NC Rural Health Research & Policy Analysis Center

Medicare Beneficiaries' Access to Pharmacy Services in Small Rural Towns: Implications of Contracting Patterns of Sole Community Pharmacies with Part D Plans

Final Report No. 95

January, 2009

725 Martin Luther King Jr. Blvd. CB 7590
The University of North Carolina at Chapel Hill
Chapel Hill, NC 27599-7590

RHRC
Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

WWW.SHEPSCENTER.UNC.EDU/RESEARCH_PROGRAMS/RURAL_PROGRAM/

Medicare Beneficiaries' Access to Pharmacy Services in Small Rural Towns: Implications of Contracting Patterns of Sole Community Pharmacies with Part D Plans

Final Report No. 95

Victoria A Freeman, RN, DrPH

Indira Richardson, MPA

Rebecca T. Slifkin, PhD

This project was funded by the federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services through cooperative agreement #5-U1CRH03714-04-00.
The authors thank Laurel Humble, Kristin Hartley and Michael Hamon for their help in the production of this report.

Executive Summary

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made significant changes to the Medicare system, including the introduction on January 1, 2006, of the Medicare Part D Drug Plan (Part D). This plan allows Medicare's 44 million elderly and disabled beneficiaries to join a private Prescription Drug Plan (PDP) or join a Medicare Advantage Plan that provides supplemental health insurance with a prescription drug benefit.[1] Under the Part D program, multiple competing PDPs serve any given area. Beneficiaries can choose a plan in which to enroll. This choice affects not only the insurance costs and benefits, but also the pharmacies that beneficiaries can use in order to have their prescription purchase covered by the PDP, as pharmacies must decide with which of the many available PDPs they will contract.

While Medicare Part D provides the means to pay for prescription drugs, ensuring access to prescriptions for beneficiaries also depends on having an accessible participating pharmacy. In small rural towns that are served by only a single retail pharmacy, beneficiary access to prescription services and associated counseling services depends on whether or not that pharmacy contracts with the enrollee's PDP. This final report describes the contracting patterns of sole rural community pharmacies, to assess the extent to which each pharmacy contracts with the most commonly used PDPs available in their state. The analysis provides a picture of the PDP enrollment choices available to both groups of Part D enrollees, regular Medicare beneficiaries and those who are eligible for a low income subsidy (hereafter referred to as LIS), which includes individuals dually eligible for Medicare and Medicaid.

PDP participation rates were examined for all rural sole community pharmacies in 16 states chosen to provide geographic representation for the country. For each of the 670 sole community pharmacies identified, a select group of PDPs representing a combined enrollment of at least 75% of each state's Part D enrollees was examined to determine if the rural sole community pharmacies accepted these plans. In those cases where the sole pharmacy did not contract with all plans, road miles to the next closest retail outlet were calculated to assess the minimum distance a beneficiary who was enrolled in a plan with which their local pharmacy did not participate would have to travel in order to have a prescription paid for by their PDP.

Findings from this study indicate that overall, pharmacy participation in Part D PDPs was good, with an average participation rate for pharmacies of 82.1% and a median participation rate of 88.9%. However, almost three-quarters of pharmacies did not participate in at least one plan. For those beneficiaries who enroll in a plan with which their community pharmacy does not participate, travel distances to the nearest town with a pharmacy varied. For half of the pharmacies with less than 100% participation, the nearest pharmacy was less than 10 miles away. For 77 pharmacies (16%) not participating in all plans, the nearest pharmacy was more than 20 miles away.

These analyses raise important considerations for rural residents selecting a Part D plan for their chronic and acute medication needs. Because participation in plans by sole community pharmacies is not universal, both regular and LIS Medicare beneficiaries are at risk for selecting or being assigned to a plan with which their local retail pharmacy does not participate. For LIS

beneficiaries this may represent a temporary disruption, as they can change plans throughout the year. However, lack of access to critical medications while the change in insurance plans is being processed is a serious concern for this population. For regular Medicare beneficiaries, selection of the "wrong" plan, in terms of participation of their local pharmacy, has longer term consequences, as these beneficiaries must wait a year before changing to a plan accepted by their local pharmacy.

