligible for the LIS subsidy might result in significant disruption. The benefits of a policy of reconsidering plan assignments for all low-income beneficiaries would have to be weighed against the costs of this disruption. Likewise, any policy to determine whether changes in plan design, changes in formularies, or changes in individuals' circumstances warrant assignment to a different drug plan might find resistance if they occur frequently or are not requested. Nevertheless, it might be beneficial to consider re-assignment in some such circumstances, such as when a beneficiary begins taking a new expensive drug.

Another potential downside to consider is the potential impact of beneficiary-centered assignment on plans participating in the program. In the program's first year, a new market was being created where none had existed. Had this approach been used nationally for the initial transition into Part D, participating plans might not have enrolled the share of enrollees guaranteed by random assignment. Without this guarantee, fewer organizations might have entered the part D market and they would have had less incentive to submit low premium bids with the goal of ending up below the benchmark for the subsidy. From the perspective of CMS, it was important in the first year to be a reliable business partner.

Now that a Part D market has been created, the circumstances have changed. Moving forward, widespread use of beneficiary-centered assignment might hasten the exit of some plans from the market. But at the same time, it could increase the competition over enrollment and strengthen the bargaining leverage of plans that achieve larger market shares. The dynamics of any marketplace are complex, and any approach to future assignments of beneficiaries to plans will have an impact on the market. CMS still needs to be a reliable business partner for the plans, but it also needs to consider the best interests of beneficiaries and of the federal treasury.

It is likely that the use of beneficiary-centered assignment would lead to greater risk selection since it will tend to cluster the enrollment of those with similar patterns of drug use into a single plan. Doing so will make plans' enrollment of beneficiaries less random and will heighten both the need for good risk adjustment and the consequences of flaws in that system.

Steps that could lessen the consequences of risk selection start with making sure that the risk adjustment system works as well as possible. As drug claims data become available, CMS will be able to recalibrate the current system with more complete data than were available before Part D was implemented. In addition, it probably does not make sense to reconsider the assignment of all subsidized beneficiaries with a system of beneficiary-centered assignment system each year. As noted above, reassignment to new plans tends to be disruptive to beneficiaries while also increasing the potential for risk selection problems. It

may make sense to use beneficiary-centered assignment only for newly eligible beneficiaries and for those in need of reassignment because their plans have left the Part D program or the premiums have risen above the regional benchmark. Although the number of beneficiaries requiring reassignment during the fall 2006 open season was low, the numbers could be higher in future years depending on decisions made by CMS about the demonstrations and guidelines for determining regional benchmarks. CMS announced in April that it would continue the demonstration and base the 2008 benchmarks on a blend half based on the enrollment-weighted average and half on the approach used in 2006 and 2007 (and would reduce the de minimis rule to a $1 premium waiver).

The experience of the states suggests that to date the use of beneficiary-centered assignment has tended to assign beneficiaries in the same pattern as those chosen by voluntary enrollees. As such, it may simply reinforce the role of beneficiary selection in a market-based system.

Limitations of This Analysis and Next Steps

Because this analysis was done on a drug-by-drug basis, it does not take into account the greater complexity represented in identifying plans where all the drugs taken by a particular patient are covered and have low cost sharing in a given plan. Nor does it take into account the impact of premiums and annual deductibles.

The most important next step in the data analysis would be to take into account the overall array of drug use for a particular beneficiary and thus consider the cost impact of the deductible, coverage gap, and other features of the Part D benefit. In future work, we might create a set of drug portfolios based on common patterns of use by low-income beneficiaries. For each portfolio of drugs, we would determine total cost sharing under each LIS plan in 3 states, including the shares of cost sharing incurred by the beneficiary and by the government. These findings would increase MedPAC's ability to estimate the government's costs resulting from random assignment of duals into Part D plans and the potential for savings if a different mechanism were used.

