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Medicare Part D: Successes and Continuing Challenges

Impact of Medicare Part D on Massachusetts Health Programs and Beneficiaries

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Impact of Medicare Part D on Massachusetts Health Programs and Beneficiaries

Executive Summary

On January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) implemented the Medicare Drug Benefit, or "Medicare Part D." The program offers prescription drug coverage for the one million Medicare beneficiaries in Massachusetts. Part D affects Massachusetts state health programs and beneficiaries in a number of ways. The program:

- provides prescription drug insurance, including catastrophic coverage, through a choice of private prescription drug plans (PDPs) or integrated Medicare Advantage (MA-PD) health plans;
- shifts prescription drug coverage for dual-eligible Medicare / Medicaid beneficiaries from Medicaid to Medicare Part D drug plans;
- requires a maintenance-of-effort, or "clawback" payments from states to CMS designed to capture a portion of states' Medicaid savings to help finance the benefit;
- offers additional help for premiums and cost sharing to low income beneficiaries through the Low Income Subsidy (LIS); and
- provides a subsidy to employer groups that maintain their own prescription drug coverage for retired beneficiaries.

This paper summarizes the activities involved in implementing Medicare Part D, the impact it has had on Massachusetts health programs, and the experiences of beneficiaries and others conducting outreach and enrollment. The data are drawn from interviews with officials and documents provided by state health programs, CMS and the Social Security Administration, and representatives of provider and advocacy groups involved in the enrollment and ongoing support of Medicare beneficiaries.

Enrollment: Enrollment into Medicare Part D in Massachusetts was achieved through a complex set of activities in the public and private sectors. Activities included educating outreach counselors, beneficiaries, providers and insurers on the numerous plan options (51 PDP drug plan options and 43 MA-PD plans were available in 2007); identifying eligibility for subsidies; assisting with applications; and undertaking proactive efforts to minimize transitional problems. CMS provided direction nationally and through the Boston regional office, in collaboration with the Social Security Administration, which determined eligibility and enrolled beneficiaries to receive subsidies. Massachusetts health programs, partner organizations (public agencies and private organizations), pharmacists and community groups devoted considerable resources to enrollment and outreach activities, and to problem solving once members enrolled and continued to use the program.

As of January 2007, approximately 777,000 Massachusetts beneficiaries (or 78 percent of those eligible) either enrolled in Medicare Part D or had insurance through employers considered equal

to that of Part D. This total includes 195,000 dual eligible beneficiaries now receiving Medicare drug coverage and 194,000 Medicare beneficiaries whose employers receive a subsidy from CMS to maintain drug coverage. An additional estimated 100,000 beneficiaries may be covered through the Veterans' Administration (VA), other employers, or by additional supplemental coverage. In total, nearly 90 percent of Medicare beneficiaries now have drug coverage. This is well above the participation rate in many other federal programs and above the rate of drug coverage prior to implementation of Part D. However, it must be noted that there may be 125,000 Medicare beneficiaries in Massachusetts (12 percent) who may still be without drug coverage.

About 37,000 low-income Massachusetts residents who do not qualify for Medicaid have qualified for Part D subsidies. According to one estimate, ***fewer than half of beneficiaries who may be eligible for Low Income Subsidy have been approved for assistance***.

Beneficiary Experiences: The considerable efforts in Massachusetts and other states to support enrollment and transition helped to mitigate transition problems, but issues still arise at many levels. Many problems at the outset -- such as systems, initially, not recognizing large groups of enrollees when they attempted to obtain medications; double coverage; and the limited usefulness of CMS's point-of-sale facilitator plan -- were resolved to some extent within the first year. Problems deducting premiums from Social Security payments occurred at first, and remain an ongoing problem.

Additional problems stem from the design of the program, and may continue. For beneficiaries not receiving the Low Income Subsidy, out of pocket drug costs are still considerable. Annual increases in drug plan premiums are already evident. As no Massachusetts Medicare drug plans cover brand name drugs in the coverage gap or "doughnut hole," beneficiaries with annual drug costs between $2400 and $5451 are faced with paying the full cost of brand medications (although the benefit provides catastrophic coverage above that amount). As well, nearly 200,000 dual eligible beneficiaries in the state are now often subject to limited drug choices through private plan formularies.

While the majority of beneficiaries transitioned without incident, and national surveys indicate that the majority of beneficiaries are satisfied with their drug benefit, advocates across the state report numerous examples of beneficiaries having continued problems obtaining drugs once enrolled in Part D. Problems include:

- limited drugstore networks for particular plans;
- unanticipated cost of drug copayments;
- changes to medications because of specific formularies; and
- the cost of drugs in the coverage gap.

There are countless stories of beneficiaries who have had problems accessing drugs and navigating the appeals process, often involving one or more drugs for serious and disabling complex diseases. For these beneficiaries, such obstacles can lead to devastating outcomes.