Rural Part D enrollees are less likely to have had insurance that covered prescription medication before the availability of the Part D program and may be unfamiliar with the decisions that must be made for participation in a Part D plan. Enrollment in Part D is not simple, as enrollees must consider the cost of plans, benefits provided, and whether any medications they use are covered. Whether or not their local pharmacy participates in a plan being considered may be the last issue beneficiaries contemplate or, in the case of persons unfamiliar with insurance restrictions, may not be considered at all. Clear instructions on Part D enrollment websites and forms that inform the enrollee of the requirement that they use only certain pharmacies are essential. Additionally, it is important that advocates who work with Medicare beneficiaries make those they counsel aware of all of the aspects of plan choice they must consider and the access implications of those choices. Part D is an extremely important addition to Medicare, and has been examined and debated by policy makers, researchers, advocates, and citizens since its inception. Ongoing fine-tuning of the program is necessary in order to provide the best prescription drug coverage for rural Americans as possible.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made significant changes to the Medicare system. A key change was the introduction, on January 1, 2006, of the Medicare Part D Drug Plan (Part D). This plan allows Medicare's 44 million elderly and disabled beneficiaries to join a private Prescription Drug Plan (PDP) or join a Medicare Advantage Plan (MAP) that provides supplemental health insurance with a prescription drug benefit.[1] Under the Part D program, multiple competing PDPs serve any given area. Beneficiaries can choose a plan in which to enroll. This choice affects not only the insurance costs and benefits, but also the pharmacy or pharmacies that beneficiaries can use in order to have their prescription purchase covered by the PDP, as pharmacies must decide with which of the many PDPs available in their area they will contract.

While Medicare Part D provides the means to pay for prescription drugs, ensuring access to prescriptions for the elderly and disabled also depends on having an accessible participating pharmacy. Although many PDPs offer prescriptions by mail order, which can provide access to maintenance medications, a physical retail outlet is necessary for medications for acute health problems and also for in-person advice and counseling. In urban areas and in many larger rural towns, access to a participating pharmacy is not a concern as there are multiple retail pharmacies and the likelihood that at least one will contract with an individual's PDP is high. For the elderly with multiple medications, however, loss of clinical continuity of care might occur if it is necessary to switch from a long-time provider. In small rural towns that are served by only a single retail pharmacy, beneficiary access to prescription services and associated counseling services depends on whether or not that pharmacy contracts with the enrollee's PDP.

In 2007, there were 2,019 pharmacies in the United States listed as the sole pharmacies in their community. Furthermore, 1,044 of those sole community pharmacies were located at least 10 miles from the next nearest pharmacy.[2] Many rural sole community pharmacies are independently owned, which can effect the number of PDPs with which these pharmacies participate. In a study conducted by the Office of the Inspector General (OIG) in 2007 it was determined that only forty-four percent (44%) of independent pharmacies contract with every PDP available in their region compared to eighty-four percent (84%) of chain pharmacies.[3] The reasons why certain sole community independent pharmacies do not contract with all available PDPs vary. In telephone interviews from two separate studies, pharmacist-owners at independent sole community pharmacies noted that low reimbursement rates, difficulty working with plans, slow processing of payments, and changes in contract terms were the main reasons why they did not contract with certain PDPs.[4,5]

This final report describes the contracting patterns of sole rural community pharmacies, to assess the extent to which each pharmacy contracts with the most commonly used PDPs available in their state. Examination of contracting patterns of these essential pharmacies provides a picture of the PDP enrollment choices available to Medicare beneficiaries who depend on local pharmacies. In those cases where the sole pharmacy does not contract with all plans, road miles to the next closest retail outlet were calculated to assess the minimum distance a beneficiary who was enrolled in a plan with which their local pharmacy did not participate would have to travel in order to have a prescription paid for by their PDP.