One could take this analysis a step further by considering the potential savings if beneficiaries switch drugs, especially if they switch to generic alternatives in the same drug class instead of more expensive brand-name drugs. Subsidized beneficiaries have only a limited financial incentive to make this switch. This additional step is more challenging, however, from both a clinical and an analytical perspective. Such substitutions are not appropriate in all drug classes; therefore, identifying the potential savings would require decisions about which substitutions are appropriate.

APPENDIX

Table A-1. Plans (and Contract Numbers) Eligible for Low-Income Subsidy Auto-Enrollment in Three Regions

Plan	Region 3 – New York	Region 20 – Mississippi	Region 25 – Iowa and Other States
AARP MedicareRx Plan		S5820_019	S5820_024
AARP MedicareRx Plan Saver	S5921_203	S5921_321	S5921_247
Advantage Freedom		S5644_181	S5644_059
Advantage Star	S5644_004	S5644_195	S5644_080
Aetna Medicare Rx Essentials		S5810_054	S5810_059
Bravo Rx II	S5998_001		
Cignature Rx Value	S5617_013	S5617_098	S5617_123
Community Care Rx Basic	S5803_072	S5803_089	S5803_094
First Health Premier	S5569_003		
Fox Rx Care Choice			S5557_003
HealthNet Orange Option 1	S5678_003	S5678_046	S5678_056
HealthNet Orange Option 2		S5678_045	S5678_055
HealthSpring PDP	S5932_004	S5932_019	S5932_024
HIP Standard	S5741_001		
Humana PDP Standard	S5552_003	S5884_078	S5884_083
Medco YOURx Plan		S5660_020	
Medicare Rx Rewards Value	S5960_003	S5960_020	S5960_025
NMHC Medicare PDP Gold		S8841_020	S88241_025
Prescription Pathway Bronze	S5825_045	S5597_085	S5597_090
SilverScript		S5601_040	S5601_050
Simply Prescriptions Rx 1	*S3521_001*		
Sterling Rx	S4802_024		
United American Silver		S5755_058	
UnitedHealth Rx Basic		S5921_322	S5921_248
WellCare Classic	S5967_140	S5967_157	S5967_162
WellCare Signature	S5967_037	S5967_054	S5967_059
Wellmark MedicareBlue Rx 1			S5743_001
Windsor Rx		S2505_005	

Table A-2. Drugs and Dosages Included in this Study: 100 of the Drugs Most Commonly Used by Medicaid Beneficiaries

