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Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists

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

Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists

FINAL REPORT

SUBMITTED TO:

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Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists

EXECUTIVE SUMMARY

Medicare Part D, enacted as part of the Medicare Modernization Act of 2003, has been providing subsidized prescription drugs to Medicare beneficiaries since January 2006. To capture the initial experiences of program participants as well as successes and challenges faced by the program, MedPAC contracted with researchers from NORC at the University of Chicago and Georgetown University to conduct a series of 13 focus groups in Denver, Colorado; Richmond, Virginia; and Portland, Maine. The sessions were held between July and October 2007.

This report presents findings from the focus groups, and includes rich details of experiences of beneficiaries and providers in dealing with Part D. We also examined steps taken in the state of Maine to broaden the Medicare Savings Programs' eligibility criteria and make more patients eligible for the Part D low-income subsidy, the details of which are included in an appendix to this report.

Overall Satisfaction

For the most part beneficiaries, especially those with moderate drug costs, report being satisfied with Medicare Part D. In general, they report having access to the drugs they need, often at reduced cost. Most beneficiaries have not switched plans and do not intend on doing so, in part because they are satisfied with their current plans but also because they are unwilling to undergo the complex process of selecting and learning to use a new plan.

Physicians generally share the view of beneficiaries that Part D is benefiting the patients and increasing their ability to obtain needed drugs. Some called it “the best thing to happen to Medicare since Medicare.”

Pharmacists are less likely to be satisfied with the experience of filling prescriptions under Part D. They tend to bear the responsibilities for addressing the issues when a prescription cannot be filled and for communicating that news to their patients. Although these cases may make up a minority of pharmacists' customers, they have colored pharmacists' view of the program.

The overall satisfaction of all three types of program participants was tempered by their concerns about specific issues as documented throughout this report. Our impression is that although participants are satisfied overall with the drug benefit, they get frustrated at the occurrence of problems – both long-range issues such as the coverage gap and specific events such as a prescription being rejected at the pharmacy counter or an inability to reach a customer service representatives who can answer a question. But beneficiaries remain happy that they have a source of drug coverage, and physicians and pharmacists are happy that their patients have improved access to needed drugs.

Experience with Plan Formularies

While many beneficiaries say they are aware that their plans use formularies, physicians and pharmacists were skeptical that beneficiaries really understood plan formularies. Physicians also expressed frustration trying to figure out whether a prescribed drug is covered by the patient's plan, and if it is, whether restrictions are placed on that coverage. They rarely do so at the point of prescribing. Some physicians have changed their prescribing habits and prescribe drugs that they think are most likely to be covered by most plans. More often, they write a prescription and expect to hear from the pharmacist if there is a problem.

Nearly any situation where the prescription is rejected by the drug plan – either because it is off the formulary or requires prior authorization – creates additional work for both the pharmacist and physician, and probably a delay for the patient. In general, the physician is more likely to change the prescription to an alternative medication than to seek a prior authorization or exemption from formulary restrictions. Pharmacists report that the messaging from the plan does not always identify alternative drugs, which would speed this drug switching process.

Most cases are resolved within a few days, so that the beneficiary has a modest delay in getting his or her prescription filled. In some cases, beneficiaries may pay the full price to get the drug or not get the drug at all. Only a few beneficiaries reported appealing plan decisions or requesting exceptions, and more than half of the beneficiaries were unaware of their right to do so.

Drug Substitution

Because many of these situations lead to the substitution of one drug for another, we asked participants, especially the physicians, about their willingness to substitute drugs. In many drug classes, physicians find it acceptable to switch drugs, including the statins used to treat high cholesterol, proton pump inhibitors used for gastrointestinal conditions, and several types of treatment for hypertension (ARBs and ACE inhibitors). By contrast, they are reluctant to make substitutions for psychotropic medications. When patients have been stabilized on a particular drug, particularly for mental health conditions, physicians are less willing to make changes.

Both providers and beneficiaries are generally comfortable with switching from brands to generics. Physicians have very few concerns about placing their patients on generics, with the exception of a few medications (e.g., Synthroid and Coumadin). A few beneficiaries expressed skepticism about generics being truly equivalent to brands, but pharmacists generally find that large differences in copayments will cause most beneficiaries to overcome their initial reluctance and try generics.

Experience with Drug Costs

The most significant cost issue that arose in the focus groups was the coverage gap or “donut hole.” Although most claimed to be aware that the benefit includes a gap, beneficiaries were confused about how the gap works or how to know when they are approaching it. Beneficiaries in the gap who cannot afford to pay full price for their drugs may obtain samples, make a prescription stretch by splitting pills or taking them every other day, or go without them entirely.

Beneficiaries and physicians mentioned a variety of methods for saving on drug costs more generally, the most common being the use of free samples. A few physicians reported reviewing

drug regimens to save their patients money. Pharmacist participation in formal medication therapy management (MTM) programs was low. No beneficiary reported being enrolled in such a program.

Pharmacists and Pharmacies

No beneficiaries cited problems finding a pharmacy that would accept a particular drug plan, and some low-income beneficiaries reported improved access. Pharmacists are viewed as important allies by beneficiaries and play a critical role in helping beneficiaries when various types of problems arise. Many beneficiaries reward them with considerable loyalty. However, some beneficiaries reported extensive shopping among various pharmacies to get lower prices on their medications.

A significant number of beneficiaries are aware that mail order can be a money-saving strategy. Those utilizing this service are generally satisfied and recommended it to others.

Programs for Low-Income Beneficiaries

Physicians generally do not know about the low-income subsidy for Part D or other help that is available for Medicare premiums and cost sharing. Pharmacists are more aware of these programs, but tend not to discuss it with customers for fear of offending them. But a few pharmacists played an active role in telling customers how to get enrolled.

Beneficiaries did not seem to understand fully how the subsidy works. Those who were automatically enrolled in Part D because they were deemed eligible reported being generally satisfied with their plan assignments, despite some confusion surrounding enrollment and benefits.

Access to Information

Beneficiaries reported having some difficulty obtaining information about their drug benefits. They reported long waits when calling 1-800-Medicare and their drug plans. Providers were concerned that many beneficiaries are confused by automated phone systems and, even when they get someone on the line, that they do not know the right questions to ask. Several low-income beneficiaries said that they had not heard of 1-800-Medicare, and none had visited the website for assistance.

Providers offer little help to beneficiaries in selecting plans. They tend to feel they are not adequately informed themselves, they lack the time to work with their patients, and they are unfamiliar with patients' financial situations. There is strong interest in in-person counseling services, but little knowledge of the resources that exist such as State Health Insurance Assistance Programs (SHIPs). Many beneficiaries work with insurance agents to choose and enroll in a plan.

Medicare Advantage and Supplemental Insurance

A number of beneficiaries had difficulty explaining to us the combination of coverage options they have. Some participants, especially in Denver, had signed up for Medicare Advantage (MA) plans. Some MA enrollees were happy to be in these plans, but others were surprised to learn that some of their doctors did not participate in their particular plan networks.

Participants in every group reported aggressive marketing practices by some MA plans. Some participants had been enrolled in a plan without realizing it. They discovered problems when they

went to fill a prescription or when they made an appointment to see their doctor. Beneficiaries found that it took considerable time and effort to be re-enrolled in their original drug plan.

A few beneficiaries had chosen to stay with drug coverage through their Medigap plans rather than enrolling in Part D. Some physicians shared the view that maintaining Medigap drug coverage was superior to Part D, despite the lack of government subsidy for that coverage.

Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists

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Experiences Obtaining Drugs under Part D: Focus Groups with Beneficiaries, Physicians, and Pharmacists

Medicare Part D, enacted as part of the Medicare Modernization Act of 2003, has been providing subsidized prescription drugs to Medicare beneficiaries since January 2006. While the program seems to be successful in increasing access to drugs for Medicare beneficiaries, especially those with no coverage prior to 2006, it is still early to evaluate how well the program is faring overall. To capture the initial experiences of program participants as well as successes and challenges faced by the program, MedPAC contracted with researchers from NORC at the University of Chicago and Georgetown University to conduct a series of focus groups in three cities – Denver, Colorado; Richmond, Virginia; and Portland, Maine – between July and October 2007.

We asked focus group participants whether any issues were arising in obtaining needed drugs and whether their overall out-of-pocket costs were lower or higher compared to before the start of the Medicare drug benefit. In particular, we sought to learn whether the formulary status of drugs, requirements such as prior authorization, or cost-sharing levels were leading to changes in costs or substitutions for the originally prescribed drugs. We also asked beneficiaries, physicians, and pharmacists about their reactions to any such changes.

Another topic in the focus groups was drug costs. Even with expanded coverage, costs remain significant for some beneficiaries – particularly those with costs high enough to reach the donut hole. We spoke with participants about their experiences with the donut hole and strategies for keeping costs low.

Access to pharmacies was another key concern of policy makers as they designed the Part D benefit. Beneficiaries in our groups did not describe any access problems. They described for us their use of both local and mail order pharmacies.

As part of this project, we also explored the specific experience of beneficiaries with the low-income subsidy that is incorporated into the Part D program and other aspects of the program that apply specifically to low-income beneficiaries. We also examined changes in the state of Maine to redesign the state's pharmaceutical program so that it complements the Part D program and provides enhanced benefits. Several of our focus groups were composed of low-income beneficiaries so we could target these topics.

This report presents findings from the focus groups, and includes rich details of experiences of beneficiaries and providers in dealing with Part D. In general, beneficiaries were quite satisfied with their Part D experiences, although that satisfaction was tempered by concerns about specific issues. This report points to many areas in which beneficiaries, physicians, and pharmacists believe there is room for improvement in the program, but none of these change the fundamental finding that the majority of beneficiaries in our groups reported that they have access to the drugs they need, often at a lower cost than they were paying before implementation of Part D.

METHODOLOGY

We conducted a total of 13 focus groups from July through October, 2007. More detailed information on the attributes of the beneficiaries, physicians, and pharmacists who participated in the focus groups is provided in Appendix 1.

Table 1. Focus Groups Conducted, By Type of Participant and Location

Focus groups	Richmond, VA	Portland, ME	Denver, CO	Total
Beneficiaries (non-low income, non-rural)	1	1	1	3
Beneficiaries (low-income)	1	2	1	4
Beneficiaries (rural)	1			1
Physicians	1	1	1	3
Pharmacists	1		1	2
Total	5	4	4	13

We sought beneficiaries who were enrolled in a Part D plan and who currently use at least two prescription drugs, so that they could speak about their experiences filling prescriptions under Part D. We limited the number of Medicare Advantage (MA) enrollees in each group, based on the percentage of the local Medicare population enrolled in Medicare Advantage. Questions on demographic characteristics were also asked during the screenings to ensure a mix of beneficiaries.

We screened physicians for both practice type and specialty, seeking a diverse mix. Physicians included solo, small-group, and large-group practitioners, as well as some who practice in clinics and nursing homes. Physicians were primarily in family practice and internal medicine, but also included psychiatrists, cardiologists, gerontologists, gastroenterologists, and other specialties likely to prescribe medications for Medicare beneficiaries. Participants were required to spend at least 20 hours a week on patient care and have at least one fifth of their patients enrolled in Medicare, though many had a higher percentage. Physicians who were unaware of their patients' enrollment in Part D program were also deemed ineligible. Physicians were not included if they were affiliated with a single managed-care plan, the Veterans Administration, or military facility, because they would be unlikely to have experience working with a variety of Part D plans.

Pharmacists were required to practice in a retail pharmacy open to the public, not affiliated with a single managed care plan. They came from independent drugstores, chain pharmacies, discount stores, and grocery stores.

All participants received an honorarium. The amount varied by location and category of participants. Each focus group lasted for approximately 1.5 hours. The discussions were facilitated by researchers from NORC and Georgetown University, with two moderators leading each group. Discussion protocols were used as guides, but the discussions were also free-flowing, built on participants' responses. Each discussion was recorded and transcribed. Quotes included in this report are verbatim, from those transcriptions. All procedures and protocols for the focus groups were approved by the Institutional Review Boards (IRBs) at both NORC and Georgetown, and participants were promised that their names and other identifying information would be protected.

OVERALL SATISFACTION

In each focus group, we sought to assess beneficiaries' and providers' overall satisfaction with the program. We gathered this information not only by asking participants directly, but also indirectly through discussions about issues such as changing plans. For the most part beneficiaries and physicians report being satisfied with Medicare Part D, while pharmacists are less likely to be satisfied.

Beneficiaries generally report being satisfied with Part D. Although many have specific complaints about or general opinions about how Part D should be changed, people with moderate drug costs seem content with their plans. Beneficiaries generally report saving money, and some had stories of significant savings.

Respondents generally reported that prices are about what they expected, but some have noticed what they consider significant increases in 2007 compared to 2006. In particular, a few participants were surprised and annoyed at premium increases between 2006 and 2007. (One beneficiary noted inconsistent copays from month to month, but this was not a common complaint.)

The beneficiaries most surprised by changing prices were those who reached the coverage gap unexpectedly. Beneficiaries' experiences with the coverage gap are discussed in a separate section of this report.

Most beneficiaries have not changed plans, and are not interested in changing plans. Two factors seem to drive this attitude. First, beneficiaries are basically happy with their plans. Some said they do not want to “rock the boat” by trying another plan.

In addition, many beneficiaries are overwhelmed by the complexity of the research required to find out whether a different plan would be better. Although it was not the focus of our discussions, several beneficiaries brought up how difficult it had been for them to select plans for 2006 or when they became eligible more recently. Based on this experience, most beneficiaries did not want to shop around for another plan during the open season. As one beneficiary told us, “I don't know why it has to be so complicated...as far as comparing plans and switching every year, I can't – I just don't have the time for that.” This was true even for several beneficiaries who complained that their premiums had risen significantly: they still did not want to research whether another plan would now be less expensive for them.

However, a handful of participants had changed plans, with varied success. For example, one well-educated beneficiary successfully changed plans to maintain coverage for a particular drug. Another reported trying to change plans, but had extensive administrative troubles.¹

¹ This respondent told us:

On July second this year, just July, I got a letter from [Plan B] saying “We're sorry that you [disenrolled].” ...And I called them up and they said “Well Medicare never approved you.” After many hours and hours on

Physicians generally report being satisfied with Part D. Most physicians felt that although they have some hassles with Part D plans, the program is working fairly smoothly and doing good things for their patients. Several physicians noted that beneficiaries may be more likely to fill prescriptions now that they have drug coverage. As one put it:

I've seen patients get their drugs that have never been able to get them in the past. I can do all the diagnosing and testing and the like that I want to do, but if I can't treat the patient, it's of no use. So I still think it's the greatest thing that happened to Medicare since Medicare.