Due to extensive problems with the initial transition to Medicare Part D in early 2006, Massachusetts, like most states, provided emergency drug coverage to dual eligible beneficiaries and Prescription Advantage members during the first months of 2006. Over $17.6 million was spent to provide emergency coverage to MassHealth members, most of which has been reimbursed by Medicare.

In order to further minimize transitional problems, Massachusetts passed legislation in December 2005 (Chapter 175 of the Acts of 2005) that provided a funding vehicle to assure MassHealth dual eligible beneficiaries access to drugs while systems were being implemented, and to enable Prescription Advantage to fill in gaps in Part D coverage. Chapter 175 has been successful in helping maintain access to drugs during and after the transition. The Commonwealth has spent approximately $4.6 million for prescriptions and copayment assistance to MassHealth members provided under Chapter 175 through December 31, 2006. Availability of 30-day emergency medication supplies under Chapter 175 expired in December 2006, although 72-hour medication supplies and copayment assistance remain available.

Fiscal Impact on Massachusetts Health Programs: Current estimates suggest that Part D will have positive financial impact on state health programs in the first two years. In 2006, savings to Massachusetts health programs included an estimated $21-25 million to MassHealth, $20-50 million to Prescription Advantage, and $21 million to the state retiree group insurance program. An additional $10 million savings was realized by the Executive Office of Health and Human Services for dual eligible and Medicare only clients at the various Department of Public Health (DPH) and Department of Mental Health (DMH) institutions across the Commonwealth.

Future Programmatic Concerns: Although the majority of beneficiaries in Massachusetts were successfully enrolled into Medicare Part D, a number of issues should be monitored over the next several years:

- Since over 125,000 eligible beneficiaries in Massachusetts may still be without drug coverage, and many Low Income Subsidy-eligible beneficiaries have not yet applied, continued outreach is warranted. This is true especially for traditionally difficult to reach populations, such as non-English speaking and racial and ethnic minorities.
- Part D drug plan premiums have increased after one year, with some doubling in price. Fewer than half of the PDPs offered in Massachusetts include any drug coverage through the "standard benefit coverage gap" that occurs between $2400 and $5451 in total drug costs. The changing Part D market may cause disruption and lead to increased out-of-pocket costs.
- Stories of individuals having difficulties accessing Part D drugs in the first 18 months have been common, with drug management and appeals conducted across many private Part D plans. These stories may reflect the most difficult cases, or they may be the tip of the iceberg. However, there are enough anecdotes, with new survey reports emerging, to suggest that access problems exist, particularly for the most vulnerable beneficiary populations. Access problems, appeals and grievances should be quantified and monitored within this state.

- For MassHealth in particular:
  - Clinical management of dual eligibles (particularly in the Senior Care Options Program, a demonstration serving frail and institutionalized beneficiaries) may be an increasing challenge because financing of the medical and drug benefit is split between Medicare and Medicaid, and enrollees are subject to limited formularies.
  - As dual eligible beneficiaries are subject to formularies and private sector drug management, which represents a change from Medicaid's preferred drug list, clinical outcomes may be affected.
  - Future state savings from Part D may be eroded as "clawback" (phase down payments) are subject to national spending increases.
- Although in 2007 only 1000 fewer beneficiaries have employer drug coverage than in 2006, the risk remains that employers will decide to drop more generous retiree drug coverage as drug costs increase and Medicare Part D establishes itself further.
- The rollout of Part D holds many lessons for the enrollment and implementation of Massachusetts Health Care Reform. These include the need for:
  - pre-implementation coordination of training and outreach activities;
  - ample testing of data systems before the program goes on line;
  - streamlined communications and data transfer systems;
  - sufficient safety net features to respond to transition and ongoing problems at point of service;
  - a flexible and extended transition period that maximizes enrollment; and
  - particular attention to the needs of low income and minority populations in identifying and enrolling those who may be eligible.

I. Medicare Part D Landscape and Enrollment in Massachusetts

Medicare Part D of the Medicare Modernization Act of 2003 (MMA), implemented January 1, 2006, represents the most sweeping benefit change to the Medicare program in its history. The program has been projected to cost between $500 and $700 billion dollars, nationally, and over a ten-year period, it is intended to provide prescription drug benefits to Medicare beneficiaries, including over one million in Massachusetts. Main features of the program include:

- Prescription drugs provided through either private regulated drug-only prescription drug plans (PDPs) or Medicare Advantage (MA-PD) plans providing integrated medical and prescription drug coverage;
- Standard drug benefit, with increases tied to drug inflation, consisting in 2007 of a $265 annual deductible, 25% cost sharing, a gap in coverage starting at $2400 in total drug spending
- Catastrophic coverage beyond $5451 in total drug costs;
- Private plans are free to offer any design of basic prescription drug coverage as long as it is at least "actuarially equivalent" to the standard benefit (most offer designs that differ from the standard benefit). Plans are also allowed to offer enhanced coverage options;
- A subsidy to Medicare Advantage integrated health plans to encourage participation;
- Beneficiaries who are not in Medicaid or who do not maintain employer drug coverage enroll directly with drug plans, which charge premiums directly to beneficiaries;
- Eliminating Medicaid prescription drug benefits for all dual eligible Medicare/Medicaid beneficiaries and "autoenrolling" these beneficiaries into Medicare drug plans, with a full subsidy for premiums and minimal cost sharing. Only "basic" PDPs with premiums below the state weighted average ("benchmark") are qualified for autoenrollment of dual eligibles;
- Extra assistance for additional low income beneficiaries who are not Medicaid eligible, with incomes up to 150% of the Federal Poverty Level (FPL)[1] and resources up to $10,210.[2] This extra help covering premiums and cost sharing, called the Low Income Subsidy (LIS, or "extra help"), is granted through application to the Social Security Administration;
- Formularies and other drug utilization management tools are allowed, following certain CMS guidelines;
- A subsidy to employers to maintain retiree coverage if it is at least as generous as the standard benefit. The employer subsidy in 2007 is 28 percent of prescription drug spending between $265 and $5451.

Massachusetts Part D Plan Offerings

As in all states, Massachusetts Part D plans include both freestanding Prescription Drug Plans (PDPs) and Medicare Advantage (MA-PD) plans. In 2007, 51 PDPs and 43 MA-PDs are offered

[1] In 2007, 150%of the Federal Poverty Level is $15,315 for a single person.
[2] An additional $1500 is allowed for certain expenses.

by 10 sponsors in Massachusetts. Following a national trend, this number represents an increase from 44 PDPs and seven MA companies in 2006. Even with this wide range of offerings, Massachusetts is still among the states with the lowest number of stand-alone prescription drug plans offered. Of the 51 stand alone prescription drug plans in the Commonwealth in 2007, 15 have premiums close to or below the benchmark and thus available to Medicare/ Medicaid dual eligible beneficiaries, up from 11 in 2006.

Massachusetts is one of thirteen states in 2007 that have no stand alone prescription drug plans with drug coverage for both brand and generic drugs in the coverage gap (from $2400 to $5451 in total drug costs). Fifteen PDPs in Massachusetts cover only generic drugs in the coverage gap, and the remaining 36 have no drug coverage in the gap. On a national level, about 40 percent of beneficiaries in drug plans with no gap coverage and not receiving LIS are expected to reach the gap in coverage, and 15 percent will have drug costs above the $5451 catastrophic level.[3]

Monthly premiums in 2007 for PDPs in Massachusetts range from $13.40 to $87.40, an increase from the 2006 range of $7 to $65. The average PDP premium in Massachusetts is $34.47 in 2007, about $2 lower than the national average. In spite of the wide range of options, only four PDPs in Massachusetts have premiums below $20 per month, and 29 PDPs have premiums above $30 per month. It is important to remember that Part D premiums are in addition to the premium Medicare beneficiaries must pay for Part B, which in 2007 begin at $93.50 per month, and increase with income.

Part D drug benefit plan premiums and cost sharing change from one year to the next based on bids submitted to CMS by drug plan sponsors. Between 2006 and 2007, while the average premium increased by less than $2, particular plans had significant premium increase, with some more than doubling the monthly cost of coverage. About half of Massachusetts PDPs increased premiums in 2007. Half of these increases were under $5 per month, and three increased more than $10 per month. Some low-cost plans more than doubled in price, as low initial prices were offered to acquire the highest possible market share.[4]

There are also 43 Medicare Advantage drug plan (MA-PD) plan options offered across the Commonwealth in 2007 (See Appendix). Offerings vary by county, with as many as 19 MA-PD options offered in certain counties. Most (26) MA-PD plans offer no drug coverage in the gap, with 16 covering generic drugs, and only one offering coverage for brand and generic drugs in the gap. Drug-only premiums range in 2007 from $0 to $58.50. For MA plans, savings on medical services and efficiencies in integrated care can offset the cost of the drug premium. As a result, MA plan premiums that include comprehensive medical and drug coverage are often lower than separate Part B and Part D premiums purchased through PDPs.

A number of special needs plans (SNPs) for dual eligible or institutionalized beneficiaries, or those with chronic disease, are also offered in Massachusetts. The MMA required that the health plans participating in the Senior Care Options (SCO) demonstration program, which were already providing integrated care to dual eligible beneficiaries, become Medicare Advantage special

[3] Stuart B et al. Riding the roller coaster: The ups and downs in out of pocket spending under the standard Medicare drug benefit. Health Affairs 2005;24(4):1022-1031.
[4] Krasner J. Insurer hits millions with drug cost hike. The Boston Globe, December 31, 2005.

needs plans. Implications for these programs are discussed later. As of March 2007, about 13,100 beneficiaries are enrolled in Medicare special needs plans, of which SCOs are a subset.

Part D Enrollment in Massachusetts

Table 1 shows Medicare Part D enrollment in 2006 and 2007.