Rank	Generic Name	Brand Name	Dose collected
1	FUROSEMIDE	Lasix	FUROSEMIDE TAB 40MG
2	ATORVASTATIN	Lipitor	Lipitor TAB 10mg
3	POTASSIUM CHLORIDE ORAL	Klotrix	POTASSIUM CHLORIDE CR TAB 20MEQ CR
4	METOPROLOL	Lopressor	METOPROLOL TARTRATE TAB 50MG
5	LANSOPRAZOLE SR	Prevacid	Prevacid CAP 30mg DR
6	AMLODIPINE BESYLATE	Norvasc	Norvasc TAB 10mg
7	LEVOTHYROXINE SODIUM	Levoxyl	LEVOTHYROXINE SODIUM TAB 100MCG
8	LISINOPRIL	Prinivil	LISINOPRIL TAB 10MG
9	HYDROCODONE/APAP	Vicodin	HYDROCODONE/ACETAMINOPHEN TAB 5-500MG
10	CLOPIDOGREL BISULFATE	Plavix	Plavix TAB 75mg
11	WARFARIN SODIUM	Coumadin	WARFARIN SODIUM TAB 5MG
12	ATENOLOL	Tenormin	ATENOLOL TAB 50MG
13	OLANZAPINE	Zyprexa	Zyprexa TAB 5MG
14	RISPERIDONE	Risperdal	Risperdal TAB 1MG
15	HYDROCHLOROTHIAZIDE	Microzide	HYDROCHLOROTHIAZIDE TAB 25MG
16	SERTRALINE	Zoloft	SERTRALINE HCL TAB 100MG
17	QUETIAPINE	Seroquel	Seroquel TAB 200mg
18	SIMVASTATIN	Zocor	SIMVASTATIN TAB 20MG
21	RANITIDINE	Zantac	Zantac SYP 75mg/5ml
22	METFORMIN HCL	Glucophage	METFORMIN HCL TAB 500MG
23	DIGOXIN	Digitek	DIGOXIN TAB 0.125MG
24	DIVALPROEX SODIUM	Depakote	Depakote TAB 500mg DR
25	DONEPEZIL	Aricept	Aricept TAB 10mg
26	ESOMEPRAZOLE MAGNESIUM	Nexium	Nexium CAP 40mg
27	ZOLPIDEM TARTRATE	Ambien	Ambien TAB 10mg
28	ESCITALOPRAM OXALATE	Lexapro	Lexapro TAB 10mg
29	PHENYTOIN SODIUM	Dilantin	PHENYTOIN SODIUM INJ 50MG/ML
30	ALENDRONATE SODIUM	Fosamax	Fosamax TAB 70mg
32	ALBUTEROL INHALER	Ventolin	ALBUTEROL AER 90MCG
33	PANTOPRAZOLE	Protonix	Protonix TAB 40mg
34	CELECOXIB	Celebrex	Celebrex CAP 200mg
35	GLIPIZIDE	Glucotrol	GLIPIZIDE TAB 5MG
36	ISOSORBIDE MONONITRATE	Ismo	ISOSORBIDE MONONITRATE TAB 20MG
37	PROPOXYPHENE NAP/APAP	Darvocet	PROPOXYPHENE-N/ACETAMINOPHEN TAB 100-650
38	GABAPENTIN	Neurontin	GABAPENTIN TAB 600MG
39	TRAZODONE	Desyrel	TRAZODONE HCL TAB 100MG
41	VALSARTAN	Diovan	Diovan TAB 80mg
42	RISEDRONATE SODIUM	Actonel	Actonel TAB 35mg
43	ROSIGLITAZONE MALEATE	Avandia	Avandia TAB 4MG
44	AZITHROMYCIN ORAL	Zithromax	Zithromax Z-Pak TAB Z-PAK
45	SALMETEROL XINAFOATE/ FLUTICASONE PROPIONATE XINAFOATE/ FLUTICASONE PROPIONATE	Advair Diskus	Advair Diskus MIS 250/50
46	PIOGLITAZONE	Actos	Actos TAB 30mg
47	MONTELUKAST SODIUM	Singulair	Singulair TAB 10mg
48	PAROXETINE HCL	Paxil	PAROXETINE HCL TAB 30MG
50	LEVOFLOXACIN	Levaquin	Levaquin TAB 500mg
51	TRAMADOL	Ultram	TRAMADOL HCL TAB 50MG
52	CARVEDILOL	Coreg	Coreg TAB 25mg
53	TOLTERODINE TARTRATE	Detrol	Detrol TAB 2MG
54	VENLAFAXINE HCL	Effexor	Effexor TAB 75mg
56	TRIAMTERENE/HCTZ	Dyazide	TRIAMTERENE/HCTZ CAP 37.5-25
59	CLONIDINE HCL	Catapres	CLONIDINE HCL TAB 0.1MG