Pharmacists are much more likely to hear complaints than success stories. In general, pharmacists were less satisfied with their experience with the program than beneficiaries and physicians were. Their conversations with customers, physicians, and plans are generally focused on problems that have come up. When a drug is not covered, the pharmacist must work to resolve the issue with the physician and the plan. Likewise, when a beneficiary reaches the coverage gap, it is the pharmacist that has to deliver the news. Although they acknowledged that the benefit is likely helping beneficiaries, pharmacists are much less likely to hear this from their customers. One told us, "today I had a daughter of a lady tell me that her mother was very happy that Medicare D came along. That's the only one I've had since it started. Many have complained. And one has been satisfied."

hold on the telephone; afternoon after afternoon for two weeks, I finally found out that the reason they canceled me was because...they still had me insured with [Plan A]. So for six months [Plan B] has been paying a portion of my drugs when I went to the [pharmacy]. We thought I got it straightened out, but [Plan A] has cancelled me twice in the last week. Right now I have no insurance at all. But I don't know why...if I call [Plan A] right this minute and they say "Oh you're not covered." I call Medicare and Medicare says, "Oh you're covered with [Plan A]." I have been through hell and back again with this ...In the meantime, Social Security dumped all of the money that I've been, they've been holding, you know, they've been paying for my drug coverage, my premium. They dumped it back in my checking account and I don't know what to do with it...Do you know Medicare said? "That's not my problem."

EXPERIENCE WITH PLAN FORMULARIES

One of the major goals of our focus groups was to learn more about the experience of beneficiaries, physicians, and pharmacists with the formularies of Part D plans. We sought to learn how well they understand plan formularies, and what happens when a drug is not covered, requires prior authorization, or is on a non-preferred tier.

As described in this section, the most common scenario is that the physician provides the beneficiary with a prescription without consulting the formulary for that beneficiary's plan. When the beneficiary presents that prescription at the retail pharmacy counter, the pharmacist submits the information electronically to the plan and receives a message back immediately. That message either approves the prescription and provides payment information, or indicates that the prescription is rejected. Payment information would include the appropriate cost sharing for the tier to which the drug is assigned, where applicable.

A rejection notice normally provides information on the reason for rejection. Reasons may be that the drug is not on the plan's formulary or that some additional action is required before the drug will be approved. Such situations typically include prior authorization (where the physician must provide some additional information before the drug will be approved), step therapy (where the physician must indicate that another drug has been tried before the drug will be approved), or quantity limits (where the number of pills requested exceeds the limit for that drug). The process required to fulfill such requirements may differ among plans. Often, requirements such as prior authorization can be resolved by the physician and pharmacist without further involvement by the beneficiary. If the necessary actions are taken, then the pharmacist can resubmit the prescription for approval.

By law, beneficiaries have certain rights to request exceptions to plan policies. For example, a beneficiary may request that an off-formulary drug be covered for his or her circumstances or that a non-preferred drug is covered at the cost sharing level for a preferred drug. If an exception, prior authorization, or other request is not granted, then the beneficiary has the right to appeal that decision first to the plan and then to an independent review entity.

This section of the report provides more detail on these various stages of the process. First, it discusses the degree to which beneficiaries, physicians, and pharmacists are familiar with both plan formularies and the tier structure used by most plans. It then presents findings on what happens when prescriptions are rejected based on plan formularies or utilization management indications. It then discusses the awareness and use of beneficiaries' rights to request exceptions and appeals. Finally, this section looks at whether there are differences among plans in these considerations and whether greater standardization might improve the process.

Plan and Formulary Awareness

In an ideal case, beneficiaries would communicate with their physicians about their insurance coverage and any formulary used by their plan. This would allow the physician to take costs and coverage into account at the point of prescribing. However, this ideal case appears to be the exception in Part D, not the rule.

Beneficiaries do not always understand what plan they are in. There is some general confusion among beneficiaries about the combination of coverage options they have, such as Medicare Advantage and Part D. Some beneficiaries think about their Part D plans as clearly part of Medicare, while others do not.

In addition, beneficiaries do not always remember the name of the plan they are enrolled in. This was particularly true for low-income beneficiaries, most of whom had been switched from Medicaid to Medicare coverage for drugs and did not choose their Part D plans, but were automatically enrolled. In the low-income group in Richmond, for example, half of the beneficiaries in the group could not tell us what plan they were in. In many groups, beneficiaries would pull their cards out of their wallet or their purse to tell us the name of their plan.

Physicians confirmed that this was common. One physician said,

I tell you most of my patients do not have a name for their plan...They don't think of it like an Anthem plan or a John Hancock plan or a Golden Rule plan or whatever their names are...whereas commercial patients know they're in Cigna or Anthem or whatever it is. So these people just think they're in a plan and I'm not sure that they know there are several different types of plans.

Beneficiaries say they are aware of formularies, but providers disagree. The beneficiaries in our focus groups generally said they understood that their drug plans had a list of drugs that they cover, and that other drugs may not be covered. Many beneficiaries said that they had booklets at home from their plans that list the covered drugs, but others said they had never seen a copy of their plan's formulary. Again, confusion seemed higher for low-income beneficiaries; several were not aware that plans had formularies.

Occasionally beneficiaries indicated that they really understood and paid attention to their plans' formularies. For example, in a few cases, beneficiaries reported looking up particular medications on their plan's formulary:

They called me and said, "Your cholesterol is high. We need you to go on a medication." I think she wrote a prescription and sent it to me and I found out that was not one that was listed on my plan. Because I looked in the book. And so then I told her what was on the list. And we came up with one, and that's how I went with the generic.

I got the PDR out and looked up the chemical name of one of those and then went back and looked on the same formulary but over in the lesser price and found that same drug. And then I went to the doctors and said hey, how come the same chemical over here costs

half of what the chemical does over here? And he kind of said, “You know I never noticed that before” and changed the prescription.

Physicians and pharmacists were much more likely to say that beneficiaries are unaware of formularies. When we asked a group of pharmacists whether their customers understand that their plans have formularies, it inspired this discussion:

PHARMACIST 1: Oh no. (Laughter).

PHARMACIST 2: No clue.

PHARMACIST 3: That’s the bottom—I think it’s just no clue. Just no clue.

MODERATOR: How does that come out to you?

PHARMACIST 2: When they come to pay for their prescription.

PHARMACIST 4: And you say it’s not covered.

PHARMACIST 1: “Well how come?”

When we asked a similar question of physicians, one physician said, “They just come in. I don’t think they understand the formularies at all. I think they just come in and expect me to pick the drug that is best for them.”

Prescribers generally do not know how a patient’s plan treats a specific drug.

Physicians face multiple hurdles in determining ahead of time whether a drug they want to prescribe will be covered by a beneficiary’s plan. First, in general, physicians do not know what plan a beneficiary is in when they see the patient. Second, even when they do know the plan name, they do not have access to up-to-date formularies for all plans. Physicians frequently complained that plan formularies seem to change frequently, adding to their confusion over what is covered.² For example, one nephrologist told us:

One month the patient is approved for Protonix, next month they go on something else. The same company, the same coverage, has different [coverage] for medications. It is very difficult because I see it every week...It creates a lot of hassle.

Physicians who tried electronic systems for looking up formulary coverage did not find them as helpful as they would like. Very few of the physicians in our groups reported using such systems. The two main complaints by those who had tried them reflected the problems that physicians have in learning about their patients’ formularies more generally. First, there might be errors in looking up the formulary because of confusion over which specific plan a beneficiary has or which PBM that plan uses. Secondly, physicians reported the systems did not keep up with frequent changes in plan formularies.

Because of these challenges, although a handful of physicians had tried to determine whether a drug would be covered ahead of time, most relied on pharmacists to get back to them with formulary information. This physician was typical in his remarks:

² Other research suggests that Medicare plans generally do not change formularies during the year (and in fact are not allowed in most cases to make access more restrictive). Physicians may see such changes in formularies used by their commercial patients and assume that the same thing occurs for Medicare, or they may be seeing variations among plans and thinking that they represent formulary changes. Beneficiaries did not commonly complain about within-year formulary changes, though a few did experience inconsistencies.

It's useless to me if a patient comes in and says, "I'm CIGNA." It means nothing to me. I just prescribe them and let the nurse sort it out [after the pharmacist reports that a particular drug is not covered]. Then the nurse sorts it out and then we make a decision at five o'clock in the afternoon...as to which one we are going to substitute and that's the end of it...To think that you know the plans you're fooling yourself. Patients don't know them. Doctors don't know them. Pharmacists don't know them.

Tiering

Although some Part D plans use the standard benefit design, which charges 25 percent coinsurance for all drugs, most plans have altered that design. A common design is to have several tiers of drugs with a different copayment level for each tier.

Most, but not all, beneficiaries are aware of tiers, and some seek out lower-tier drugs.

Patients generally seem aware of tiers. A small number of participants are very sophisticated about seeking out less costly alternatives from their physicians and proactively asked to switch drugs. For example, a retired nurse told the group:

Sometimes your doctors just order the latest medicine made for a certain disease. The old ones still work and they're much cheaper. And if you talk to the doctor about that, he will prescribe one of the older ones that will do the same job and lighten your pocketbook – or put some weight in it.

Others do not perceive the difference in copayments as large enough to seek out an alternative immediately – or an alternative is not available.

BENEFICIARY: It's never that much, just the idea that...to pay a \$35 and then all of a sudden you got to pay \$47, you want to know why, you know?

MODERATOR: Is that a situation where you would consider asking your doctor whether there was a different alternative that was less expensive?

BENEFICIARY: No, you just go ahead and pay it. You know, you got to have it, that's the thing...you're not going to argue about \$12...the next time you got to go back [to the doctor] and just go ahead and speak on it, and you'll be taken care of.

One beneficiary said she stopped taking a medication rather than pay the non-preferred copay.

I stopped taking the medication that cost too much...it is so expensive, even with the drug plan. So my doctor said, "Well let's wean you off of it." He did and oh my gracious, those sweats at night, I'd just be sweating for an hour. And so he said, "Well then go back on it." And so I went back on. And it costs so much I said I wanted to stop taking it because it's just too costly...It was on a high tier, it was over \$60 a month. And to me that's too much...If it's something I don't really need I'm not going to take it. I did wean myself off.

Pharmacists occasionally suggest a beneficiary could seek a tier switch. They might tell the beneficiary to talk to the prescribing physician, or they might call the doctor directly. However, they noted that this does not always happen in a busy pharmacy. Several pharmacists who

mentioned the possibility of suggesting a tier switch said, “We’ll do that, but it takes time.” Furthermore, the message to the pharmacist from the plans generally gives the cost sharing for that drug, but not information on tier placement or whether an alternative drug might have lower cost sharing. Obtaining that information generally requires extra work.

Awareness of tiers among physicians was more mixed. While some physicians were able to talk about specific drugs and the likelihood that they would be on high tiers, another asked, “On Medicare there are tiers?” Several physicians said that although they were aware of tiers, they could not predict a drug’s tier status, just as they did not know if it would be covered. As one said,

I think that’s kind of hard for us to know too because there are some drugs that have surprised me both ways that I thought would be tier 2 and they’re tier 3. Some of them I would just know they’re tier 3 aren’t. They’re tier 2.

Utilization Management and Off-Formulary Drugs

In addition to placing some drugs on a higher tier, plans may also choose not to cover some drugs at all, leaving them off the plan formulary. Furthermore, plans use a variety of techniques, including prior authorization, step therapy, and quantity limits, to control the utilization of certain drugs. The law allows each plan to establish its own formulary within certain guidelines outlined by the Medicare program.

From the plan’s perspective, the formulary is a key tool to manage drug utilization. The plan may use a formulary to encourage use of the most effective drugs and to negotiate with manufacturers to obtain lower prices for the preferred drugs on its formulary. To the patient or physician, formulary placement tends to be seen as a restriction on access or on their freedom to prescribe the drugs they think are best. We asked physicians and pharmacists how these tools work in practice, and we asked beneficiaries about their experiences with drugs that are either off-formulary or under some utilization management requirement.

Most beneficiaries were satisfied with their ability to obtain needed drugs. A small number had paid full price or gone without a drug. While these cases were not normal, most physicians and pharmacists similarly reported in some cases they were not able to get approval for drugs they thought beneficiaries needed. Most of the time, they were able to find a workable solution – sometimes with a fair amount of effort that may or may not be obvious to the beneficiary.

Off-formulary status and prior authorization both make a drug “uncovered.” As the coordinators between plan requirements and their customers’ physicians, pharmacists appear to think of prior authorization requirements, step therapy requirements, and lack of coverage as interchangeable. Both physicians and pharmacists said it is more likely that a physician will change a prescription to another drug than seek prior authorization, because obtaining authorization is too much of a hassle. Many echoed one physician’s comment: “You try like crazy to avoid prior authorization.”

Even when a physician puts in the time to make a request, there is no guarantee that the plan will grant authorization. Even after following a plan's step therapy or fail-first requirements, one physician reported still not being able to get a drug covered for a patient:

It's only when we get to something that is involved or something relatively new, or there is no alternative, that then they fight us because they want us to use something that really isn't what we want it for. And those can be difficult. Sometimes you just have to check and say give me a list of drugs that I have to fill first, and then I go through the list and I try them on every one of them. Whatever it takes to see that they've failed and that we tried. And even then, sometimes it's the same old same old, they say it's not covered. So why do you go through these hoops if you weren't going to pay for it anyway?

One pharmacist described this particular case that gave her insight into why physicians might be more interested in switching drugs than pursuing prior authorization:

The nurse practitioner was trying to get a prior authorization through one of the plans...I've been faxing her for a month straight...Well, she calls me, and she's saying, "Thanks for faxing me again and keeping me on my toes"...She called [the plan] three times. And every time they roadblocked her. And then they told her they wanted her to fax an article [from a scientific journal] to support her position...I mean – no wonder. After one experience like that...Do you want to pursue [prior authorizations]?

When physicians change the prescription rather than pursuing prior authorization, it is also easier for pharmacists, because they are able to fill the new prescription quickly without waiting for some resolution between the physician and the plan. Thus, most pharmacists said they will suggest alternatives that are covered without any restrictions when they contact the physician about a prior authorization request or an off-formulary drug. As one described it,

We turn around and basically call the physician who is where the prescription originated. And tell him what drugs are covered in that category and let him pick. And usually the doctors are amenable to going along with it. Very few times will they get uptight and will call and get...prior authorization.