Table 1: Overview of Massachusetts Medicare Part D Enrollment, As of January 2007[5]

Beneficiary group	June 2006 Enrollment	Jan 2007 Enrollment	Population and change in coverage moving to Part D
Total number of Medicare beneficiaries (2005)[6]	**999,121**	**1,007,212**	
Total number of beneficiaries in Part D plans or in retiree plans receiving subsidy	**757,745**	**776,727**	**Includes MassHealth, Prescription Advantage members, Veterans enrolled in Part D, or retiree drug coverage, and all other beneficiaries in Part D plans**
Medicaid dual eligible beneficiaries (includes 20,000 "partial duals" in Medicare Savings Programs)	192,429	195,656	Medicaid to Medicare Part D plans; autoenrolled into randomly assigned PDPs; subject to Part D formularies, coverage rules and PDP drug management
Beneficiaries in employer plans (includes state retirees)	195,022	193,802	Maintained creditable coverage, CMS subsidizes employers 28% of drug costs between $265 and $5350 (2007).
Beneficiaries in stand alone PDPs (non-dual eligible)	174,492	191,215	Part D basic or enhanced benefit, formularies and drug management.
Beneficiaries in Medicare Advantage (MA-PD) Plans (non-dual eligible)	140,546	143,390	Part D health plan coverage; standard or enhanced benefit
Federal retirees	55,256	52,664	Maintained FEHBP or TriCare
Prescription Advantage (SPAP) enrollees, also enrolled in PDPs or MA plans (included in above categories)	66,723	69,721	Prior to 2006, covered majority of drug costs, net of deductibles, co-pays and some premiums. Now, wrap around coverage for Part D premium, deductibles, gaps and some uncovered drugs, as secondary payer.
Other beneficiaries with potentially creditable coverage (estimate)[7]	**108,904 (est.)**	**104,907 (est.)**	**VA coverage, other retiree coverage with no subsidy, active workers with Medicare Secondary Payer, other Medicare supplemental**
Beneficiaries with no identifiable source of creditable coverage	**132,472 (est.)**	**125,578 (est.)**	**Continued outreach**

[5] Sources: Centers for Medicare and Medicaid Services, 2007; Kaiser Family Foundation, www.statehealthfacts.org.
[6] Source: CMS, Market state/county penetration files, 2005, as reported by Kaiser Family Foundation, Fact Sheet: Medicare Part D Plan Characteristics, 2007.
[7] Medicare provided national estimates for this category. State estimates determined by calculating the proportion of Medicare population included in this category each year, and applying the same proportion to the state beneficiary total.

As shown in **Table 1**, 78 percent of beneficiaries are enrolled into Medicare Part D plans as of January 16, 2007, an increase of 19,000 beneficiaries over June 2006. Between 2006 and 2007, most growth was in PDPs and MA plans, with a slight decrease in employer coverage. The majority of Part D enrollment was accomplished through "autoenrollment" (MassHealth), facilitated through health programs (Prescription Advantage and previous Medicare Advantage plan members), or through employers that maintained coverage and did not require beneficiaries to enroll in Part D.

The number of beneficiaries with "other creditable coverage" is estimated based on the proportion of beneficiaries reported by CMS on a national level with Veterans Affairs (VA) coverage, active workers with Medicare as a secondary payer, and other employer coverage with no subsidy (see Table 1 footnote). By this method, 125,000 Medicare beneficiaries in 2007 may still be without drug coverage.

Low Income Beneficiaries

Particular challenges exist in enrolling low income beneficiaries into Part D. All Medicaid dual eligible beneficiaries, including those with partial Medicaid coverage, were deemed eligible for LIS and "autoenrolled" into PDPs. Prescription Advantage facilitated enrollment and application for LIS for its members through a series of activities described later. However, other low income beneficiaries who were not enrolled in these programs had to register, select a plan, and apply for LIS on their own.

Low income beneficiaries not enrolled in other health programs are difficult to identify. One estimate places the number of Medicare beneficiaries residing in Massachusetts without MassHealth coverage, who may be eligible for LIS, at over 113,000.[8] **Table 2** shows the number of Massachusetts beneficiaries that applied and were approved for LIS in 2006. Those not qualifying for LIS are subject to the standard Part D cost sharing requirements.

Table 2: Medicare Part D Low Income Subsidy Applications and Number Qualifying as of December 29, 2006[9]

Income/eligibility category	Number
Number of applications for LIS	133,291
Number of applications processed (excludes deemed beneficiaries)	102,934
Number qualifying for LIS	37,634 (36.6%)
Number not qualifying for LIS	65,300 (63.4%)

[8] Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes*. National Council on Aging, 2005.
[9] Sources: CMS Boston regional office, 2007.