This study provides a picture of overall Part D pharmacy service availability in small rural towns. The implications of residing in an area served by a single pharmacy that does not contract with all PDPs differ for the two distinct groups of Part D enrollees, regular Medicare beneficiaries and those who are eligible for a low income subsidy (hereafter referred to as LIS), which includes individuals dually eligible for Medicare and Medicaid. When regular Medicare beneficiaries choose their plan, they may or may not be aware of the need to verify that their local pharmacy contracts with the PDP they choose. If an individual inadvertently chooses a plan with which their pharmacy does not contract, they must wait a full year until they are allowed to switch to another PDP. In the meantime, the beneficiary cannot use their Part D insurance at their local pharmacy and must seek pharmacy services at another location. Medicare LIS beneficiaries may be auto-assigned to a PDP (described in detail in the Appendix), and therefore could be assigned to a plan that their local pharmacy does not take. These individuals can change plans throughout the year, and so can switch to a plan with which their local pharmacy contracts. Still, they may not discover that their pharmacy does not participate in their plan until they attempt to fill a prescription, resulting in a delay in receiving needed medication. Further, because of the program design, LIS beneficiaries can be auto-assigned to a new PDP as frequently as once a year.

Additional details about aspects of the Part D program relevant to this study can be found in the Appendix. Areas covered include the enrollment process, LIS beneficiary reassignment, and recent regulations.

Methodology

PDP participation rates were examined for all rural sole community pharmacies in 16 states. For each sole community pharmacy identified in study states, a selected group of PDPs was searched to determine if the rural sole community pharmacies accepted these plans.

Creating a Sole Community Pharmacy Database

A pharmacy database was created from state Board of Pharmacy lists of licensed pharmacies in 16 states.[*] The states were chosen to provide geographic diversity in the pharmacy sample. The sample was restricted to only rural pharmacies, defined as those located in a nonmetropolitan county or in a metropolitan county with a rural urban commuting area (RUCA) code of four or higher. The sample was further restricted to only retail pharmacies, including compounding pharmacies, and to those pharmacies that were the only pharmacy listed for their town name. Retailers providing only durable medical equipment were also excluded. The final file consisted of 670 sole community pharmacies across the 16 states with the number of pharmacies per state ranging from three to 120.

[*] States selected included Alabama, Alaska, Arizona, Arkansas, Florida, Illinois, Maine, Nebraska, Nevada, North Carolina, North Dakota, Pennsylvania, Texas, Vermont, Washington, and Wyoming

Linking Pharmacies to Prescription Drug Plans

Enrollment information for PDPs in each study state was obtained from the Centers for Medicare and Medicaid Services website and included data as of August 2007.[6] Only plans that were considered to be available to the general public including LIS beneficiaries were included; employer-based PDPs were excluded. On average, study states had enrollees in an average of 30 plans with the number of plans per state ranging from 18 to 49. Forty-one (41) PDPs with unique contract identification numbers were searched for the 16 states as a group.

To determine participation of individual sole community pharmacies in PDPs with enrollees in their state, we searched the internet-based pharmacy locators available at the websites of the individual PDPs, mimicking the process that a potential Part D enrollee might use to determine if a pharmacy in their town participated in a PDP. This process was labor intensive and to reduce the amount of time required while obtaining the most valuable data possible, only selected PDPs were searched for each state based on the number of enrollees and the availability of a pharmacy locator function at the PDP website. Using these criteria, we determined pharmacy participation in plans that had a combined enrollment of at least 75% of each state's Part D enrollees. Enrollment in most states appears to be concentrated in a subset of available plans: to reach the 75% threshold, on average only 38% of plans offering coverage in a state were searched (range 18-78%). Pharmacy participation was searched for an average of 10 plans for each state. Searches using PDP pharmacy locators took place in 2007 and 2008.

Identifying Next-Closest Pharmacy

Using a national database of pharmacies (National Council for Prescription Drug Programs, 2006, Pharmacy Database Files Standard, Version 2.1), the driving distance to the next closest pharmacy was calculated for each pharmacy in the sample. These data were used to determine the burden of travel for those persons whose local pharmacy did not participate in all of the plans that were examined. The sole community pharmacies and neighboring pharmacies were assigned latitudes and longitudes based on street addresses with MapMarker Plus geocoding software. Of all of the pharmacies, 85% geocoded to street level, 5.6% geocoded to ZIP centroid, and the remainder to qualities in between. Scripts for the ESRI ArcGIS software's network functions were written to determine the nearest driving-distance neighbor for each sole community pharmacy.

Results

Participation in PDPs for sole community pharmacies in the aggregate was examined (Table 1).