Quantity limits present different issues. Some plans use quantity limits as another utilization management tool. However, rather than switching drugs, pharmacists and physicians said they are sometimes able to circumvent quantity limits with a prescription for a higher dose. For example, pharmacists cited fluconazole (used to treat yeast infections) as a common case in which the physician prescribes more pills than plans' quantity limits. If a plan has a quantity limit of one pill, a physician intending that a patient take 150 mg each day for two days might write a prescription for a single 300 mg dose, and explain to the patient that she should split the pill and take half each day.

When a drug is not covered, physicians want to know what will be covered. While pharmacists generally reported that their policy is to tell the physician which unrestricted drugs they could substitute for a problem prescription, physicians repeatedly expressed frustration because they do not get that information. Some described it as a guessing game, having to repeatedly try prescriptions until one is covered. In these cases, physicians said that pharmacists told them that

they were unable to look up coverage for a class of drugs, instead having to submit individual prescriptions for coverage.

PHYSICIAN 1: It's totally unhelpful to have somebody tell you this drug's not covered. I want to know, but what is? I don't even want to know it's not covered until you tell me what are my choices.

PHYSICIAN 2: Most often that is, "We don't know until we submit it."

PHYSICIAN 1: The commercial HMO's, they had their list...When the pharmacist called they would always send you the alternatives and that wasn't so hard to deal with.

Pharmacists would like accurate, detailed messaging from the plan. Information on which other drugs a plan would approve without restriction is not always part of the messaging pharmacists receive when a prescription is submitted to the plan. In addition, there is other information pharmacists would like to see included in rejection messages. One gave this example:

A lady had gotten [Ambien] a month before that said, "Refilled too soon" or something like that. So I had to call the insurance company to find out why it was being rejected. And he said, "Well they can only get a 14-day supply in 30 days." So you're trying to bill them for 30...If [the rejection message] just said, "You can only give 14 pills in a 30-day period"...it would have saved a whole lot of time.

Uncovered drugs require both staff and physician time for resolution. For both Medicare and non-Medicare patients, physicians report that they hear from pharmacists about multiple prescriptions per week or per day that are not covered because they are off-formulary or require prior authorization. Each rejection requires consideration of the alternatives: either switching a patient to another drug, working to obtain prior authorization, or making no changes and asking the patient to pay for the uncovered drug.

Most physicians report that they rely on a combination of support staff and their own time to work with the pharmacists and plans. Some large practices had staff that could handle a lot of the work. For example, one nephrologist at a large group practice said her involvement was primarily just signing off on a nurse's recommendations for drug switches. The structure of many small practices and solo practitioners requires more physician time to handle the same issues. One solo practitioner described his strategy for making this less burdensome:

I do my paperwork while I listen [on hold waiting to talk to a plan] ...The really tough ones, it's very tough to get through...I may deal with maybe one or two a week where I have to make the phone call myself. I just do it when I'm doing my paperwork at night. And I get through 95 percent of the time...because I will be persistent, I will sit on the phone waiting for a person to talk to...When we get something we have to fight for, then I do all of that at nighttime. My staff is gone, because I don't want my staff on the phone for thirty minutes dealing with these people, because they have better things to do.

Although most physicians did report making at least some phone calls to resolve prior authorization requests, many prefer communicating with plans by fax, because plans frequently put them on hold for a long time when they call. One physician told us:

We don't call at all. We did tell the patient that if they want pre-authorization, they can call the plan and get the plan to fax it to us. We'll deal with a fax. We do not call and we have not called for five years. We never call. If the patient says, "You have to call," I make them come in, charge them an office visit, I put them on the phone and they sit there for 20 minutes and deal with it. After a while they go, "I understand your problem."

A common frustration was that sometimes plans require physicians to do things they believe their staff should be able to do.

A lot of times, erroneously they say doctor needs to call as opposed to somebody from the office. Or the nurse that works with you. They want you personally so you end up calling and then they say, "Can you give us the Social Security [number] for the patient?"

While most physicians described a reluctant willingness to put in the time it takes to obtain coverage for their patients' drugs, one physician said he refused to deal with any changes in prescriptions or prior authorizations: "I don't pre-approve anything, I just write the prescription. I let the patient figure it out ...I write no change and send it back. I do not change it. I have written it. That's what I want." Some pharmacists in another city reported they had seen the same behavior, but it was rare.

Similarly, pharmacy staff report increased time resolving coverage issues. Pharmacists report that it takes a minimum of 15 to 30 minutes of staff time (sometimes more) to resolve a prescription that needs to be changed or needs prior authorization. Independent pharmacists believe they are particularly affected by the increased time it takes to resolve issues as both commercial and Medicare plans use various management strategies. Some saw changing staff patterns, such as more technicians per pharmacist. Others report increased wait times because of the time spent, not only for Medicare beneficiaries but for all customers at the pharmacy.

Some physicians are changing the drugs they prescribe to avoid hassles. Several physicians report changing their prescribing habits to start by prescribing a drug they think is most likely to be covered by most plans. One told us, "It's way simpler just to guess at the right drug...if you have enough, you get a feel." Many said they will often prescribe a generic rather than a newer drug in a class because generics will usually be covered by the plans, eliminating the need for back-and-forth with the pharmacy and the plan.

Some physicians reported that this preference for prescribing drugs that will be "below the radar" extends even to classes in which they do not consider the drugs perfectly equivalent. They are willing to prescribe drugs that they do not consider the very best in the class, as long as they can find something that seems to work for their patient.

My prescribing has sort of shifted in a way that it doesn't seem to turn on red lights. I fly under their radar most of the time. And it's not to the patients' disadvantage, either. I mean, I think the patients are just as well served. And the fact that you can get access to any drug, I think is important. Does it have to be the branded or the best drug for that condition? That is not necessarily always the case. But if there are side effects so they don't tolerate it, then we ratchet it up to the next level.

PHYSICIAN: One example I run into sometimes if somebody has an ACE inhibitor cough I pick an ARB for them.³ I come to find that I think that something...has a lot better coverage. So I might tend to write that, figuring I will have less hassle down the road. So it will influence you which one you're going to pick sometimes.

MODERATOR: Is that a case where you feel like it is a perfectly ok choice amongst them all so you really are just picking among equals or are you....

PHYSICIAN: Not always.

MODERATOR: So there are cases where maybe it's not the ideal drug but you know it's going to be the least hassle therefore it's most likely to get through.

PHYSICIAN: I like Benicar but I think that one is turned down by a lot of plans.

A few physicians reported a different strategy. They write on one prescription the name of several acceptable drugs or give the beneficiary five different prescriptions for five drugs in the particular class. One example was the proton pump inhibitors used to treat gastric reflux and other gastrointestinal conditions, where many consider the alternative drugs to be mostly interchangeable. This approach allows the pharmacist to go through the process of checking which drugs are covered without having to contact the physician again. Pharmacists did not report seeing this regularly.

Physicians and pharmacists report frustration with plan staff. Many prior authorization requests and other interactions with plans are resolved easily. However, physicians and pharmacists reported that it is not uncommon to encounter difficulties when they try to resolve issues by phone. One complaint was that phone staff are not trained to handle the calls. One pharmacist complained,

You spend a lot of time talking to them and they don't have an idea what you're talking about. And you know it's on their plan, but they haven't been trained sufficiently to work with you. So you end up beating your head against the wall with, not only the patient, but the insurance company employee.

Another described a particularly bad experience:

I got one company and they say, "Well, you need to talk to the fourth floor.... we can't do anything about that." So then you call the fourth floor, and they say, "Well her coverage is on the third floor." I'm not making this up. I've literally had this conversation with people. So then, after I had this conversation...I call Medicare's complaint number. Oh, my God. I was so mad that I did it. But it took an hour to do a complaint. An hour...I will never do that again.

One physician complained that the people he deals with on the phone are not the ones able to truly make a coverage decision:

You ask for the pharmacist, the head pharmacist, the administrator, head administrator, finally you say, "can you make the decision?" and they say no....there's no one person who can make a decision to override the formulary based on the information you get.

³ Coughs may occur as a side effect of some ACE inhibitors. Both ACE inhibitors and ARBs are common treatments for hypertension.

Another said,

The problem is it's not an argument you can make with anybody who's a coequal. You're talking to a clerk who's looking at a list and so it's sort of like trying to argue with the people at the DMV. It doesn't do you any good. People making the decisions are only looking at the bottom line. How can you argue? I mean you're just looking at different things. If you're looking at "this drug is cheaper" and I'm looking at "this one works better," you talk a different language.

Knowing that issues sometimes take a significant amount of time for resolution with physicians and plans, one pharmacist told us she has started suggesting to beneficiaries that they call 1-800-Medicare instead. She has experienced multiple cases where this strategy was successful.

Drug switches and prior authorization were usually successful. Several beneficiaries, but a minority of each group, had the experience of being told that a drug was not covered or required prior authorization when they went to the pharmacy. Most reported working with their physicians (or the office staff) in those cases to be switched to a covered drug. For some, the process took some time and effort, but eventually worked. Beneficiaries were generally satisfied with the results. However, a few beneficiaries reported being confused or frustrated by the process. For example, one low-income beneficiary described her confusion about how to obtain coverage for a medication:

They swap over sometime between November and December and don't tell you until you need to go send a new prescription in and then they say "You need [prior authorization], you need this, you need that." Well, okay, if I need it, how do I get it?... "Well, you need to get it." Well, how the hell do I get it? Do I call my doctor? Do I call the state? Who do I call?

A small number of beneficiaries paid full price or went without the uncovered drug. For some beneficiaries, the price of an uncovered drug was low enough that they chose to pay the full price of the drug, possibly bringing up the issue the next time they went to the doctor. A few reported not getting a drug because it was not covered and they could not afford the full price.

Pharmacists report that it is rare to give a beneficiary a small supply of the drug while the issue is being worked out. Because uncovered drugs are frequently expensive, they do not want to risk providing a supply of drugs that will not be covered. They also reported that it is rare that a beneficiary will choose to pay cash for a temporary supply.

Switches and prior authorization are rarely handled in one day. If a beneficiary brings in a prescription that is not covered, the situation will almost never be handled while the patient waits, and very rarely in the same day. One pharmacist described the constraints within the pharmacy:

It's just one more thing. Some days you feel like all you do is get on the phone regarding insurance issues. And I'm going to be honest and say I work in a relatively busy place, and yeah, sure, I'll help you, if I have time right now. But there are a lot of times where you just say, "It's not covered. I'm sorry. We're going to have to call and change it or whatever, but I can't do it right this second." ...So it's a headache... Sometimes there's one tech and if you're in a busy store they're taking care of all the customers. And so all these other phone call issues can come later on in the day when there's overlap [in staffing]. You can do it if

you're not so backed up. So it's not a priority to get those calls out because there just isn't staff to do it.

These time pressures are similar in the physician's office receiving the calls or faxes from the pharmacy. One pharmacist estimated, "If the doctor is going to change the medication it takes probably a day or two depending on how fast the doctor will get back with me. If we can't do prior authorization then it may take up to a week." Beneficiaries' stories were consistent with this account. A handful of physicians reported cases that took even longer to resolve with the plans; one pharmacist reported a case she had been waiting for a month to resolve.

The only hope for resolving a coverage issue while the beneficiary waits for a prescription is an instant answer from the physician. One pharmacist did say this was sometimes possible:

The key to the whole thing is having an office where they will pick up the phone and call. There may be a few offices where you – I've got offices where I had a rapport with the staff. And I can call. And I can [say], "So-and-so needs a prior authorization on this." And they'll call me back in 15 minutes and say, "Do it." And then you've got other offices where you'll call up and you never get [a person who will help you]...If the offices are run well, then yes, sometimes you can get quick answers.

One physician noted that the situation in which these delays cause the biggest problem for his patients is when a prescription for an antibiotic is not covered.

Usually we find out after five o'clock or after office hours. The pharmacy calls and the office is closed. So the infection is pneumonia or whatever the infection is...and the patients end up in the ER or somewhere because their antibiotic was not covered.

Additional office visits or costs may result from switches and prior authorization.

Whether switching requires another office visit seems to depend on the condition, the patient, and the physician. While most physicians approve a switch to another drug over the phone, they may ask the patient to come in for monitoring sooner than they would have with the original drug. Physicians have different strategies for making that happen:

PHYSICIAN 1: I've had people who are in good control with a statin and they switch and they knock it out of control on the next one. So you've got to bring them back. So rather than writing a 90 [day] refill you write a 30 [day] refill and they come back and you see them and you either bless it or don't bless it.

PHYSICIAN 2: Exactly. Well, I write it all 90 [day] forever refills and tell them to come back – and if they're not smart enough to come back, then that's too bad.

Physicians also complained that when they want to get approval to keep a patient on a certain drug or dosage that may also cause additional specialist visits or tests. For example, one primary care physician had found that a gastroenterologist could get approval for a drug regimen when she could not. Others had similar experiences with other drugs:

PHYSICIAN 1: Someone comes back to me with severe esophagitis...and they're on a [twice-a-day regimen]. And the [plan] people say it's once a day and they won't take my

letter, so I have to send them back to [a gastroenterologist] to give the Good Housekeeping stamp of approval even though that's where [the original prescription] came from.

PHYSICIAN 2: That brings up the expense that is not in this calculation. If we can't get drug approval...we'll send the ENT or send the neurology, psychiatrists, whomever, just to get a drug approved. Take our word for it, they need something [twice a day].

PHYSICIAN 3: And a lot of times they won't get their PPI unless we do a scope...I have heartburn, it's doing great with Prilosec. Why do you need a scope? It's going to be normal, of course.

MODERATOR: So how often do you think you run into a patient that you have to send off to a specialist?

PHYSICIAN 2: Every week. To get them on the drug you want. It's not worth wasting an hour a week.

Changing plans may require switching multiple prescriptions. A few physicians reported going through a beneficiary's entire drug list when a beneficiary changes plans, or becomes newly eligible for Medicare. They described the amount of drug switching that may occur at this time as a disruptive process: "Even the people who take a few drugs, it's a confusing switch...a confusing month or two when they try to straighten it all out."

Exceptions and Appeals

All beneficiaries enrolled in Part D have the right to request exceptions to their plans' formularies. They also have the right to appeal coverage determinations. However, this appears to be fairly uncommon.