60	INSULIN 70/30	Humulin	Humulin 70/30 INJ 70/30
61	TAMSULOSIN HCL	Flomax	Flomax CAP 0.4mg
62	LOSARTAN POTASSIUM	Cozaar	Cozaar TAB 50mg
63	ALBUTEROL/IPRATROPIUM	Combivent	Combivent AER
64	FLUOXETINE HCL	Prozac	FLUOXETINE HCL CAP 20MG
65	AMLODIPINE/BENAZEPRIL	Lotrel	Lotrel CAP 5-20mg
66	PREDNISONE	Deltasone	PREDNISONE TAB 5MG
67	PRAVASTATIN SODIUM	Pravachol	PRAVASTATIN SODIUM TAB 40MG
68	GLYBURIDE	Micronase	GLYBURIDE TAB 5MG
69	NIFEDIPINE	Adalat	NIFEDIPINE CAP 10MG
70	LATANOPROST	Xalatan	Xalatan SOL 0.005%
71	CLOZAPINE	Clozaril	CLOZAPINE TAB 100MG
72	FAMOTIDINE	Pepcid	Pepcid SUS 40mg/5ml
73	FLUTICASONE PROIONATE	Flonase	FLUTICASONE PROPIONATE SPR 50MCG
74	METOCLOPRAMIDE	Reglan	METOCLOPRAMIDE HCL TAB 10MG
75	DILTIAZEM	Cartia XT	DILTIAZEM HCL CAP 360MG
76	VALSARTAN/HCT	Diovan HCT	Diovan HCT TAB 160/12.5
78	OXYBUTYNIN CHLORIDE	Ditropan	OXYBUTYNIN CHLORIDE TAB 5MG
79	OXYCODONE/ACETAMINOPHEN	Endocet	Endocet TAB 5-325mg
80	ACETAMINOPHEN/CODEINE	Tylenol #3	ACETAMINOPHEN/CODEINE #3 TAB 300-30MG
81	IBUPROFEN	Advil	IBUPROFEN TAB 800MG
82	INSULIN N, INSULIN NPH	Humulin N	Humulin N INJ U-100
84	POLYETHYLENE GLYCOL 3350	Miralax	Miralax POW 3350 NF
85	MELOXICAM	Mobic	MELOXICAM TAB 7.5MG
86	ARIPIPRAZOLE	Abilify	Abilify TAB 10mg
87	INSULIN R, INSULIN REGULAR	Humulin R	Humulin R INJ U-100
88	BENZTROPINE MESYLATE	Cogentin	BENZTROPINE MESYLATE TAB 1MG
89	ESTROGENS CONJUGATED ORAL	Premarin	Premarin TAB 0.625mg
90	AMITRIPTYLINE HCL	Elavil	AMITRIPTYLINE HCL TAB 25MG
91	CEPHALEXIN	Keflex	CEPHALEXIN CAP 500MG
92	RAMIPRIL	Altace	Altace CAP 10mg
93	OXYCODONE	OxyContin	OXYCODONE HCL TAB 5MG
95	FENTANYL TRANSDERMAL	Duragesic	FENTANYL DIS 50MCG/HR
96	EZETIMIBE	Zetia	Zetia TAB 10mg
97	SPIRONOLACTONE	Aldactone	SPIRONOLACTONE TAB 25MG
98	MECLIZINE	Antivert	MECLIZINE HCL TAB 25MG
99	CYCLOBENZAPRINE	Flexeril	CYCLOBENZAPRINE HCL TAB 10MG
100	MIRTAZAPINE	Remeron	MIRTAZAPINE TAB 15MG
101	SULFAMETHOXAZOLE/TMP	Bactrim	SULFAMETHOXAZOLE/TRIMETHOPRIM SUS 200-40/5
102	GLIMEPIRIDE	Amaryl	Amaryl TAB 4MG
103	NITROFURANTOIN MCR	Macrobid	NITROFURANTOIN MACROCRYSTALLINE CAP 50MG
104	LOVASTATIN	Mevacor	LOVASTATIN TAB 40MG
105	FENOFIBRATE	Tricor	Tricor TAB 145mg
106	TOPIRAMATE	Topamax	Topamax TAB 200mg
107	CARBIDOPA/LEVODOPA	Sinemet	CARBIDOPA/LEVODOPA TAB 25-100MG
109	ENALAPRIL MALEATE	Vasotec	ENALAPRIL MALEATE TAB 10MG
111	RALOXIFENE	Evista	Evista TAB 60mg
112	NITROGLYCERIN PATCH	Nitrodur	NITROGLYCERIN TRANSDERMAL DIS 0.4MG/HR
114	PROMETHAZINE	Phenergan	PROMETHAZINE HCL TAB 25MG

NOTE: Rank indicates position of the drug in the OIG's list.