As **Table 2** shows, 37,634 beneficiaries in Massachusetts have qualified for LIS. The majority of applicants for LIS in Massachusetts (64 percent) have been judged ineligible. LIS qualification is based both on income (up to 150% FPL) and resources (up to $10,000 for a single individual). According to SSA, nationally, 41 percent of LIS applications are denied because of excess resources, 50 percent due to excess income, and 8 percent due to both. If these numbers hold for Massachusetts, there may be up to 25,000 beneficiaries with incomes below 150% of FPL (41 % of 65,300) who did not qualify for LIS; if they are not enrolled in Prescription Advantage, they must pay full Part D premiums and cost sharing to obtain drug coverage. Further, if the above estimate of 113,000 beneficiaries in the state eligible for LIS is accurate, up to 75,000 Medicare beneficiaries eligible for LIS (113,000 minus 37,634) may not have enrolled in Part D, or have enrolled but have not applied for LIS.

Massachusetts Part D Enrollment Activities

The goal of initial CMS Part D outreach and enrollment was to educate as many beneficiaries as possible about the new drug benefit (including families, providers, health programs and others involved with beneficiaries), and to encourage all beneficiaries to enroll in a Part D plan, unless they had comparable drug coverage. The overall national strategy of CMS in enrolling beneficiaries into Part D was to provide information directly, and to partner with thousands of organizations at all levels in the public and private sector including advocates and service providers. CMS partner organizations in the national effort included the: Social Security Administration; Area Agencies on Aging; Veterans' Affairs; Health Resources and Services Administration (HRSA); Housing and Urban Development (HUD); Administration for Children and Families (ACF); and more traditional partners such as hospitals, state medical societies, and professional provider associations (including pharmacists).

In Massachusetts, nearly 400 partner organizations were involved in initial outreach and enrollment into Part D, including: MassHealth; the Massachusetts Executive Office of Elder Affairs (and Prescription Advantage); the SHINE program (Serving the Health Information Needs of the Elderly); the Medicare Advocacy Project (MAP) housed in the Greater Boston Legal Services; Action for Boston Community Development (ABCD) elder services; AARP; and hundreds of other advocacy groups working at the community level. Many activities were coordinated and attended by CMS officials, and some were initiated through partners. Additional resources were provided by agencies such as the National Council on Aging, which provided funding to ABCD elder services specific to Part D activities. Individual providers such as physicians and other staff across clinical settings such as outpatient and nursing facilities were also heavily involved in assisting patients with enrollment and support.

There were numerous CMS-led programs to train counselors and others to assist in enrollment. Private national advocacy groups also worked for months to "train the trainers," and information would flow to community level service programs. Established groups were critical, as was face-to-face counseling. Activities were as diverse as marathon LIS enrollment sessions by the Boston Bar Association to the Association of Industries of Massachusetts sending emails to all members. Thousands of individual sessions took place at pharmacies, provider organizations, and community agencies. To illustrate the scope of enrollment activities, SHINE program reports that counselors held over 1,000 group education sessions, and 57,000 one-on-one

sessions helping individuals sign up for coverage in the first year. Individual sessions often took over one hour each. One counselor at ABCD worked personally with beneficiaries to submit 650 applications to LIS.

CMS outreach and enrollment efforts have continued into 2007 with many of the same parties, although at a lower level of activity than during the initial enrollment period.

II. Beneficiary Experiences with Enrollment and Ongoing Part D Services

After an initial transitional period, most beneficiaries are now enrolled in Part D plans that assist with the payment for the majority of their needed drugs. Based on interviews with individuals involved with enrollment and support of beneficiaries as Part D was implemented, strengths of the enrollment process in Massachusetts included:

- Well organized, educated, and extremely dedicated volunteers;
- Strong outreach to the general public;
- Strong health advocacy infrastructure;
- Extensive state participation (e.g. Prescription Advantage; MassHealth); and
- Quick and decisive legislative action (e.g. Chapter 175)

At the same time, the vast number of individuals involved in the outreach and enrollment process, combined with a very complex Part D program and with technical difficulties, created considerable challenges. Implementation problems are both transitional and ongoing. While the majority of beneficiaries transitioned without incident, most outreach workers who were interviewed for this paper provided anecdotes of individuals encountering obstacles both in enrollment into Part D during the initial months, and in accessing their drugs once enrolled. Without a survey of beneficiaries, it is difficult to determine the extent of the unresolved problems. However, anecdotes are numerous and involve sufficient ongoing issues, which warrant further monitoring. As reported by those involved in outreach, enrollment and ongoing support, common challenges include the following:

Problems Related to Part D Program Design:

1. Incomplete or erroneous information. Part D design complexity requires substantial knowledge about the program to assist in enrollment. The large number of individuals involved in enrollment and outreach was a major advantage, but also led to some misinformation among outreach workers. These problems were largely resolved as beneficiaries and those assisting them have become more familiar with the drug benefit and its details.

2. Complexity. The lack of complete information was coupled with a tremendously complex program that may have had too many choices. Many seniors were admittedly apprehensive because they had little or no contact with computers. Even with assistance, they are faced with a number of confusing scenarios. According to advocates and volunteers, it takes an average of 45 to 90 minutes in one-on-one sessions to help beneficiaries understand and choose their Part D

coverage. Even with intense counseling, beneficiaries report being surprised at copayments and their financial responsibilities when they reach the coverage gap.