Only a few beneficiaries in our focus groups had filed exceptions or appeals. For the most part, the beneficiaries in our focus groups were satisfied that they had been able to obtain the drugs they needed. Many had no hassle at all, while others had experienced a minor delay or had needed to expend some effort in order to obtain a new prescription from their physician or authorization from the plan. Only a few beneficiaries had faced a rejection of coverage of their drug that was appealable. Some may also have been in a situation where they could have requested a tiering exception, but this was difficult to determine in the course of the focus groups. Among those who described cases in which they could possibly have requested an exception or made an appeal, even fewer actually took that action.

Likewise, few physicians report reaching the level of making an appeal. However, they may go through several rounds with the plan at a level they consider below an official appeal. As noted above, many physicians did not clearly distinguish between prior authorization, requesting coverage for an off-formulary drug, or other types of appeals and exception requests. For example, a handful of physicians described following up multiple times with plans to get coverage for a drug they thought their patient needed. One reported sending a patient's entire chart to overwhelm the plan reviewers with information.

More than half of beneficiaries did not know about appeals or exceptions. Many beneficiaries believed, as one put it, "If it's not on the formulary, it's not on the formulary."

Similarly, one beneficiary complained about paying more for a higher-tier drug in a situation in which he might be able to request a tiering exception:

If you insist, or your doctor insists, that you have the name brand, then your insurance, Medicare Part D carrier, whatever it is, puts you with a different tier level for the name brand verses the generic. And that's not fair. If the doctor justifies it as medically necessary, you ought to pay the same copay. They shouldn't be a higher tier.

One physician thought beneficiaries might be discouraged from appealing because of the way that plans word their coverage denials.

The structure of the plan's [denial letter] says, "We want your doctor to do this." That's what the letter says. It doesn't say, "Your doctor sent us the information and we disagree with him and we are denying you." They say, "We failed to get the necessary [information]"...so the patients, in general, really are not aware that their Part D is as restrictive as it actually is, so they keep going back to their doctor.

Some beneficiaries and physicians doubt whether appeals work. When they heard about the option to request exceptions or file appeals, some beneficiaries expressed doubt that they would be successful.

I think [my plan] has told me that I could try [an exception or appeal] but I just didn't have any faith in thinking that they would change their minds...if that were the case why don't you just go ahead and put Nexium on your list to begin with? And why do I have to go through all of this?

Similarly, some physicians were also discouraged about the ability to make a successful appeal, such as the one who told us:

If something is really expensive ...the denial rate is higher even with the information they need. [In those kinds of cases,] if they don't get it they might need a transfusion in a month or so. It's a big deal but they deny it routinely as if you did not give that information. And underneath it says, "history doesn't support," or "information doesn't support." And that is a misstatement that they throw all the time.... And if you call and you are trying to appeal it doesn't go anywhere.

Beneficiaries who did appeal reported mixed results. Of the limited number of appeals in our groups, some were successful and others were not. One beneficiary whose appeal was successful reported that her situation took about two months to resolve:

BENEFICIARY: I was on a drug ...that they don't agree with. They didn't agree that I was still getting it, because they put five months' life span on how long I should get it. I have been on it for a couple of years and want to continue with it. And my doctor got on the bandwagon and talked to them about keeping me on it, that I need to be on it, and that it's the only drug that doesn't interfere with my MS drugs and that to take me off it would be

irresponsible...So that was cool, and it was all the doctor's work. I didn't really have to do much of anything. I think I had to fill out one form....

MODERATOR: And in the meantime did you have to pay for the drug?

BENEFICIARY: Actually I had cut down on it in fear that I wouldn't be approved to get it anymore and so I still had a little bit.

Plan Comparisons and Standardization

Providers differ on whether Part D formularies are similar to employer plans. One group of pharmacists clearly believed that even with changes in the employer-sponsored market, Part D plans remain more restrictive:

PHARMACIST 1: Company insurance we see is a better coverage than Medicare Part D.

PHARMACIST 2: Absolutely.

MODERATOR: So you see more folks with uncovered drugs in Part D?

PHARMACIST 1: Right. Versus what they had when they were currently working. Obviously the copay is going to be different. But that was the biggest shock. They go "I've been taking this forever." I say, "Well, I'm sure you have been, but now it's not covered." So that's a little frustrating. You know the doctors don't feel comfortable with it either.

MODERATOR: Are you saying that an individual over time is seeing their formulary get tighter? Or is it that the Part D plans are more restrictive compared to the employer plans that people have right now?

PHARMACIST 3: I think they're more restrictive for Part D.

Other groups were less willing to assert that Part D plans were more restrictive than other plans. For example, one physician put it this way:

When D came out it was the most complicated pharmacy program going. But if you notice, the commercial insurance companies have increased the complexity of their plans, so that they are very hard to understand as well. So we're getting complaints across the board from all age groups about, "I don't understand this pharmacy benefit."

A few physicians had opinions about which plans were harder to deal with. Despite generally not knowing what plans their patients are enrolled in, physicians generally know which plans they are calling when there is a problem. Some physicians say certain plans create more of a hassle for them than others, although they do not always agree on which plans are the most difficult. Examples were offered in two different conversations.

PHYSICIAN 1: I deal with at least seven or eight [plans]. And I know the bad ones...PHYSICIAN 2: [Plan X] is a problem. That's the one I make the most phone calls on.

PHYSICIAN 1: And [Plan Y].

PHYSICIAN 2: Yes, [Plan Y]. Those are the two that stand out...that you have to make the most phone calls to.

PHYSICIAN 1: Anything to do with [Plan A]. They are from my perspective the most difficult, recalcitrant, nasty people to deal with.

PHYSICIAN 2: [Plan A] was easier to deal with than [Plan B].

PHYSICIAN 1: We've had the opposite experience. [In Plan A, the] more [you need] certifications, the more you have to talk to the medical director. They seem to go out of their way to throw out obstacles to the doctor and the patient.

Some physicians raised the need for better oversight. One gerontologist who worked with nursing home patients was frustrated with what he saw as a lack of oversight by CMS. A second physician expressed agreement.

PHYSICIAN 1: There should be a way for us to say this [plan] is giving us a lot of grief and then if enough complaints go in then it puts it on [CMS] to say, "You either clean up your act or we will drop you. No matter how good a bid you put in we are not going to accept you because you just don't provide good service."

PHYSICIAN 2: Or do audits. There are no audits right now. They don't go and do mock [prescriptions] to see how they deal with [problems]. There is no quality assurance that's standardized by the government.

Providers said it would be helpful to have more standardization among plans. Many physicians and pharmacists were frustrated by the overwhelming variety among plans in both benefit structure and formulary and wished they could be simpler. Typical comments included:

I'd be ok if there were 100 plans as long as there are only six different schedules of benefit. Even 1,000 as long as there are only six different schedules of benefit...like the [standardized Medigap] kind of thing so you could offer bunches of companies but they have to come up with a set of standards and stick to them.

If they had fixed it so that it would be a smaller number of [plan] options...people still wouldn't necessarily understand it. But I think we would have a better chance of maybe helping them with it if there were like five or six plans.

We have 50 different plans. You can't understand 10 percent of them much less the other 90 percent. And that's why I think you need standardization.

SATISFACTION WITH DRUG SUBSTITUTIONS

A second focus of our discussions, particularly with physicians, was the extent to which drug substitutions work for patients. As discussed above, physicians often choose to switch beneficiaries to a different drug within a class to find an on-formulary drug, to avoid a prior authorization request, or to find a drug that is available on a lower tier. We asked both physicians and beneficiaries about substitution of generics for the equivalent brand name drug as well as substitutions among different chemical entities within the same class.

Substitutability within Classes

In many classes, physicians find switching drugs completely acceptable. In particular, physicians singled out statins, PPIs, ARBs, ACE inhibitors, and calcium channel blockers as classes in which drugs are interchangeable. One physician put it this way, and was seconded by his peers:

If they want us to use some other drug in their class, there's almost always something else acceptable in the class. I just didn't prescribe [it] for the person...I have come to believe that there are very few differences between the modern drugs in certain classes, in most classes. Very few differences.

Physicians are most willing to select the plan's preferred drug when starting a new patient on a course of treatment. They are somewhat more wary when switching a patient who is stable on a particular medication.

Physicians are generally unwilling to switch psychotropic medications. When we asked physicians which drugs they were not willing to switch, psychotropic drugs were always the first response. For these drugs, they repeatedly expressed the sentiment, "Once you have something that works don't change it." One described her experience with the detrimental effects of switching non-Medicare patients from one drug to another at the request of a plan.

I've had it come up in some of the commercial plans, when depression is well controlled and they didn't cover the drug and I switched them and they crashed. I had a whale of a time getting the drug for them. ...I have a patient that is suicidal and ...[the commercial plan] said, "She can pay for it." "We're not going to pay for it."

Likely because of the requirement that Part D plans cover all anti-depressants and anti-psychotics, most physicians did not have particular complaints about pressure to switch Medicare patients to different psychotropic drugs. However, a gerontologist working in nursing homes raised some specific cases of switching requests for Lexapro and Celexa, the one case in which CMS treats two drugs in a protected class as substitutable and allows plans to opt to cover only one of these two drugs. This physician has found in his practice that dosing issues between Lexapro and Celexa create problems when patients are switched from one to the other: in his opinion, patients are sometimes stable but undermedicated.

Plans are still allowed to require prior authorization for some anti-depressants, and the same gerontologist had run into trouble getting approval to use Cymbalta to treat both depression and neuropathic pain. He argued that this would save plans money because he would be able to stop giving patients drugs such as Neurontin, Lyrica, or Oxycontin.

Physicians also raised issues about length of action among psychotropic drugs. While plans must cover at least one form of each drug, they are not required to cover long-acting versions, which are often more expensive. A psychiatrist said she was willing to make some tradeoffs on the length of action of some psychotropic drugs. “I just don’t make it super long anymore,” she told us, “Because I know that’s going to be a prior auth.” However, she noted, switching to a drug that can be taken only once a day can significantly improve patient compliance.

Physicians substitute cardiovascular drugs within a group, but not across groups. Many physicians echoed the comments of one who told us “an ACE is an ACE, an ARB is an ARB.” Likewise, many saw both the statins and the calcium channel blockers as groups where drugs are largely interchangeable within the group.

As with any class of drugs, there are exceptions to this interchangeability for individual patients. One beneficiary had the experience that statins were truly not interchangeable for her:

When...it was time for me to take something to lower my cholesterol I asked my doctor if I could take a statin because that’s the thing. So she tried to put me on the statin and first blood test came back and it wasn’t working. And she doubled the dose and it still didn’t work. She said, “It’s time to put you on Lipitor.” ...So when I took it to the pharmacy they had to call the doctor because they had to get her pre-authorization for them not to substitute anything for the Lipitor.

Some physicians also said that while statins are generally interchangeable when first prescribed for a patient, once they have cholesterol levels under control they do not like to switch to another drug.

The problems more commonly raised with cardiovascular drugs had to do with the interchangeability of drugs in different therapeutic groups. In particular, because there are no generic ARBs, physicians sometimes get pressure from both patients and plans to use a generic drug from a different group, such as ACE inhibitors. Physicians are less willing to make this switch. For example, one patient said he asked his doctor if he could change from Diovan to something else, and the reply was, “Do you want to enjoy good health or do you not want to enjoy good health?” One physician who treats a lot of African American patients noted that he had a strong preference for ARBs over ACE inhibitors because they cause fewer side effects in his patients. He was trying to get samples from the drug manufacturers to help his patients with the cost of the drugs.

One physician who works part-time at the VA noted that the VA formulary recently instituted step therapy for Coreg (an alpha/beta blocker that only came off patent after these group sessions) that requires trying sotalol (a beta blocker) first. Although no physicians raised this as an issue in Medicare, it is an example of the non-substitutability of different therapeutic groups within the cardiovascular category. He noted this change created problems for his patients, particularly if they had already been stable on Coreg and were switched to something else.

One beneficiary had problems with interchangeability of diabetes medications. Her plan made two changes that she did not like. They denied her prescription for Avandia, an oral medication that can reduce or eliminate the need to take insulin for certain patients.⁴ They also switched her from insulin in pre-filled pens to one she found more difficult to use.

Generic Substitution

Providers and beneficiaries are generally happy to switch from brands to generics. We asked both physicians and beneficiaries about their willingness to substitute a generic drug for the brand-name version of the same drug. With the exception of a few specific drugs, physicians were very comfortable having their patients use generic drugs. Some younger doctors had the perception that they are more likely to go with generics first than their older colleagues.

Most beneficiaries were willing to switch from brand name to generic in order to save money. As one beneficiary put it, “You’re just paying for a name.” Some had actively sought out generics at the pharmacy and their physician’s office; many reported their pharmacy made the switch automatically.

However, a few beneficiaries do not trust that generics are truly equivalent. Some beneficiaries said they would go for the brand name if the difference in price was small, while others would always opt to save the money. One beneficiary who preferred brands told us:

I hate to say this but...I know I did read [that] generic brands are not as good as the brands the doctors prescribe. Now my doctors I go to I’ve been going to them like 25 or 50 years. I don’t change doctors. I just keep going to the same one and I know my doctor...he’s looking out for me and he’ll say, “Well I want you to take this and not a generic one.” And I’d rather pay a little bit more than take the generic.

Pharmacists agreed that they had some customers who shared this skepticism. Some said that older generations tend to be more skeptical, but seem to be learning that generics are equivalent to the brands they are replacing. In particular, they said, most beneficiaries quickly agree to switch when they see a large price difference:

PHARMACIST 1: [I tell them] “The generic is \$5, the brand is \$60. You tell me what you want to pay...”

PHARMACIST 2: When I get a person that’s uncomfortable with that...I say “Well, why don’t you go ahead and try the generic for one month. We can always change you back...” Usually, they’re OK.

Generic substitutions lead to beneficiary confusion for other reasons. Some beneficiaries complained that when they were switched from brands to generics, they no longer recognized the names of their drugs. They would like to have the name of the brand that the generic is replacing printed on the bottle. One said, “you get used to the brand name and then all of a sudden I’m going, what is this for?” One physician reported that a patient was extremely agitated by the change in names:

⁴ Recently, Avandia has been the subject of safety concerns – that may explain this plan’s action.

I had one call me in the middle of the night, she went berserk because somebody – [she thought] he gave her the wrong pill...She was completely off the wall. So we had to go through all her medicines, put the proprietary names, generic names, everything. But we don't get paid for that.