Table 1:	Sole Community Pharmacy Participation* in Prescription Drug Plans for All Pharmacies Combined (N=670)	
Average participation for individual pharmacies		82.1%
Median participation for individual pharmacies		88.9%
Range of participation for individual pharmacies		0 – 100%
Number and % of pharmacies that participate in:		
0 plans	3 pharmacies	0.4%
1-25% of plans	16 pharmacies	2.4%
26-50% of plans	34 pharmacies	5.1%
51-75% of plans	115 pharmacies	17.2%
76-99% of plans	322 pharmacies	48.1%
All plans	180 pharmacies	26.9%

*Includes participation in plans with a combined enrollment of at least 75% of a state's Part D beneficiaries, an average of 10 plans per state.

On average, sole community pharmacies contracted with 82.1% of PDPs, but the median participation rate was higher at 88.9%. Almost three-quarters (73.1%) did not contract with all plans, although the number that contracted with less than three-quarters of the plans was relatively small (n=168, 25.1%).

Participation in PDPs by sole community pharmacies varied by state (Table 2). The state-level mean participation rate ranged from a high of 90% to a low of 43%.

Table 2: Sole Community Pharmacy Participation* in Prescription Drug Plans for All Pharmacies Combined by State (N=16)

	Mean	Median	Range
Illinois	90.0%	100.0%	(40-100%)
Wyoming	90.0%	90.0%	(60-100%)
Arkansas	88.9%	88.9%	(33-100%)
Maine	88.9%	100.0%	(11-100%
Nebraska	88.9%	88.9%	(11-100%
Pennsylvania	84.6%	92.3%	(31-100%
North Carolina	81.8%	81.8%	(45-100%)
Texas	81.8%	90.9%	(9-100%)
Vermont	80.0%	90.0%	(50-100%)
Wisconsin	80.0%	100.0%	(10-100%)
Florida	77.8%	88.9%	(22-100%)
Washington	77.8%	88.9%	(0-100%)
Alabama	72.7%	81.8%	(0-100%)
Arizona	72.7%	81.8%	(9-100%)
Nevada	63.6%	81.8%	(27-100%)
North Dakota	57.1%	64.3%	(0-100%)
Alaska	42.9%	42.9%	(29-57%)

*Includes participation in plans with a combined enrollment of at least 75% of a state's Part D beneficiaries, an average of 10 plans per state.

When sole community pharmacies participate with all PDPs, Medicare beneficiaries can choose between competing plans based on costs and benefits. There are several consequences of sole community pharmacies not participating with all plans. Beneficiaries who choose their own plan knowing that not all pharmacies contract with all plans may limit their choice to those plans with which their local pharmacy contracts, possibly choosing a plan with less than optimal benefits. However, beneficiaries who choose their own plans without that knowledge may inadvertently choose a plan with which their local pharmacy does not contract, forcing them to travel to another community to received covered services. LIS beneficiaries who are auto-assigned to a plan might be assigned to one without a participating pharmacy in their community, forcing them to travel to another community for services as well. However, LIS beneficiaries have the ability to change plans throughout the year and would face disruption in pharmacy services only while the change of plans is being processed. To assess the impact of less than full pharmacy participation, the distance to the next-closest pharmacy was calculated for the 490 sole community pharmacies that did not contract with 100% of PDPs (Table 3).

Table 3: Distance to Closest Pharmacy for Pharmacies Not Participating in 100% of Plans*

	% (n) of Pharmacies where Closest Pharmacy is:					
	<10 miles away		10-20 miles away		>20 miles away	
Level of participation:						
0 plans	33%	(1)	33%	(1)	33%	(1)
0-25% of plans	19%	(3)	44%	(7)	38%	(6)
26-50% of plans	32%	(11)	29%	(10)	38%	(13)
51-75% of plans	49%	(56)	36%	(41)	16%	(18)
76-99% of plans	55%	(176)	33%	(107)	12%	(39)
Total	50%	(247)	34%	(166)	16%	(77)

*Includes participation in plans with a combined enrollment of at least 75% of a state's Part D beneficiaries, an average of 10 plans per state.