For example, one advocate explained how many seniors were faced with the choice between higher premiums and more services, or lower premiums and fewer services, often with increased co-payments. Calculations like these amounted to rather difficult risk estimates, something that the beneficiaries were not prepared to consider. As drug plans and formularies change annually, beneficiaries must reassess their drug plan each year. Advocates say that this has required continued counseling leading up to and during the 2007 enrollment period.

3. Problems accessing medications at the point of service. While most beneficiaries have been able to access needed medications, there have been reports of beneficiaries with complex and serious diseases having problems obtaining their drugs because of lack of timely enrollment confirmation by drug plans, formulary requirements or Part D plan procedures. A critical point that was raised by many of those interviewed was that cost sharing was greater than beneficiaries expected. Individuals were required to switch medications, and some just did not understand fully the implications of the new plan. These reports are consistent with several systematic surveys documenting the experiences of beneficiaries nationally who are disabled and who have mental health conditions.[10] [11]

4. Appeals. Several Massachusetts organizations provide support to beneficiaries who have encountered problems obtaining needed drugs. Representatives of these organizations, such as Greater Boston Legal Services' Medicare Advocacy Project, report that appeals processes are often difficult. Appeals may be simple or complex and can be critical, as in cases of cancer patients whose Part D plan did not approve certain necessary drugs. Also, because appeals are initiated through individual drug plans, there is no uniform resolution or overarching decisions made for all beneficiaries. There is further concern that there may be many individuals with Part D-related problems who do not know how to access services for assistance with appeals or other grievances.

Technical Difficulties: At the outset of the program, outreach workers enrolling beneficiaries relied almost exclusively on a new Medicare Part D website that was scheduled to be completed before enrollment began. The lack of an accurate website at first (e.g. incorrect data on the number of plans in a state; incorrect or outdated information about one or more specific plans offered; confusing or erroneous instructions about how to enroll in a plan; inaccurate pricing information) hindered the ability of volunteers and beneficiaries to correctly evaluate options. However, in the end the system proved very useful in expediting enrollment.

Inadequate Communication Between Parties: The technical problems and complex program design are at times exacerbated by poor communications among multiple parties (volunteers-enrollees, CMS-State agencies, CMS-insurers, insurers-pharmacies, state agencies-pharmacies).

[10] Hall JP et al. Transition to Part D: An early snapshot of barriers experienced by younger dual eligibles with disabilities. *American Journal of Managed Care* 2007; 13(1):14-18.

[11] West J et al. Medication access and continuity: the experiences of dual eligible psychiatric patients during the first four months of the Medicare prescription drug benefit. *American Journal of Psychiatry* 2007; 164 (5):789-796.

In a series of focus groups held by CMS in 2006, New England partner organizations reported these communication-related problems:

- inability to get through on Medicare help lines;
- lack of updated training materials;
- not being notified of procedural changes early on; and
- inability to target enrollment efforts because CMS would not provide enrollment data.

Pharmacists were not universally advised regarding the point-of-sale facilitator PBM for beneficiaries whose enrollment was not in the system. Problems also have been related to data transfer between entities (i.e., plans do not know that members were enrolled or that enrollees were approved for LIS), and had to be resolved temporarily by emergency coverage. A May 2007 report by the U.S. General Accounting Office documented these problems for dual eligible and low income beneficiaries. Improvements are currently being implemented by CMS to avoid such problems.[12]

Minority and Disadvantaged Populations: Enrollment and outreach information was available in different languages and among different community groups. While CMS has not provided numbers or expectations for minority enrollment, outreach partners report that some hard to reach populations (particularly Hispanic and Asian), many of whom may be eligible for Part D and LIS, are still not enrolled. In CMS-sponsored focus groups, outreach partners reported that organizations serving these groups are often left out of local partner coalitions.

III. Impact of Part D on Massachusetts Health Programs

Medicare Part D has had a considerable impact on health programs in Massachusetts, particularly MassHealth, Prescription Advantage, and the Group Insurance Commission's retiree health plan. This section describes the activities the programs conducted around implementation of Part D, the impact on members, future challenges, and current estimates of budgetary effects.

MassHealth

On January 1, 2006, the 192,000 dual eligible beneficiaries in MassHealth were moved from MassHealth drug coverage to Medicare Part D plans. All dual eligible beneficiaries were automatically enrolled by CMS into one of 11 drug plans. These are basic plans with premiums below the "benchmark" PDP premium and therefore do not charge a premium to individuals with the full Low Income Subsidy. In 2007 the number of "autoassignment" plans is 15, with the benchmark premium set at $27.35, down from $30.27 in 2006.