In addition, physicians and pharmacists said that when a pharmacy switches from one manufacturer to another for the same generic drug, beneficiaries are frequently confused by the change in appearance of their pills. One beneficiary enrolled in a Kaiser plan commented that he liked the fact that the pharmacy warned him when this happened: “This is the same prescription, just a different color.” It appears many beneficiaries would benefit from receiving that information.

Problems sometimes occur when switching thyroid drugs and blood thinners. There was a general consensus among the physicians in our groups on the important exceptions to acceptable generic substitution. Doses need to be carefully adjusted for each patient individually for both Levoxyl (thyroid supplement) and Coumadin (blood thinner) as well as their generic counterparts (levothyroxine⁵ and warfarin), because of the need for precision in how much of the chemical reaches the blood stream in a given time. When a patient is switched from the brand to the generic (or vice versa), it may take several months to stabilize the patient on the correct dosage for the new version of the drug. Some pharmacists said there were also differences between different generic manufacturers of the same drug.

Several doctors told us about these drugs, “I don't think one's any better than the other. The problem is when they start switching from one to the other.” Others did not trust the generics. For example, one physician told us, “I've never written generic Coumadin and I'm not really sure...I just don't think warfarin is the same drug as Coumadin.”

Likewise, some pharmacists said they would not automatically change these drugs from the brand to the generic as they might with most other drugs. Others said they would switch to the generic, and let the physician know they should be monitoring the patient's blood levels. For example:

I found that most of the people who've been on Synthroid I keep it on. If they want generic I'll switch it to the generic—call the doctor and let him know I'm going to do that so he can monitor blood level. And then they're happy with their copay. You kind of have to weigh, what is their situation. If they're really destitute then you need to try to keep the copay at a minimum...And make sure that the doctor is actually following through with them.

We also heard from a handful of beneficiaries about their experiences with these drugs. One beneficiary said her physician refused to consider changing her thyroid medication to a generic, because Synthroid was working for her. Another beneficiary said that when her Coumadin prescription was changed to the generic at the pharmacy due to a state law mandating generic substitution, she had difficulty with the change. Because she had selected a plan that covered brand-name Coumadin, she was able to switch back fairly easily, although her copay was higher.

Physicians reported less common drugs for which generics may not be equivalent. A nephrologist working in a dialysis facility reported that there are several drugs for which the generics do not work

⁵ Synthroid is a commonly used “branded generic” form of levothyroxine.

as well as the brands for her patients. For example, she said, generic Miralax does not dissolve well for her patients. Another physician had found differences between brands and generics in some of the anti-epileptic drugs, such as Dilantin.

EXPERIENCE WITH DRUG COSTS

There is a research literature that suggests that physicians typically do not discuss cost-related issues with their patients and tend to be unaware of the cost of drugs – both the absolute cost of the medications and the typical cost-sharing amounts for those with coverage. The result is that in many cases the drug selected for the patient’s original prescription is based primarily on clinical considerations (though perhaps influenced by patient preferences and marketing by the manufacturers). Given the lack of awareness of plan formularies discussed earlier in this report, this appears to be the case for many beneficiaries. However, the extent of drug switching after prescriptions are initially written indicates many physicians are willing to work with beneficiaries to lower their costs. In this section, we describe some of the other methods beneficiaries and physicians use to lower drug costs.

The situation that is most likely to lead to a physician-patient conversation about drug costs is Medicare’s coverage gap. In most of our groups, there were beneficiaries who had reached the gap, and physicians and pharmacists all had patients who had reached the gap. We asked participants about their experiences with the gap and their strategies for maintaining access to drugs in the gap – or for avoiding the gap in the first place.

Strategies for Lowering Drug Costs

Beneficiaries and physicians reported several ways they have worked to reduce drug costs.

Samples. Samples appear to be a major component of how some beneficiaries obtain their medications – and not just for new prescriptions. Most (but not all) beneficiaries in our groups were aware that physicians have samples of drugs that they can give away for free. Some noted their physicians would not volunteer the samples, but make them available when asked. Several said they commonly walk out of their doctors’ offices with a full bag of pills. One beneficiary said by using samples, she was able to completely avoid paying for two of her regular medications.

Physicians also frequently talked about samples as a way to save beneficiaries money. One told us, “I’m sure the drug companies would not like me saying this, but I think I give away more PPIs than I prescribe.” Pharmacists said one of their suggestions to beneficiaries who are having trouble paying for their prescriptions is to tell them to ask their physician for samples.

Some low-income beneficiaries in Denver reported that they now receive fewer samples than they used to. One specifically stated being told this was for liability reasons.

I asked the nurse, “Does he have any of these samples that he can give me to hold me over, because I can’t get to the pharmacy for a couple of days?” She said, “No, we quit doing that, because if the doctor gives you a prescription and something happens and it goes bad, if it’s out of his office and you get sick, then he’s liable for it. But if he writes that prescription and you take it to Walgreens and you get sick, then they’re liable for it.”

Coupons and low-cost pharmacies. Beneficiaries, physicians, and pharmacists were all widely aware of the \$4 generic drugs available at Wal-Mart and other pharmacies that match Wal-Mart's prices. Some beneficiaries also regularly use pharmacy coupons to save on their medications. These strategies are discussed in more detail in the section of this report on pharmacies.

Reviewing drug regimens. A few physicians noted that they had been able to save their patients money – and possibly improve their health – by reviewing drug regimens to eliminate drugs they do not need and assure that their drugs are treated favorably by their plan formularies.

PHYSICIAN 1: In my clinic, most of my patients are on way too many medications that maybe they don't need. And once somebody puts them on something, they're on it indefinitely. I get people who are on two or three different kinds of anti-psychotics and a couple of different mood stabilizers, maybe an anti-depressant...one who's been diagnosed bipolar since age 16. She's always been on these whoppingly expensive anti-psychotics. She's gained 100 pounds on them. Nobody has ever put this woman on Lithium, which is available as a generic. You take her off these expensive drugs, put her on Lithium, she loses 80 pounds...So that's one thing, huge combinations of very expensive meds and nobody's periodically reevaluating them.

PHYSICIAN 2: Yeah, it comes up all the time...And you have to sit down with the individual company's formulary, look through others to both eliminate and switch to the cheapest.

None of the beneficiaries in our groups reported that they had been approached about a plan's Medication Therapy Management (MTM) program, though some said they would be interested in such a program. Pharmacists were familiar with the programs, but most were not participating. As one noted,

There's a huge time element to get involved in a MTM. And the reimbursement for your time is so miniscule, so forget it. We have enough trouble trying to get these prescriptions filled dealing with insurance companies. We don't have time...

Some suggested that they would be more likely to become involved if they were compensated adequately. Others noted that some of the plans have in-house pharmacists who perform MTM tasks. They send letters to members suggesting that they switch to lower-cost drugs.

Two pharmacists in Richmond indicated that reimbursement is available from a particular plan for the time they spend on MTM, and that they had colleagues who were providing this service. The pharmacies receive a list of patients eligible for MTM services, and the pharmacist is responsible for meeting with those patients about their prescriptions. The pharmacists in our group had not yet participated in this process, and were not aware of its impact on the beneficiaries receiving MTM.

Pill splitting. Another strategy mentioned by physicians, pharmacists, and beneficiaries is splitting pills. This works especially when the cost of a prescription twice as strong as a beneficiary needs is about the same as the actual dose. One beneficiary said, "I've got a cute little gizmo that does it. Just put the cover down and lift it up and there's one half here and one half there." The only catch, said one physician, is that some plans "come back and say your patient is being noncompliant ...because they're only filling it every other month."

Avoiding combination drugs. One physician noted that in her experience, one prescription for a combination medication is often more expensive than two prescriptions for the medications it combines. “So when you hear that from your self-pay patients, you can move that over into your Medicare Part D and your other patients,” she told us.

Canada and Mexico. Beneficiaries, physicians, and pharmacists all reported that getting medications from Canada or Mexico remains an option for obtaining lower-cost medications. Although going to Canada or Mexico does not offer an additional benefit for drugs that are well-covered, lower prices in those countries may reduce costs for beneficiaries in the donut hole or those whose drugs are not covered by their Part D plan.

The Coverage Gap

Part D coverage includes a gap, often referred to as the donut hole, in which patients are liable for the full cost of their drugs. In 2007, the plan provided coverage on the first \$2,400 of drug costs, with the full cost of each prescription counting toward that coverage limit. After the gap is reached, the beneficiary must pay full price until total drug costs are about \$5,450 (under the standard benefit design).⁶ At that point, the beneficiary becomes eligible for catastrophic protection and pays only modest cost sharing.

Beneficiaries are confused and surprised by the coverage gap. Although most beneficiaries are aware of the coverage gap, many don’t understand it. In particular, we spoke with multiple beneficiaries who hit the donut hole but did not see it coming:

I’m in the donut hole. I think that aspect of the program is very frustrating.... I went to the pharmacy: \$238.50...that’s very serious...I really think that the problem is the shock more than anything else. That if they had the same copays over the year, even if higher, people would budget for that. But when they get hit all of a sudden, with these very large costs...

Right now...I have to pay the whole thing for my medicine. Because I take ten [medications for] \$314 a month...it really sets me back this summer because I wasn’t planning on paying for it...Right now I’m so confused...I didn’t go through those [information sessions]...I really didn’t know how to get there. And there wasn’t any close by that I could drive to, so I missed it...Nobody told me nothing – when I got to [my drug store], that was it and I was trying to figure out, why didn’t they say something before I got there?...But I didn’t know [the pharmacist] well enough to start asking questions. So I just paid it and walked away.

Several reported that the documentation their plans send them is helpful in estimating whether they may reach the gap. Others said even with the documentation, they couldn’t be sure whether they would hit the gap or not, or they simply did not pay attention to the mailings.

I did hit [the donut hole] last year...It was towards like August or September. I was shocked.... I didn’t know it was coming.... Well they send you a thing every month, so...I don’t know, I guess I was just in denial or something.

⁶ Under alternative benefit designs, the total amount spent on drugs before the gap ends may vary somewhat. The threshold is defined by total out-of-pocket costs, not total drug costs.

BENEFICIARY 1: [My plan] keeps me informed every month about what's going on. So they said if I keep on the way I am I will fall into the donut hole.

BENEFICIARY 2: Yeah. Every month they send you a little summary.

BENEFICIARY 1: But it's so confusing. I really don't understand it.

BENEFICIARY 3: I don't either. I just throw it in the trash can.

Several beneficiaries were scared they would fall into the donut hole, even though their plan documentation showed that this was not likely. "You just can't tell," they said. They worried that they might get sick, or drug prices might rise, putting their total spending over the coverage limit.

Pharmacists said beneficiaries were often confused by the way accounting for the donut hole works. They may expect to be covered until they have paid \$2,400 out-of-pocket, rather than having the full cost of their drugs accruing toward the limit. As one pharmacist described it, "They're paying five dollars and five dollars and it can't possibly be \$2,400." Physicians also reported they were personally confused about exactly how the donut hole works; in one group, fewer than half said they felt like they understood the policy.

Physicians can take some steps to prevent reaching the donut hole. A few physicians said they try to help their patients avoid the donut hole by prescribing generics from the beginning, whenever possible. Some take that strategy further, telling beneficiaries to buy inexpensive generics without using their coverage, to make the initial coverage period last longer. The flip side of these strategies, one noted, is frustrating – when a patient hits the donut hole despite the physician's best efforts, there aren't many other changes that can be made to the drug regimen if the physician has already managed it to lower costs.

Pharmacists understand the gap, but can do little to help if beneficiaries reach it. The pharmacist is often the person asked to explain the donut hole policy to a patient who has reached the coverage gap. Beneficiaries "get a letter," one said, "They come in with the letter and ask you what the letter says." Another said it's more common that beneficiaries do not know they've reached the gap until they are asked to pay full price for their prescriptions:

I've never known anybody to be aware that they're in the donut hole. You just ring them up and they say "What?" "It's supposed to be five." "Well you must be in the donut hole." "Oh no, I can't be in the donut hole yet. There's no way."

As one pharmacist put it, "They think we processed it wrong." Another had this story:

I had a case where a lady came in. And you can look back and see that she was paying a copay. And then all of a sudden it was 300 or 400 dollars. So she's all upset. And she goes home. And then her daughters come back and they want to know what's going on. They want to take them up to Wal-Mart, because they are going to get them for \$4 there. So I had to call the insurance company, and they said, "Yeah. She's in the gap now." So then I say, "She's in this donut hole." And they look at me like, "Donut hole?" They don't know what's going on. The lady apparently didn't know anything about the gap, either. And it comes as a shock to them.

This puts pharmacists in a tough position. “And then how bad do we feel?” one said. “I mean it’s just horrible.”

The quote above highlights another logistical complaint pharmacists had about the donut hole. The computerized system they use to submit claims and get information from the plans does not explicitly tell them that a beneficiary has reached the gap. Several said that information would be helpful, so they would not have to call the plans to confirm the reason the beneficiary is being charged full price. Another gave this example:

I have one lady...she was on this antidepressant patch that’s \$480. And she got it one time, and the doctor had to get it through a lot of red tape to get them to cover it. And she paid – her copay was \$65. And when she tried to order it this week, it came up \$480. I called, and they said they did have the approval, that they would cover it; but she had reached the gap – a good thing to know.

Samples are a common solution to help in the gap, when available. For drugs that are readily available as samples for physicians from pharmaceutical company sales representatives, it is possible for physicians to use samples to supply a beneficiary with enough medication to make it through to the end of the year. One beneficiary told us he used this strategy for his asthma medication when he hit the donut hole:

Last year I paid it myself, but this year I said “My doctor’s going to give me samples.”...I immediately went to the doctor and said, “Let’s have them.” He gave me two discs...I was hoping for the catastrophic 95 percent, but I’ll never make that because I’m not paying another nickel if I can get free samples.

Physicians generally agree with this strategy, and most are more than willing to help patients in this way, particularly for patients who seem to need the help financially. However, some noted that because the value of drugs received as samples does not count toward the catastrophic threshold, beneficiaries may only delay the onset of catastrophic coverage through the use of samples – ultimately only reducing their total spending for the year by a minor amount. As one put it, “[if] they get there in mid November, yeah you can support them a little while and save them. Otherwise it’s a futile exercise. They’re going to spend the money.”

Patient assistance programs are not a common solution. Some manufacturers offer patient assistance programs to help beneficiaries in the gap. Only one physician in our groups offered this as a potential solution. Others said they did not participate in these programs.

PHYSICIAN 1: Some of the drug reps they have special plans to enroll patients. It requires a lot of paperwork but luckily we have a social worker in the dialysis unit so we encourage enrolling them in these programs.