For half of the rural communities where the sole local pharmacy does not contract with all available PDPs, the next-closest pharmacy is less than 10 miles away. There were very few places where a beneficiary would have to travel more than 20 miles to access another pharmacy. However, it does appear that in communities that are more remote (i.e. the distance to the next closest pharmacy is far), pharmacies are more restrictive about the PDPs with which they will contract, limiting beneficiary choice.

Discussion

Sole community pharmacy participation in Part D plans was assessed for 16 states, selected to provide geographic representation for the country as a whole. For the combined 16 states, participation in Part D PDPs was good, with an average participation rate for pharmacies of 82.1% of plans serving their state that were searched and a median participation rate of 88.9%. Over one-quarter of pharmacies (26.9%) participated in all the plans. Participation rates did vary by state with pharmacies in two states, Alaska and North Dakota, participating at levels below both the overall mean and median. Alaska represents a special case as there are few sole retail community pharmacies in rural areas and prescription services are sometimes provided by clinic pharmacies that were not included in this analysis. The lower than average participation rate for most of North Dakota's 33 sole community pharmacies raises concerns about access to local pharmacy services for Part D enrollees in that state.

Despite the overall encouraging participation rates, almost three-quarters of pharmacies did not participate in at least one plan. For those Part D beneficiaries who enroll in a plan with which their community pharmacy does not participate, travel distances to the nearest town with a pharmacy varied. For half of the pharmacies with less than 100% participation, the nearest pharmacy was less than 10 miles away. For 77 pharmacies not participating in all plans (16%), the nearest pharmacy was more than 20 miles away. These calculations only address the potential burden of travel for those small-town residents who may not be able to use their local

pharmacy, as it is not known whether travel to the next closest pharmacy would provide access since that pharmacy also may not participate in all plans.

These analyses raise important considerations for rural residents selecting a Part D plan for their chronic and acute medication needs. Because participation in plans by sole community pharmacies is not universal, both regular and LIS Medicare beneficiaries are at risk for selecting or being assigned to a plan with which their local retail pharmacy does not participate. For LIS beneficiaries, this may represent a temporary disruption as they can change plans throughout the year. However, lack of access to critical medications while the change in insurance plans is being processed is a serious concern for this population. For regular Medicare beneficiaries, selection of the "wrong" plan in terms of participation of their local pharmacy has long term consequences, as these beneficiaries must wait a year before changing to a plan accepted by their local pharmacy.

Rural Part D enrollees are less likely to have had insurance that covered prescription medication before the availability of the Part D program and may be unfamiliar with the decisions that must be made for participation in a Part D plan. Enrollment in Part D is not simple, as enrollees must determine the cost of plans and the coverage they provide. For beneficiaries using medications for chronic conditions, coverage for their specific medications is also an important part of their decision. Whether or not their local pharmacy participates in a plan being considered may be the last issue beneficiaries contemplate or, in the case of persons unfamiliar with insurance restrictions, may not be considered at all. Clear instructions on Part D enrollment websites and forms that inform the enrollee of the requirement that they use only certain pharmacies are essential. Additionally, it is important that advocates who work with Medicare beneficiaries make those they counsel aware of all of the aspects of plan choice they must consider and the various access implications of those choices. Under current Part D regulations, pharmacists are precluded from recommending a specific benefit plan to their patients. This restriction removes one of the most often used sources of pharmacy information for rural residents.

The analysis reported here is not without limitations. The analysis included only a portion of states and those chosen may not represent the country has a whole. Additionally, only those plans with the majority of enrollees were searched and it is possible that they have many enrollees because most pharmacies participate in their plan. If anything, this analysis may overestimate the participation rates of sole community pharmacies in Part D plans.

Part D is an extremely important addition to Medicare, and has been examined and debated by policy makers, researchers, advocates, and citizens since its inception on January 1, 2006. Continued scrutiny is important as Part D is still a work-in-progress and ongoing fine-tuning is necessary in order to provide the best possible prescription drug coverage for Americans.

Appendix

Part D Enrollment Process for LIS Beneficiaries

Under Part D, beneficiaries with low incomes and modest resources, including beneficiaries eligible for full Medicare and Medicaid benefits ("dual eligibles", who previously received coverage for prescription drugs under Medicaid) receive premium and cost-sharing subsidies (low income subsidy, hereafter referred to as LIS). Other Medicare beneficiaries who elect Part D coverage must pay premiums and cost sharing.