The shift in coverage had various administrative, clinical and financial consequences. First, this population is now subject to drug utilization management by private health plans, each of which

[12] U.S. General Accounting Office, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries.* May 2007. (GAO-07-272).

has its own formulary[13] and procedures for drug management. Several drug classes that MassHealth previously covered are excluded from coverage through Part D, including benzodiazepines (sedatives such as Xanax and Valium) and over-the-counter medications. MassHealth continues to cover these "excluded" classes of drugs for dual eligible beneficiaries and remains eligible to receive Federal matching funds. The state, however, does not receive Federal matching funds for coverage of drugs that are in covered classes but not in a plan's formulary.

As required of all states, in mid 2005 MassHealth began to send a monthly file of all dual eligibles to CMS. CMS used this data to autoenroll all dual eligibles by 1/1/06 and then followed up with data on new duals to autoenroll them each following month. While preparations for 2007 were by no means as cumbersome as 2006, CMS had to reassign a limited number of dual beneficiaries whose plans were no longer eligible for autoenrollment. Reassignments can be expected each year as plan premiums and the benchmark continue to change. In addition, as beneficiaries change into and out of "deemed eligible" status for LIS, they must be notified and/or reassigned by CMS, with the additional step posing a potential administrative barrier to continuity of coverage.

MassHealth Enrollment and Coverage Challenges:

Annual Enrollment and Reassignments: As might be expected in a one-day shift of 200,000 beneficiaries into an entirely new program, issues arose across communities and settings. Repeated one-on-one counseling was required to solve problems, and MassHealth officials at all levels provided support. As systemic problems were resolved, individual transition problems diminished. A considerable problem was related to the CMS contracted "point of sale facilitator," designed to provide temporary coverage for any beneficiary whose enrollment into Part D was not recognized at the pharmacy. The point of sale facilitator did not work as well as anticipated, however, as many pharmacists were either unaware of this coverage or unable to access the program.

Changes in plan premiums occurred between 2006 and 2007, and in an effort to minimize coverage disruptions, CMS implemented a "de minimis" policy, directing that plans with premiums just above the benchmark could retain dual eligible beneficiaries. Nonetheless, in 2007, CMS had to reassign a small number of dual eligible beneficiaries. In addition, in 2007, 16,000 former MassHealth enrollees lost LIS "deemed" status, and were no longer automatically qualified for LIS. This population had to actively apply for LIS in order to maintain benefits.

Data Systems and Communication: Every time a MassHealth member becomes eligible for Medicare, although Medicare drug benefits begin immediately, CMS can take up to two weeks or more to process the information. This time lag is an ongoing problem. As long as eligibility and enrollment data are transferred from MassHealth to CMS via batch data systems rather than in "real time," there will be a gap of at least several weeks. Such difficulties and resulting

[13] Formularies specify which medications are covered by prescription drug plans. Each Medicare Part D plan must comply with CMS requirements to cover an extensive list of drugs and classes. However, with some exceptions, drug plans have flexibility to determine which specific drugs to cover within each class, and cost sharing for those drugs. There is thus variation in covered drugs across plans.

disruption to drug therapy have since been documented on a national level.[14] Because of the nature of this process, this problem will persist beyond the transitional years, for those beneficiaries whose status changes from time to time. In late 2006 CMS began asking states to include information on prospective duals as well as current duals in their monthly files. This allowed CMS to autoenroll most individuals prior to their Medicare start date.

Beneficiary Coverage and Cost Sharing: Beneficiaries are now subject to PDP and MA plan formularies and other management strategies. CMS has strict formulary requirements to ensure that Part D coverage is as broad as possible. Nevertheless, studies analyzing Part D formularies elsewhere indicate that drug plans cover between 76 and 96 percent of the top 200 drugs used by Medicare beneficiaries.[15] Although Medicaid has had a preferred drug list managed by the Medicaid program, dual eligible beneficiaries have not previously been subject to formularies managed by private drug plans.[16] Anecdotal reports from advocates indicate that dual eligible (as well as other) beneficiaries were required to change specific drug regimens to comply with Part D formularies. This is supported by one recent study indicating that nearly 20 percent of dual eligible beneficiaries with mental health conditions have had to switch medications and up to half report having problems accessing prescriptions.[17]

Another major change for dual eligible beneficiaries involves copayments for medications. Under the Medicaid program, pharmacists were required to dispense medications if the enrollee said the he or she could not pay a copayment. Under the MMA, this is not required. Part D drug copayments for dual eligible beneficiaries are: $1.00 for generic drugs and $3.10 for brand drugs for dual eligibles with income less than or equal to 100% of the Federal Poverty Level (FPL); $2.15 (generic) and $5.35 (brand) for dual eligibles with income over 100% FPL, and zero for all dual eligible nursing home residents. As noted later in this report, state legislation requires MassHealth to bring dual eligible beneficiaries' Part D copayments to MassHealth levels. Many dual eligible beneficiaries have multiple chronic drug needs and multiple copayments. Advocates report that beneficiaries have expressed surprise at this requirement, although no data are available to confirm the extent to which this particular feature of the benefit has been a barrier to access.