PHYSICIAN 2: The problem with those is they deliver the drugs to you. I don’t really want to be the pharmacist and so we do it very minimally because I don’t want to have to stock drugs for everybody...If they delivered them to the patient, that would be easier but they want to ship them to us.

Some beneficiaries cover the full price in the gap, sometimes for the first time. One surprised beneficiary described the impact that paying the full price of her drugs had on her:

[When they told me I had to pay full price] I got them all. But, you know, I had to put up \$314 and I was thinking, I didn't figure those in my monthly income...I needed it so I just paid it...I called my son and told him I need some help.... I just have to say, well, just drop everything, you don't get no shoes and no extras.... I got to have it, so you couldn't argue because everything was on the line.

Some providers correctly pointed out that many of the beneficiaries who reach the donut hole had already been paying full price for their drugs in previous years before the Medicare benefit went into effect. Although these beneficiaries might be surprised by the coverage gap, they were certainly better off overall than if they had been paying for their drugs out of pocket all year long. Other beneficiaries, however, had lost sources of payment that were previously covering these costs, including employer-based insurance and the patient assistance programs that manufacturers offer to individuals without insurance.

Other beneficiaries in the gap stop taking their drugs. Beneficiaries in the gap who cannot afford to pay full price for their drugs may go without them entirely, or they may try to make a prescription stretch by splitting pills or taking them every other day. Some physicians had specific examples of patients for whom this had happened. One psychiatrist had two patients end up in the hospital when they could not pay for their drugs in the donut hole:

In psychiatry it's been a double whammy with many of our meds, especially the atypical anti-psychotics....⁷ You're using those drugs and the drug reps are also not giving you enough drugs to supply patients. So I've had two patients end up in the hospital because there weren't alternatives. One couldn't take the typical anti-psychotics, he...couldn't breathe, so that was out. And, you know, as a solo person I don't have the time to beat down the drug reps for several months' worth of meds. And they're running out in June and July. One of [my patients] that went into the hospital hit the donut hole, and there was no way he was going to be able to pay the \$1500. He was never coming out of the donut hole until January.

Other physicians were concerned that their patients stopped taking their drugs without telling them. Many pharmacists believe this is true.

MODERATOR: So do some of them come back then with new prescriptions? Do you think they're going to their doctors and getting—

PHARMACIST 1: Some are, some aren't.

PHARMACIST 2: I never hear from them.

PHARMACIST 3: They'll wait till the year starts then go back on their medication then.

Another pharmacist described one case that he knew in which the beneficiary had lost help from a manufacturer program when she gained drug coverage through Part D:

⁷ The atypical anti-psychotics are the newer, more expensive drugs used to treat some serious mental health problems. The typical anti-psychotics are older, less expensive drugs. At least one recent study has offered evidence that the older drugs are just as effective with no greater side effects.

I know of one instance where the copay was \$2,500 in the donut hole and there's no money. In this family household income is around \$16,000 a year. They're not going to be spending \$2,500. And that's just one drug in the beginning of the donut hole.

Patients in this situation will never reach the catastrophic benefit because they cannot afford to spend the money out-of-pocket that is required to reach that coverage.

Pharmacists also said patients frequently ask them for advice about which drugs they can safely cut back, although they rarely are comfortable giving such advice. As one put it, "Some take them every other day. Some of them are cutting tablets... They're being as creative as they possibly can without realizing the consequences."

PHARMACIES AND PHARMACISTS

Beneficiaries all reported being able to go to the pharmacy they wanted to use. Many beneficiaries pointed out the critical role played by pharmacists in helping them navigate the program. This section reports on some different observations about the roles of pharmacists and the ways beneficiaries make decisions about where to fill their prescriptions.

Pharmacists are viewed as important allies by beneficiaries. Most Medicare beneficiaries said that they check with their pharmacists when they have questions about their prescriptions. One beneficiary explained, “The pharmacist can answer most of your questions too without having to go back to the doctor and he’s much easier to get a hold of than the doctor.” Another noted, “I talk with [the pharmacist] before I talk with my doctor about the medications because I figure that’s all he does, you know, is the medications.” Even when beneficiaries use mail order pharmacies, some will stop by a local pharmacy to ask questions in person.

Some participants prefer to use the same pharmacist on a regular basis. Loyalty to pharmacists, and particularly to local pharmacies, was a common sentiment expressed by participants. For some beneficiaries, this was based on the convenience of going to a pharmacy close to their home or their doctor’s office. For others, however, it was based on relationships. A number of participants talked about having used the same pharmacy for many years. For example:

I have personal relationships with that particular pharmacy. Those people saved my life a couple times. And so don’t discount that fact that you’re dealing with a human being right there in front of you...We’ve all had these nightmares now of dealing with organizations over the phone and being put on hold and all this stuff. When you’re talking about something that affects your life it’s good to be talking to an individual.

I watched them build my drug store in 1957 and we’ve been there ever since. I’ve never changed...If you find a cheaper price, if you mention it, they’ll change it for you because they don’t want to lose you...I go to the same druggist all the time. I don’t like to have nobody else, I want just the man I want to talk to and that’s it.

The thing is to go to the same one, don’t keep switching pharmacists. Because when you switch pharmacists, he’s not familiar with you. When he gets familiar with you...he’s going to help you. He will give you prescriptions, believe me.

Some reported shopping for a lower price at different pharmacies. A number of participants said that they are aware of prices charged by different pharmacies. Word of mouth was mentioned as an important information source. One participant said she calls around to all the drug stores when she has to fill prescriptions. She also looks for coupons that she can use at some of the bigger stores. Beneficiaries, physicians, and pharmacists were all widely aware of the \$4 drugs available at Wal-Mart, and many mentioned that other pharmacies will match Wal-Mart’s prices.

Some low-income beneficiaries reported improved pharmacy access. Some low-income participants noted that they had previously had difficulties because pharmacies would not fill Medicaid prescriptions. Likewise, several low-income participants in one community said that the pharmacy they once regularly used, which was part of the local safety net system, was frequently out of the drugs they needed. With their Part D coverage, they were able to switch to other pharmacies that more reliably carried their drugs.

In our limited sample no particular pharmacy access problems arose in rural areas. In the one group convened of rural beneficiaries, participants were satisfied with their access to pharmacies. Some reported having to travel as far as 20 miles to the nearest pharmacy, but most had a pharmacy within 2 to 5 miles. Rural beneficiaries were accustomed to traveling some additional distance for errands compared to urban or suburban beneficiaries. Some chose not to use the closest pharmacy in order to find a larger establishment to obtain their prescriptions, either for cost reasons or because the closest pharmacies do not carry some products they need.

Those who use mail order are quite happy with it. There is some awareness and use of mail order; those who used it generally were satisfied and frequently recommend it to others as being convenient and a way to save money. Low-income beneficiaries seem slightly less likely to use mail order, but those who do are satisfied.

Although plans cannot require that participants order their drugs by mail, participants often mentioned that plans had contacted them and encouraged them to use mail order, as this beneficiary described:

The plan that we're in sent us information saying that this is what you've been buying and what we're paying for, but if you consider going to this mail order firm, you could probably save...They did the math for us. So we just tried it. We have 90 days [supply and] we don't have to go to the pharmacy...You just call them up on the telephone and they say "No problem. You'll get them in a couple days." So it works great. It saves a lot of money.

Pharmacists have seen a difference in their customer base as a result of the increased use of mail order, both in Medicare and in the commercial insurance market. They note that people who were previously regular customers now come in only for antibiotics and other prescriptions where they cannot wait for mail-order delivery. Some pharmacists expressed frustration that mail order takes their customers but still creates work for them in both counseling and emergency dispensing. For example, customers will come to them when the mail order doesn't arrive, and then the pharmacist must call the insurance company before dispensing a one- or two-week or a month's supply. Furthermore, patients may still consult their local pharmacists for advice even when their prescriptions are being filled by mail.

Participants voiced concerns about rules on refilling prescriptions. There were a variety of issues related to refills that participants raised during our groups. Participants noted that it is inconvenient to refill different prescriptions at different times, but they do not have a way to put them all on the same schedule. Others want to refill prescriptions early so they do not have to worry about running out of pills, but complain that they are sometimes told it is too early to refill.

Low-income beneficiaries mentioned that on a tight budget, it can make a difference that prescriptions are only for 30 days even when a month has 31 days.

[I pay] \$1.00 for the generics and \$3.00 for the brand names. But I'm still struggling with that on my benefits each month. Especially when you take in consideration for the months they only give you 30 days when there's 31 days. So like right now I have to buy some of my prescriptions at the end of the month when I don't have any money. I have to watch out how much I spend over the month, to make sure I get it. Then the other ones I can still get at the first of the month when I get my money but that's coming close to getting into the next month before too long. That's going to be cutting it kind of hard...I wish I could [just skip those pills] but I can't skip any days or I lose my kidney and all that money, taxpayers' money that pays for my surgery goes to waste – and that was over \$200,000 for a kidney transplant.

Plan rules that limit beneficiaries to a 30-day supply at the pharmacy also posed particular problems for a participant living in a rural area:

Talking about pharmacy snags, I've got one going right now. We live 75 miles from Richmond and about 20 miles from the closest drugstores. And so the problem where I go to the pharmacy ...they say we can feed this to you in 30-day loads. And I look on the prescription and it says seven more refills or something like that...I said you mean I've got to drive 150 miles back and forth to pick up this prescription ...every 30 days and you know you can put it in a bigger bottle and we don't have to see you but four times a year.

PROGRAMS FOR LOW-INCOME BENEFICIARIES

There are several programs that aim to help low-income Medicare beneficiaries with their costs. The Medicare Savings Programs (often known as QMB, SLMB, and QI) pay for Medicare Part B premiums and in some cases other cost sharing for Medicare beneficiaries with incomes below 135 percent of the federal poverty level and limited assets.⁸ The Part D Low-Income Subsidy (LIS) is available to Medicare beneficiaries with incomes below 150 percent of the federal poverty level and limited assets. Depending on beneficiary income, the program covers most beneficiary premiums, limits beneficiary cost sharing to about \$5 per prescription (higher for “partial subsidy” enrollees), and eliminates the coverage gap.⁹ As part of the focus groups, participants were asked about their knowledge of and experience with these programs.

Some states run state pharmaceutical assistance programs (SPAPs) that provide additional help with drug costs. Maine operates an SPAP called Drugs for the Elderly (DEL), whereas neither Colorado nor Virginia operates such programs. Maine made significant changes to expand the Medicare Savings Programs so that eligibility for those programs would be more closely aligned with its SPAP. As a result, more state residents became eligible for the low-income subsidy. The changes are described in more detail in Appendix 2. We chose to conduct focus groups in Maine to study this expansion and also to ask low-income beneficiaries about the way Maine assigns them to Part D plans.

Understanding and Enrollment

Estimates suggest that half of those eligible for the low-income subsidy (excluding the dual eligibles) have not enrolled for it. Likewise, many beneficiaries who are eligible for the Medicare Savings Programs have not enrolled. Physicians and pharmacists generally do not discuss the programs with beneficiaries, both for lack of awareness and for fear of offending beneficiaries.

Physicians were generally not aware of the low-income programs. Although a few physicians were aware of these programs and knew that some of their patients had applied for them, most were not. Some physicians were very interested and wanted to know how patients would go about signing up. One recommended having forms available in physicians’ offices. Another physician did know about the low-income subsidy and Medicare savings programs and said that they

⁸ At the national level, the QMB program pays all premiums and cost sharing for beneficiaries with incomes under 100% of poverty and \$4000 in assets (\$6000 for a couple). The SLMB program pays Part B premiums (but not cost sharing) for beneficiaries with incomes up to 120% of poverty under the same asset limits; QI provides states with block grant funds to cover premiums for beneficiaries with incomes up to 135% of poverty, but funds are not guaranteed to cover all eligible beneficiaries. States may expand eligibility for these programs by disregarding some beneficiary income or assets.

⁹ “Full subsidy” enrollees are under 135% of poverty and/or enrolled in a Medicare Savings Program; they pay no deductibles, premiums, or the coverage gap. Within this group, beneficiaries enrolled in Medicaid paid \$1 for generics and \$3.10 for brands and non-dually eligible beneficiaries paid \$2.15 for generics and \$5.35 for brands in 2007. Beneficiaries between 135% and 150% of poverty receive a “partial subsidy” where they pay a sliding scale premium, a deductible, and up to 15% coinsurance, but have no coverage gap.

helped a lot of her patients. “[I see] really sick people,” she said. “It’s the downward drift of mental illness and they don’t have many assets...So it’s been great for them.”

Pharmacists were aware of the LIS, but most do not discuss it with customers.

Pharmacists are generally aware of the LIS because of the different copays involved. Several said, however, that they did not want to embarrass or offend their customers by suggesting that they might be eligible for the LIS. Local independent pharmacists were more likely to encourage their customers to apply. One pharmacist reported that he sends two to three customers a day to the Social Security office to apply for the subsidy. Another who had worked in the same neighborhood for many years has gone to people’s homes to help them complete applications. He explained,

We know ‘em all by name. And they’re family, and they know us...That’s why it’s hard, when you see somebody paying 50 and 60 and 70 dollars for a drug that they could get for 2 to 3 dollars...And usually the...customers are 85, 90, 95 years old, [they] call on the phone crying. They can’t pay for their medicine. And that’s the ones that I’ve gone by their house and [filled out the form].

There is confusion among beneficiaries about the low-income programs.

Many participants in the non-low-income focus groups were not aware that there was “extra help” available for low-income beneficiaries. In general, low-income participants knew that they had benefits, but were confused about the names of the plans or programs they were participating in. They could not always distinguish among Social Security, Medicare, Medicaid, the Medicare Savings Programs, Extra Help, or the actual drug plan. When the programs were explained, beneficiaries did have some familiarity with a program that pays the \$93.50 for the Medicare Part B premium. Some said, “I didn’t know the name of that but I do have that.” We determined LIS participants primarily by the copays they said they were paying.

Several participants described fluctuations in their eligibility status and indicated that they were confused by the changes. For example,

Well I was with [Plan X] first and then for some reason the Social Security said I was not disabled anymore and I could work. And for two months I lost my benefits and everything and then when they started up again...I thought I was going to go back to [Plan X] but it went with [Plan Y].

Another source of confusion was the transition of drug coverage from Medicaid to Part D. One participant asked why there was a need to make changes in a program that had always worked “beautifully” for her. She asked us, “Why did they do all this?”