As of early 2008, according to the Centers for Medicare & Medicaid Services (CMS) nearly 9.5 million beneficiaries (almost four in ten Medicare Part D plan enrollees) were receiving low-income subsidies.[1] LIS recipients have no deductibles, nominal copays, and no coverage gap.[2] Dual eligibles automatically qualify for LIS. Additionally, those who receive premium or cost-sharing assistance through the Medicare Saving Program and those eligible for Supplemental Security Income (SSI) cash assistance are also automatically eligible. Those individuals with income below 150% of the federal poverty guidelines and limited assets are also eligible for LIS but must apply for these subsidies through the Social Services Administration or their state Medicaid program.[1]

The Enrollment Process

The MMA requires CMS to automatically enroll Medicare beneficiaries that receive LIS into a randomly assigned qualifying Medicare PDP if they do not select a plan on their own.[8] The auto-assignment process does not take local contracting into consideration, and in a survey funded by the Kaiser Commission on Medicaid and the Uninsured in February 2006, State Medicaid officials indicated that they were aware of beneficiaries being assigned to a plan that did not have a participating pharmacy within 50 miles of the beneficiary's home.[9] However, LIS beneficiaries who are automatically assigned to a PDP that does not meet their needs may select a new plan any time during the year, unlike other Medicare beneficiaries who may switch plans only once a year during the annual enrollment period.[10] Random assignment of LIS beneficiaries to participating plans allows CMS to comply with the choice-based design established in the law. In addition, the use of random, automatic assignment is thought to help establish a stable market for Part D plans by guaranteeing qualifying plans an equal share of beneficiaries.[11]

For a PDP to qualify for a share of randomly assigned beneficiaries, it must meet certain requirements. Plans must be designed as a standard benefit, or actuarially equivalent, and must have a premium below the benchmark level in their region.[11] Medicare prescription drug premiums are based on PDP bids that project the cost for providing coverage for the following year. Based on the bids, CMS calculates the amount of the premium that will be paid by Medicare for beneficiaries in each region. As bids change every year the premium and subsidy can change as well. Thus, the premium for any Part D plan can be fully covered by LIS in one year and not the following year.[12] This means that an LIS beneficiary enrolled in a particular

PDP that did not charge them a premium during the current year may be faced with the possibility of having to pay a premium for that PDP the next year.[13]

LIS Beneficiary Reassignment

LIS beneficiaries that face new premiums because their PDP's premiums will be higher than the amount subsidized by the Federal government can choose to select a new plan. If beneficiaries do not select a new plan or inform CMS that they wish to pay the premiums to remain on their current plan, CMS will randomly reassign them to another PDP that will not require them to pay a premium.[12] CMS refers to this process as their "reassignment process".[13] While this policy prevents LIS beneficiaries from being charged a premium, it can disrupt continuity of service. In addition, the number of plans at or below benchmark, and therefore eligible for reassignment of LIS recipients, is limited. In 2009 only 18% of PDPs qualified for automatic enrollment of LIS beneficiaries and the number of plans at or below benchmark varies by region, from one PDP in Nevada (out of 49) to 16 PDPs in Wisconsin (out of 53).[14]

The number of Medicare LIS beneficiaries switching plans in 2008 rose dramatically as a result of changes in the way CMS calculates regional benchmark levels. In 2007, there was a $2 de minimus adjustment. This meant that if a plan moved above the benchmark level by $2 or less, LIS beneficiaries could stay in the plan without being required to contribute to the premium. However, in 2008 CMS adjusted the de minimus amount down to $1[15] and the number of LIS recipients auto-reassigned increased from 250,000 in 2007 to about 2.1 million in 2008.[16] The number of beneficiaries reassigned to a different PDP in 2008 varied widely by region, from one region with as few as 17 beneficiaries changing plans to another region with approximately 402,322 beneficiaries changing plans. The average number of beneficiaries reassigned to a new PDP was 34,044 per region.[13]