Automatic Enrollment in Part D Plans

Beneficiaries who were deemed eligible for the low-income subsidy because they receive Medicaid or MSP benefits were automatically assigned to Part D plans if they did not enroll in a plan themselves. In Maine, the state reviewed beneficiaries’ drug use and put them in a plan that appeared to cover their drugs when possible. In most other states, beneficiaries were assigned randomly to plans with premiums below a certain benchmark. From year to year, some beneficiaries’ plan assignments were

changed automatically because of changes in plan premiums. In Maine, assignments were also changed because of changes in plan formularies.

Participants were satisfied, but sometimes confused about plan assignments. Only some of the participants were aware that they had been automatically enrolled. One woman described her attempt to choose a plan by asking her doctor and reading the literature she received, but then discovered when she went to the pharmacy that she already had been enrolled in a plan. A participant in Denver expressed confusion about her plan enrollment:

Just like the other day I went to go get my prescription ...and then they got my Medicaid and my Medicare card and said, “You’re not covered no longer. You’re with [Plan X].” I said that I didn’t know that I was switched over ...so I was trying to figure out what should I do? I’m thinking about calling back down [to the local safety net organization] and talk to them because I need that medicine...I don’t understand about Medicare and Medicaid.

In Maine, the state used beneficiary-centered assignment to match beneficiaries with Part D plans that covered the drugs they were taking. Although beneficiaries received letters informing them of the change, some did not understand the process. For example, one woman said that plans are changed “without even asking you.” One participant said she never got a letter explaining that her plan assignment had changed or that there would be a change in the medications covered under her plan. Eventually she was able to resolve her situation but she explained, “I had to go to Augusta and get nasty.” One participant said she was assigned to two different companies and one said she lost her Medicaid coverage in the course of the transition from one Part D plan to another.

Participants were reluctant to change assigned plans or unaware they could change. Some of those who were not satisfied with their plans expressed concern about “rocking the boat.” For example, participants said that “a plan is better than no plan,” and “if you start poking into it they’ll probably come up with the idea that you don’t deserve it.”

Several low-income beneficiaries said they were not aware that they could switch plans at times other than the open enrollment season in the fall. Participants also were confused about who to contact to resolve plan assignment issues, with plans telling beneficiaries to speak with the state and vice versa. One beneficiary, as described in an earlier section of this report, had problems after trying to switch plans. Six months after she had supposedly switched, the plan told her that Medicare had not approved the switch and that she was not really enrolled in the new plan even though they had been paying claims. At the time of the focus group, the problem had not been resolved.

BENEFICIARY ACCESS TO INFORMATION

Beneficiaries need information about a number of topics related to the Part D program, including how it operates, how to choose and enroll in a drug plan, how to use the plan, whether and how to apply for the low-income subsidy, and how to resolve any difficulties that may arise. Although these focus groups mostly asked about issues that arose after participants were enrolled in a plan, there was some discussion about the process of selecting plans and considering whether to switch plans. This section summarizes what we learned about information needs and information sources.

Beneficiaries need information and assistance. There was some discussion among pharmacists and physicians about how the need for information has increased among beneficiaries with the introduction of the Part D program. This includes both information related to selecting plans as well as information about how private drug plans work more generally. As one physician noted,

They may not have had to deal with HMOs when they were employed or in [a commercial plan] so this is their first exposure to stuff that is not covered. Whereas people who have been working and dealing with HMOs for a while know the difference between not covered and then covered. It's a new education process really.

Pharmacists and physicians rarely provide beneficiaries with help selecting plans. In general, it was more likely that beneficiaries described working with insurance agents, rather than with their physician or pharmacist, to select a Part D plan. Many physicians and pharmacists reported that they never helped beneficiaries choose plans, because they did not have the time or the information to help beneficiaries make a good choice. As one physician put it, “you can get in hot water if you try to help somebody based on limited information.”

Pharmacists who have tried to help customers choose plans report that the process can be frustrating. Not only are the options difficult to understand, but they do not know enough about beneficiaries' current financial situation or about what will develop. As one pharmacist noted:

You also don't know what's coming down the road. They may be just doing great without any health problems, and let's face it, we're dealing with people that are high users of drugs because of their age. All of a sudden they've got an incident and ...they're not prepared for it financially, emotionally. And certainly the way the plans are written we have a hard enough time trying to understand them ourselves, imagine the lay people.

One pharmacist reported having pharmacy students help beneficiaries enroll in Part D plans when the program began, and one physician was working in a clinic that had a social worker on staff who can help patients figure out which plan to choose. More typically, if anything, physicians may have some basic handouts on hand to give patients so that they can make choices on their own.

Help is available by phone and web, but awareness and satisfaction are mixed. Medicare offers a toll-free number, 1-800-Medicare, which beneficiaries can call for assistance. In

addition, there are extensive resources on the internet, including an interactive “plan finder” that provides personalized information about plan options.

Some physicians know about 1-800-Medicare, though there is skepticism about how useful the service is. One physician reported, however, that he is pleased to have a place to send patients for information:

I give them the number 1-800-Medicare...Usually they're grateful. I mean, there is a computer program that you can put in your drugs. It actually goes through the system and you work your way through it. They're very helpful. I told them it's not my issue. It's your money and your benefit, you figure out how to do it. But 1-800-Medicare [is available] and I write it down for them so they can see it and take it home with them.

Several beneficiaries said they had not heard of 1-800-Medicare and very few had visited the website for assistance. Beneficiaries reported that their early attempts to get information by calling 1-800-Medicare or their drug plans were frustrating. They shared stories about doing housework or crossword puzzles while they were waiting. One participant said, for example,

In the very beginning things were very confusing and I'd stay on hold forever. After many, many, many phone calls and staying on hold forever...I put my phone on speaker and then just go around and do other things while I was waiting. And sometimes still, you know my battery could run out before they'd ever get to me, and I told them how frustrated I was. They said, “We're doing the best we can...” That was back a couple of years ago.

Even when beneficiaries were able to reach someone, they often remained confused. One beneficiary told us, “I called Medicare, I don't know how many times, until I got it clear. But it really wasn't that clear...they might as well write it in Spanish.” Others complained that agents at 1-800-Medicare could not answer their questions and told them to call someone else.

Participants expressed a preference for having someone they can talk to face-to-face to answer their questions. One said, “You'll be calling all day, press 5, press this. Wouldn't you love to make a phone call and hear a voice on the other end sometime?” Several pharmacists were concerned that beneficiaries are confused by automated phone systems. To illustrate her point, one said a beneficiary that had been unable to get through the pharmacy's automated system said, “That lady on the phone wouldn't let me talk to [the pharmacist]!”

Community resources are available for counseling, but few are aware of them. All states have State Health Insurance Assistance Programs (SHIPs), usually within the Area Agencies on Aging, which provide in-person counseling for Medicare beneficiaries. In addition, numerous other organizations have counselors and advocates who can assist beneficiaries. For example, a few physicians mentioned that they refer patients to counselors at local hospitals. However, awareness of these programs was low.

When pharmacists discussed the need for beneficiary assistance they agreed that it would be helpful if there were “...an office that does nothing but help..., not a 1-800 number..., [but] a local office where somebody can sit down with them and talk to them.” Neither pharmacists nor physicians were familiar with the Area Agencies on Aging or with the SHIPs, which serve this function. Some

said it would be helpful to have caseworkers who can work with beneficiaries as they do for the Medicaid program. Another pharmacist suggested that the local Social Security office could provide a venue for in-person assistance.

Low-income participants in one state who had some connection to the Medicaid program or other state services noted that they had more success when they visited the state offices and asked for help than when they tried to get assistance by telephone. One participant reported that the advocate she worked with through the Department of Mental Health was particularly helpful. One participant said she tried Legal Services for the Elderly “but they weren’t interested [in my case]” and were already overwhelmed. Most were not aware that the local Area Agency on Aging could provide assistance, though one woman had tried the agency and said she didn’t get the help she needed.

Participants are concerned about information for nursing home residents. Physicians and pharmacists were aware that nursing home residents may face additional challenges in understanding the Part D program. Because of high rates of dementia, for example, participants were concerned nursing home patients may not understand or remember the information they receive.

MEDICARE ADVANTAGE AND SUPPLEMENTAL INSURANCE

There is some confusion among beneficiaries about the combination of coverage options they have. Different beneficiaries have different ways of understanding options such as Medicare Advantage, Medigap, and Part D, without necessarily using the vocabulary of the Medicare program. When beneficiaries in our focus groups were asked, for example, if they were enrolled in MA plans, only a few were familiar with the term. When we described a plan option that allowed beneficiaries to switch to a private plan that would cover all of their Medicare services, a few more were familiar with the concept. In the course of a conversation, even after going over these two ways of talking about managed care options, it sometimes came out that a beneficiary was enrolled in a MA plan without having recognized what we had asked about earlier. Likewise, we sometimes figured out during a focus group that a beneficiary appeared to have kept their Medigap drug coverage rather than enrolling in Part D, despite our attempts to recruit only Part D enrollees in the focus groups. This section describes in more detail some of the specific experiences that participants reported with MA or Medigap plans.

Medicare Advantage

A few respondents in Richmond and Portland had signed up for Medicare Advantage plans. MA enrollment was more common in Denver, where a higher proportion of the Medicare population is enrolled in these plans.

Among those who signed up for MA plans, some were satisfied. One relatively healthy participant said that she thought she was paying a good price for the benefits she gets. Others said they appreciated extra benefits provided by the plans.

Several beneficiaries learned after signing up that their doctors were not covered. A number of participants indicated that they did not realize when they signed up with an MA plan that they would no longer have coverage for services provided by the doctors they have been seeing regularly. One man said, for example,

I'm having a problem. It doesn't have to do with ...prescriptions but it's a case where a doctor that I've been going to for years and years and years and when I signed up with [Plan A] it took effect January 1. [On] January 8 I had an appointment. They accepted the copay. Everything was fine. And then I had another one on July 2, and the gal informs me I'm not covered by insurance. And I'm going in for a major procedure.

Other beneficiaries had similar experiences: "It sounded like a really good deal and then I found out that none of my doctors would take it."

One physician explained how both patients and physicians are affected:

We spend most of the time explaining to patients that we're not participating. They've been signed up and didn't know they were signed up. We explain to them that we're not taking

your insurance...We have big signs in our office that we do not participate in any Medicare Advantage plans and don't plan to in the future...Most all of them are irritated that they signed up because they didn't know that we weren't [participating]. A few of them are sucked into it and have a year commitment and then they come back to see us.

In every group, participants described aggressive marketing practices by MA plans.

Our protocol did not include specific questions on the marketing of MA plans, but in each group beneficiaries volunteered their experiences. Two of the low-income beneficiaries we spoke with in one community reported very aggressive marketing from MA plans. One woman received several visits from an insurance agent who said he was from Medicare; she was upset that he appeared to know a great deal about her medical history. She concluded that he had lied to her and felt “bamboozled” by the experience. Another went to what she thought was an informational meeting and the plan signed her up for coverage. As she described it,

They were having this meeting on this new health care program...I went to the orientation and the next thing I know, we signed a paper when I went in. And I thought it was just that I was there...So I put down my name and address. The next thing I knew I got a card from them that I was a member. Of course I got right on the old phone and I was very mad. And they said, “Well, you're signed up and now you going to have to stay with us.” I don't have to do no such thing...I said I was bulldozed right into this...Meanwhile they had shut off my medications, I found out when I went to get my prescriptions filled...The pharmacist said, “Wait a minute. What's going on?” I said, “That's what I'd like to know.” She said, “It's been erased from the computer.” They erased it completely. And they had notified [Plan X] that I had gone on with them.

Pharmacists in another community also told about marketing abuses.

[The agent] took a lady that couldn't speak English and enrolled her into a plan and already sent her mail order. [Then she asked,] “Well you can't deliver my meds?” It's like, “No. You've got to fill it at this mail order pharmacy.” And [she said] “But I didn't know that.”

I had a lady with Alzheimer's. And she was on the phone talking to a lady. A guy forces his way in through her front door and won't leave until she signs the paper cancelling her Medicare...So if she fell down and broke her leg...the hospital wouldn't even take her, because her Medicare would have been cancelled, and the other hadn't taken effect yet.¹⁰

I've had this one lady. She's been switched like three times, back and forth and back and forth. And I'm like, don't let her talk on the phone, for God's sake.

Some beneficiaries have experienced gaps in coverage from changing plans.

Beneficiaries said that when they responded positively to a marketing appeal, it sometimes took some time to get their enrollment status straightened out.

¹⁰ In reality, the beneficiary's enrollment in traditional Medicare would remain in place through the end of the month and an admission to an out-of-network hospital should still be paid even if the person stayed in the hospital after the new month began. Services received from non-network physicians after the first of the month could be a problem, however.

When I first got [Plan X], I kept it for awhile and this [Plan Y] salesman come around. And he told me I could get [Plan Y]. It would be half the copayment [Plan X] was. It would be cheaper and told me to sign up. I said, well, I'll try anything. And not having good enough sense about it, I told him okay and we signed up for [Plan Y]. And then – in March I think – I got a thing from [Plan X] that said they dropped me. And then I called the guy who sold me the insurance for [Plan Y] and he ain't got no record of it.

You know I had a terrible time...I had some young lady that was not a good salesman. She goofed me up [by trying to switch me from Plan Z's Part D plan to its Medicare Advantage plan]. I almost ended up not having Medicare or [Plan Z's drug plan] and one day she told me I had to call Washington for that. So I got up [early] to [call] Washington by 8:00. I finally ... said I'm going to go back to Medicare and [Plan Z's drug plan]. It was just the salesgirl I think.

Pharmacists described their frustration trying to determine the plan in which a beneficiary is enrolled, especially in situations where he or she was changing plans.

PHARMACIST 1: The letter said, "If you have this letter, you should be able to fill your prescription on XYZ date." I had to read that paragraph to this lady [at the plan]. "Well he's not in our system." "How did you generate this letter?" ... "Well if you have a problem, you can file a complaint." Do you know how long that is you have to be on that phone to file a complaint? No. I'm sorry....

PHARMACIST 2: You call them up and they say they don't know anything. They ...can't help a person...The insurance company will tell you that you have to call [Medicare]. But then you call them, and you get in a loop. You go back and forth.

The pharmacists report that this confusion has been ongoing, as Medicare Advantage plans have continued their marketing.