Recent Changes to LIS Regulations

Effective May 31, 2008 CMS changed the weighting methodology used to calculate the low-income benchmark. Previously CMS calculated the weighted average based on a plan's share of total Part D enrollment. CMS will now calculate the weighted average based on a plan's share of LIS enrollment. This new methodology is expected to increase the low-income benchmarks, which should decrease the number of LIS beneficiaries who will need to be reassigned. CMS estimates that if the 2008 benchmarks had been calculated with this new LIS enrollment weighting methodology there would have been approximately 850,000 fewer reassignments. [17]

While the new LIS enrollment weighting methodology should help reduce the number of Medicare LIS beneficiaries that are auto-reassigned to new plans, there are still beneficiaries that will be forced to switch PDPs in order to avoid new premiums. It has been noted that dual eligible LIS recipients are sicker than typical Medicare or Medicaid beneficiaries. Dual eligibles have higher rates of chronic conditions such as mental illness and diabetes.[10] Due to their poorer health status, dual eligibles are also more likely to have greater prescription drugs use than others on Medicare.[18] Continuous access to pharmacy services is very important to the health of these individuals. While beneficiaries living in an area with multiple retail pharmacies may have no

trouble finding a pharmacy that participates in their new PDP, this may not always be the case in rural areas that have a sole community pharmacy.

Part D Enrollment Process for Non-LIS Beneficiaries

Each year from November 15th until December 31st there is an annual coordinated election period for Part D drug coverage. During this period non-LIS Medicare beneficiaries who do not have a Part D plan can enroll in one and those beneficiaries who have a Part D plan may elect to change plans. As many aspects of Part D plans change every year, including the list of covered drugs, co-pays, and tier structure, it is suggested that all Medicare Beneficiaries currently enrolled in a PDP carefully review their plans during the enrollment period to ensure that their current plan is still the best plan to suit their needs. In order to provide some guidance during the enrollment period CMS mails out an informational booklet entitled "Medicare and You" to Medicare recipients each Fall. The booklet provides information on all Medicare services, including Part D, for the upcoming year beginning on January 1st. The publication provides an overview of how and when to enroll in a new Part D plan and discusses potential penalties for not enrolling in a Part D plan. The publication also informs the beneficiaries of important issues they should consider when comparing and deciding on plans, such as cost, coverage and convenience.[19] While the publication provides an overview of Medicare Part D and the enrollment process it does not provide specific information on individual PDPs, information which could enable beneficiaries to choose the plan that is best for them. Rather, the publication instructs beneficiaries needing more help comparing plans to go to the Medicare.gov website or call Medicare's toll-free number to speak to a representative.

The Medicare Prescription Drug Plan Finder tool on the Medicare website can be used to enter personalized information in order to find the plans that provide the best coverage for an individual beneficiary based on current prescriptions, location and financial costs. While this tool is very helpful in comparing plans it is not available for beneficiaries without access to Internet. Those beneficiaries have the option of speaking to a Medicare representative who can help them compare PDPs over the phone. However, this may be a confusing and time consuming procedure and one that may seem too daunting to some elderly beneficiaries. In a recent study by the Commonwealth Fund it was noted that during the first two years of the Part D program a significant majority of Medicare beneficiaries that were signed up for the program reported that it was too complicated.[20] Furthermore, in a recent study of rural independent pharmacists conducted by the North Carolina Rural Health Research & Analysis Center and the RUPRI Center for Rural Health Policy Analysis, pharmacists reported that they were one of the main sources of assistance for patients that were considering changing Medicare Part D plans [5]. While some Medicare beneficiaries do not utilize the personalized plan selection resources provided by Medicare due to lack of access or perceived complexity, plan by plan comparison is very important to ensure that a beneficiary selects the plan best suited to his or her needs, particularly when considering that once non-LIS beneficiaries have chosen a plan they will often be unable to change their plan until the next annual enrollment period. For rural beneficiaries living in communities with a sole pharmacy, failing to obtain specific information about the plans their pharmacy accepts before making their choice of PDP could result in a lack of local pharmaceutical access until the next enrollment year.

References

1. Kaiser Commission on Medicaid and the Uninsured. Low-Income Assistance Under the Medicare Drug Benefit. Washington, DC: February 2008.

2. Shambaugh-Miller, M., Vanosdel, N., Mueller, K. Reliance on Independently Owned Pharmacies in Rural America. RUPRI Center for Rural Health Policy Analysis. Policy Brief No. 2007-6, November 2007.