Supplemental Insurance

Some Medigap policies issued before 2006 included prescription drug coverage. Standardized Medigap plans H, I, and J all had a \$250 deductible for the drug benefit and required 50 percent coinsurance. The H and I plans had a cap on drug benefits of \$1,250 while the J plan capped the benefit at \$3,000. Beneficiaries were allowed to drop that drug coverage and select a Part D plan, or to keep their old plan. Part D should be a better deal for beneficiaries, because it includes a government subsidy and has lower cost sharing.

In screening for our focus groups, we sought to include only beneficiaries who had enrolled in Part D. Upon further discussion, however, it became clear that one or two had kept their Medigap policies instead of enrolling in Part D.

Some believe it is better to keep Medigap drug coverage. People who kept their Medigap plans believe that their Medigap benefit is better than the Part D benefit, or they are reluctant to change their plan because it is working for them. One participant who kept her Medigap plan said that she continues because her plan pays for a very expensive medication that she uses and because:

I don't trust this business. I don't like the donut hole. I don't like the drug companies writing these programs when it could have been avoided. I have what I've always had.

A few physicians also shared the impression that Part D coverage is inferior to Medigap plans that covered drugs.

APPENDIX 1. PARTICIPANT ATTRIBUTES

Beneficiary Attributes: Plans represented, as reported by the participants

	Richmond Non-Rural, Non-Low-Income	Richmond Rural	Richmond Low-Income	Portland Non-Low-Income	Portland Low-Income (1)	Portland Low-Income (2)	Denver Non-Low-Income	Denver Low-Income
PDPs								
AARP	3	1	1	6		1	2	1
Humana		6	2				1	1
Anthem BC/BS	3	1	1	1		1		
Community Care			2					3
Cigna					3			
CVS	1							
First Health Premier					1			
Health Net Orange								1
Rx America						1		
United				1				
Anthem 2006/AARP 2007	1			1				
Humana 2006/BCBS 2007		1						
Don't Know/Unclear			6			1		1
MA-PDs								
Kaiser Permanente							3	
Secure Horizons							3	
Humana	1	1						
Pyramid		1						
Rocky Mountain HMO							1	
Denver Health Choice								1
Access Advantage								1
Other								
Kept Medigap				1				
In the process of picking	1							
Retiree insurance				1			1	
Retiree transferring to Medicaid								1
TOTAL	10	11	12	11	4	4	11	10

Physician Attributes: Specialty and Practice Type

	Richmond	Portland	Denver
By Specialty			
Family practice	5		5
Internal medicine	3	1	2
Nephrology	1		
Cardiology	1		1
Pulmonology	1		1
Geriatrics		1	1
Psychology			2
TOTAL	11	2	12
By Practice Type			
Solo practice	3	1	6
Small group	4		3
Large group	2		2
Clinic			1
Nursing homes		1	
Hospitals	1		
University Group	1		
TOTAL	11	2	12

Pharmacist Attributes: Pharmacy Type

	Richmond	Denver
By Pharmacy Type		
Grocery	1	6
Independent Drugstore	3	3
Discount Store		1
Drug Store Chain	2	1
TOTAL	6	11

APPENDIX 2: MSP PROGRAM EXPANSION IN MAINE

Background

The Medicare Savings Programs (MSP) comprise the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individuals (QI) programs. Under these programs, low-income beneficiaries receive assistance with Medicare premiums and cost sharing for Medicare Parts A and B. In addition, beneficiaries eligible for these programs are also deemed eligible for the low-income subsidy (LIS) under Part D, whether or not they would otherwise meet the requirements for that extra help.¹¹

In 2007, Maine broadened the Medicare Savings Programs' eligibility criteria. A new policy to disregard all assets – effectively eliminating the asset test for the programs – went into effect on January 1, 2007. Higher income eligibility limits for the Medicare Savings Programs became effective in April 2007. The new limits are as follows:

	Federal Income Limit (% of federal poverty level)	Maine Income Limit (% of federal poverty level)
QMB	100	150
SLMB	120	170
QI	135	185

The QI income eligibility limit was set at a level corresponding to the income limits for Maine's State Pharmacy Assistance Program, called the Low Cost Drugs for the Elderly and Disabled Program (DEL). With the new eligibility rules in effect, the state deemed all DEL enrollees eligible for the Medicare Savings Programs and the Part D LIS. Officials in Maine reasoned that some savings could be achieved on the part of the state as larger numbers of individuals enrolled in the DEL program became eligible for the LIS. The anticipated savings could then be used to provide wraparound benefits for DEL enrollees.

Interviews with Maine Stakeholders

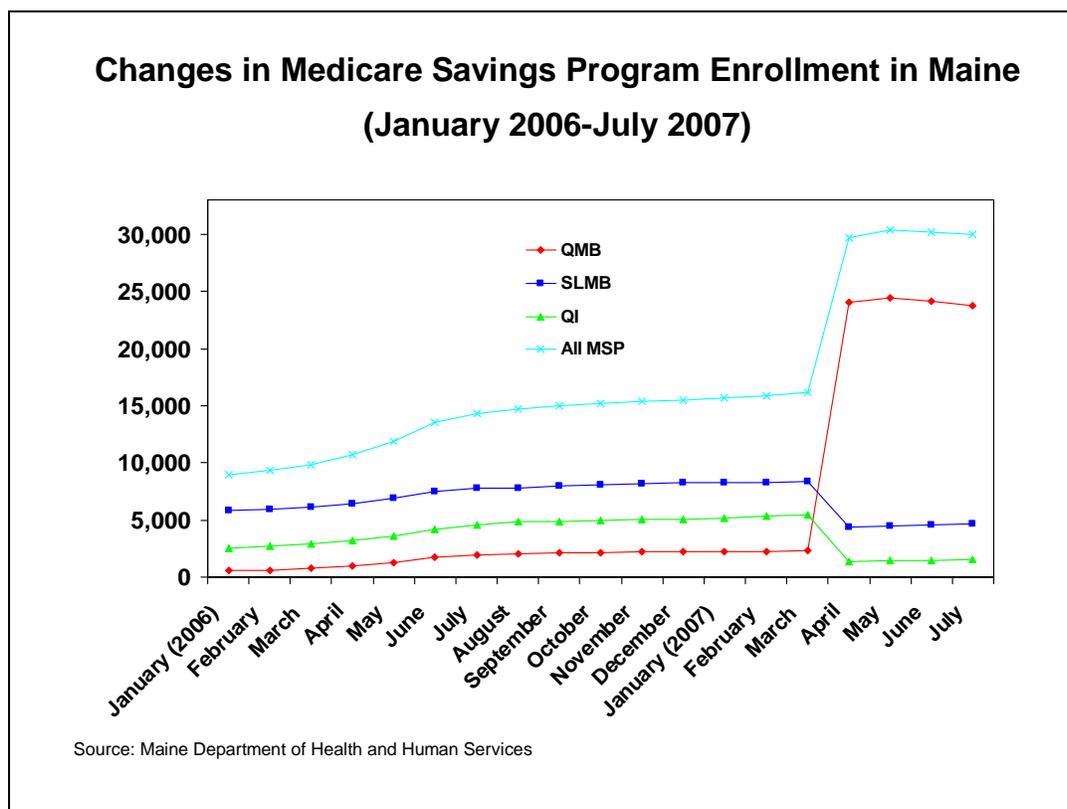
In the summer of 2007, researchers from Georgetown University's Health Policy Institute and NORC at the University of Chicago conducted interviews with a variety of stakeholders in the state of Maine including state officials involved with DEL, the state pharmacy assistance program, and MaineCare, the state Medicaid program. We also spoke with beneficiary counselors from Area Agencies on Aging, Legal Services for the Elderly, and Alpha One, an organization that works with individuals with disabilities.

¹¹ Medicare beneficiaries can qualify for the Part D low-income subsidy in two ways: they can apply independently through the Social Security Administration (beneficiaries with incomes as high as 150 percent of the federal poverty level and assets as high as \$11,710 for an individual or \$23,410 for a couple, including an allowance for funeral or burial expenses) or they can be deemed eligible for the subsidy based on their eligibility for Medicaid or the Medicare Savings Programs.

Program Participation

As anticipated, enrollment in the Medicare Savings Programs increased substantially – from almost 9,000 enrollees in January 2006 to more than 30,000 in July 2007. The largest increase occurred in April 2007 when the new income limits went into effect and the state deemed DEL enrollees eligible for the Medicare Savings Programs. Approximately 13,500 beneficiaries were added to the MSP rolls that month.

Within the Medicare Savings Programs a dramatic shift occurred as SLMB and QI enrollees became eligible for the QMB program. Prior to the change, the majority of MSP participants were enrolled as SLMBs or QIs, whereas after the change QMBs became by far the largest subgroup of MSP participants. The fact that the new income eligibility limit of 150 percent of the federal poverty line for the QMB program is higher than the former highest limit for both the SLMB and QI programs meant that all previous MSP participants became QMB participants (see Figure below).¹² The SLMB and QI programs each had fewer than 5,000 new enrollees in the first few months after the change.



Financial Implications

With the shift of so many enrollees to the QMB program, a substantial portion of the cost of providing drugs under the DEL program is now covered by the federal government. This leaves

¹² CMS required that the increase for all MSP categories be equal in value. Therefore, in order to increase the former QI limit to 185 percent of the federal poverty level to match the DEL income limits, limits for the other Medicare Savings Programs also had to increase by 50 percent.

state funds available, which can be redirected to provide wraparound benefits for DEL enrollees. At the same time, however, the shift to the QMB program meant that the state Medicaid program took on a significant new financial responsibility. The state must now pay a portion of Medicare premiums for about 4,000 enrollees whose status changed from QI to QMB.¹³ In addition, the QMB program covers Medicare deductibles and cost-sharing as well as premiums.

Figures are not yet available for the cost of this change in terms of new Medicaid spending. Spending for premiums and deductibles is fairly predictable. The outstanding question is how costly payments for Medicare services for the new QMBs will be and thus how much the state would pay for cost sharing for those services. The anticipation is that the cost will be modest, and lower than the savings to the DEL program.

The eligibility change may also have an impact on providers in Maine. Medicaid payment rates generally are lower than 80 percent of Medicare rates in Maine. Thus the Medicaid rate prevails and is considered full payment for providers. Providers will see reduced revenues on behalf of these patients, but they are not allowed to bill the patients for the difference.

Reaching and Enrolling MSP Beneficiaries

MSP enrollment also increased for reasons other than the deeming of DEL enrollees. There is general agreement among state officials, counselors, and advocates that the publicity surrounding the Part D program and the efforts to reach and enroll beneficiaries in the Part D Low-Income Subsidy led to increased enrollment in the Medicare Savings Programs. They note that people do not know what the Medicare Savings Programs are called, but now they know about the programs owing in great part to publicity related to Part D. The state has a strong tradition of collaboration among state agencies and community organizations that work with the elderly and individuals with disabilities so there was a concerted effort to publicize other programs for low-income Medicare beneficiaries along with the Part D LIS.

People's pride and a wariness of government programs have been barriers to program participation in Maine. Thus, outreach messages for the LIS and the Medicare Savings Programs presented them as providing opportunities to save money, rather than as a source of help. Counselors note that as more people participate, the programs become more accepted in the community. They also say that based on two different experiences, mailings about the Medicare Savings Programs were more effective when there was a local number for people to call.

Counselors did express some concern about the diminishing resources available for outreach and assistance after the Part D program's first year. They noted that when Medicare Part D began they had federal funding for outreach, but much less funding is available now. The Part D specialist position established at each Area Agency on Aging was funded initially by a grant and now is supported by state funds. They emphasized that because the Part D program is complicated, there is a need to provide training on an ongoing basis. There are frequent staff turnovers. Also, new people have disabilities and new people are aging all the time.

¹³ As with other Medicaid services, QMB and SLMB benefits are financed by state and matching federal funds. The QI program is federally funded.

The sense among officials, counselors, and advocates is that individuals who do not know about the program are those who are most isolated. They may be homebound or live in the most rural areas. In addition, participation among the newly disabled as well as individuals with mental health problems or cognitive disabilities is thought by some to be low. There is a perception that drugs available through DEL and Part D formularies are more oriented to the elderly and people with chronic physical conditions, than to people who need psychiatric drugs or pain medication and this may contribute to low participation rates among some groups as well.

The same application is used for all programs in Maine. This creates two barriers to enrollment in MSP. First, among the older population, concerns about estate recovery are common. Although individuals who participate in the Medicare Savings Programs are not subject to estate recovery (as they are if they participate in the full Medicaid program), the shared application includes language about estate recovery. Therefore, counselors say they spend a great deal of time explaining that estate recovery rules do not apply to the Medicare Savings Programs.

Second, the shared application requires information about assets, even though they are no longer counted in determining MSP eligibility. Two reasons were articulated for this practice. First, there is a concern that if information on assets is not collected, interest income from assets may not be reported. Second, the prevailing practice is that eligibility checks for every program are done for each application. Asset information is needed for that purpose. With the change in eligibility rules, however, the option of completing a separate MSP application that does not ask about assets and explains that estate recovery is not associated with the Medicare Savings Programs might help increase enrollment among certain groups.

Counselors also report that although applications are fairly straightforward, their clients still have difficulty completing them. Beneficiaries may face a variety of problems, from eyesight to limited literacy to cognitive disabilities, that present challenges in applying for the programs.

Finally, enrollment may be affected by the annual eligibility review required for the Medicare Savings Programs. Counselors report that they commonly help beneficiaries re-enroll in the programs because they have failed to respond to the letters they receive regarding their eligibility reviews. Beneficiaries find the letters confusing and do not realize that they have to return them in order to keep their benefits. A recent small decline in MSP enrollment may reflect difficulties related to the review process.

Administrative Issues

Many administrative challenges accompanied the MSP expansion. Beneficiaries had to contend with changes in the state DEL program, the Medicare Part D program and LIS, and the Medicare Savings Programs at the same time, so some confusion was expected. Some beneficiaries did not understand how or why they were receiving new benefits. The state made efforts to contact all of the individuals affected. They noted that sending out a notice to 22,000 people telling them about a benefit they had not heard of generates a lot of phone calls. Area Agencies on Aging report that they heard from many people who were confused, but once they understood they were happy with the new benefit. Several counselors suggested that computer-generated letters could be revised to be more user-friendly.

The state also contacted all of the drug plans directly to inform them of the change in enrollees' status as so many were converted to QMB status. The primary concern was to be sure that enrollees would be charged the correct copayment amounts after their change in status.

Changes in program structure were also accompanied by changes in the way provider payments are processed. State officials spoke about "growing pains" as the new procedures are put in place. But there is agreement that the MSP expansion was "the right thing to do."