3. Office of the Inspector General, Department of Health and Human Services. Retail Pharmacy Participation in Medicare Part D Prescription Drug Plans in 2006. OEI-05-06-00320. June 2007.

4. Radford, A., Slifkin, R., Fraser, R., Mason, M., Mueller, K. The Experience of Rural Independent Pharmacies with Medicare Part D: Reports from the Field. (Fall 2007). *Journal of Rural Health,* 23(4): 286-293.

5. Radford, A., Mason, M., Richardson, I., Rutledge, R., Poley, S., Mueller, K., Slifkin, R. One Year In: Sole Community Rural Independent Pharmacies and Medicare Part D. North Carolina Rural Health Research and Policy Analysis Center, Final Report No. 92. RUPRI Center for Rural Health Policy Analysis, Final Report P2007-1. September 2007.

6. Centers for Medicare and Medicaid Services, Department of Health and Human Services. Medicare Advantage/Part D Contract and Enrollment Data; Monthly PDP Enrollment by State/County/Contract, August 2007. http://www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/PDP%20Enrollment%20SCC%20Full%20-%20August%202007.zip.

7. Medicare Payment Advisory Commission. Part D Payment System. Washington, DC: October2007 (revised).

8. Government Accountability Office. Medicare Part D: Enrolling New Dual-Eligible Beneficiaries in Prescription Drug Plans. GAO-07-824T, May 8, 2007.

9. Smith, V., Gifford, K., Kramer, S., Elam, L. The Transition of Dual Eligibles to Medicare Part D Prescription Drug Coverage: State Actions During Implementation. Kaiser Commission on Medicaid and the Uninsured. Washington, DC, February 2006.

10. Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles and Medicare Part D. Washington, DC: February 2006.

11. Hoadley, J., Summer, L., Thompson, J., Hargrave, E., Merrell, K. The Role of Beneficiary-Centered Assignment for Medicare Part D. The University of Georgetown and NORC at the University of Chicago. No.07-4, June 2007.

12. Centers for Medicare and Medicaid Services. CMS Issues Proposed Rule to Expand Plan Choices to Medicare Beneficiaries with Limited Incomes and Resources. Press release,

Baltimore, MD: January 07, 2008. http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2808. Accessed May 20, 2008.

13. Centers for Medicare and Medicaid Services. Option for Prescription Drug Plans to Lower their Premiums for Low-Income Subsidy Beneficiaries. CMS-4133-P.Baltimore, MD: January 3, 2008. http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/CMS4133P.pdf, Accessed May 19, 2008.

14. Summer, L., Hoadley, J., Hargrave, E., Cubanski, J., Neuman, T. Medicare Part D 2009 Data Spotlight: Low-Income Subsidy Plan Availability. Henry J Kaiser Family Foundation. November 2008. http://www.org/medicare/upload/7836.pdf, Accessed January 7, 2009.

15. National Alliance on Mental Illness. Medicare Drug Benefit Update: LIS and Dual Eligible Reassignment for 2008. November 14, 2007. http://www.nami.org/Template.cfm?Section=eNews_Archive&template=/contentmanagement/contentdisplay.cfm&ContentID=53966&title=Medicare%20Drug%20Benefit%20Update%3A%20LIS%20and%20Dual%20Eligible%20Reassignment%20for%202008. Accessed May 20, 2008.

.

16. Medicare Payment Advisory Committee. Report to the Congress: Medicare Payment Policy. Washington, DC: March 2008.

17. Center for Medicare and Medicaid Services, Department of Health and Human Services. Modification to the Weighting Methodology Used to Calculate the Low-Income Benchmark Amount. 42 CFR Parts 422 and 423. Federal Register 73(65):18176-18182, April 3, 2008.

18. Kaiser Commission on Medicaid and the Uninsured. Dual Eligibles: Medicaid's Role for Low-Income Medicaid Beneficiaries. Washington, DC: February 2006.

19. Centers for Medicare and Medicaid Services, Department of Health and Human Services. Medicare and You. CMS Publication 10050. Baltimore, MD, 2008. http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf. Accessed July 11, 2008.

20. Hoadley, J. Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries. Commonwealth Fund Publication No. 1118, Vol 39. May 2008.