MassHealth and Community Based Waiver Programs: Prior to the MMA, Massachusetts was in the process of implementing a Medicaid demonstration program for dual eligible beneficiaries, called Senior Care Options (SCO), which provides integrated health and support services to frail elders in the community. Prior to 2006, several thousand beneficiaries were served through these plans. The MMA required the SCO plans to become Medicare Advantage special needs plans. This generated certain difficulties for the demonstration. First, the SCO model is based on an integrated benefit, but now systems must be revised to generate bids for both medical and Part D services, and to support Part D requirements. Plans must set up reporting systems for Part D, re-

[14] U.S. General Accounting Office, *Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries.* May 2007. (GAO-07-272).
[15] Heaton et al., *Assessing Medicare prescription drug plans in four states: balancing cost and access*. The Commonwealth Fund, August 2006.
[16] Use of preferred drug lists (PDLs) in Medicaid require prior approval for use of drugs that are not "preferred," but coverage is available if approved.
[17] West J et al. Medication access and continuity: the experiences of dual eligible psychiatric patients during the first four months of the Medicare prescription drug benefit. *American Journal of Psychiatry* 2007; 164 (5):789-796.

contract with community providers and PBMs, and compete with national SNP sponsors for enrollees.

In addition, as Medicare-only SNPs enter the market, and as capitation is provided for Medicare services, Medicaid costs may increase for this population; capitation incentives are likely to drive this cost shifting as Medicare SNPs narrow their scope of services covered by Medicaid (such as home health and nursing facilities), and actively refer their enrollees into the broad spectrum of long term care services available in Medicaid.

Budget Impact of Medicare Part D on MassHealth:

Prior to the start of Part D, concerns were raised about the financial impact of Part D on MassHealth. Under the maintenance of effort, or "clawback" provision of phase down payments, states are obligated to reimburse CMS for dual eligible beneficiary drug spending. This payment started at 90 percent of the estimated savings that states would realize by no longer covering drugs for dual eligible members through Medicaid, and decreasing to 75 percent by 2015. In September 2004, a clawback payment of $289 Million was estimated for a hypothetical state program similar to MassHealth.[18] Other major costs to MassHealth were expected to include: a loss of potential future savings from further successful state cost containment as clawback phase down payments are calculated based on national trends; administrative costs generated from determining eligibility for LIS; and the "woodwork effect" of identifying more beneficiaries that apply for LIS and are actually eligible for full Medicaid benefits.

Some of these potential costs remain a concern: to the extent that MassHealth would have continued to decrease drug spending into the future at a greater rate than Medicare, the state may be penalized through future clawback calculations' link to national health spending growth. Administrative costs related to implementation may have been considerable, but MassHealth did not hire any additional staff to work on Part D implementation. Further, no beneficiaries have applied for the LIS through the state, so the majority of identified costs have been due to mailings to notify new duals of their change to Part D. In terms of an expected "woodwork effect," the number of duals has increased only slightly since implementation of Part D, from 192,000 to 196,000 in January 2007. The number of beneficiaries receiving partial Medicaid coverage through Medicare Savings programs is currently around 19,000, which is close to 2005 levels.[19] Estimates of the direct budgetary impact of Part D on MassHealth suggest that, at least for the initial years, costs to MassHealth are lower than projected.

Table 3 shows the estimated budgetary impact of Medicare Part D on MassHealth in 2006 and 2007. As was the case in only seven other states, the clawback formula resulted in MassHealth paying less for people dually eligible for Medicare and Medicaid than it would have in the absence of Part D. According to MassHealth, Medicare Part D is estimated to save Mass Health $25.5 million in Fiscal Year (FY) 2006 and $21.4 million in FY 2007.

[18] Massachusetts Medicaid Policy Institute/Mass Health Policy Forum Issue Brief: *The New Medicare Prescription Drug Law: Implications for Massachusetts State Health Programs*, September 2004.

[19] This number dipped in July 2006 to due to a redetermination process, and is now back to 2005 levels, perhaps due in part to Part D enrollment and outreach.

Table 3: Estimated Budget Impact of Medicare Part D on MassHealth (as of 6/26/06) (in millions of dollars)[20]

Part D changes	Budget impact of Part D, as of 6/26/06 $$ in millions		
FY06 (Six month implementation of Part D)	**No Part D**	**Part D**	**Net FY 06 cost**
Dual eligible pharmacy cost	$642	$321	($321)
Clawback payment	0	$90	$90
Spending impact	**$642**	**$411**	**($231)**
FFP from dual eligibles	$321	$160.5	($160.5)
Manufacturer drug rebates	$89.88	$44.94	($44.94)
Revenue impact	**$410.88**	**$205.44**	**($205.44)**
Net projected impact FY06	**231.12**	**$205.56**	**($25.56)**
FY07			
Dual eligible pharmacy cost	$722.25	0	($722.25)
Clawback payment	0	$238.6	$238.6
Spending impact	**$722.25**	**$238.6**	**($483.65)**
FFP from dual eligibles	$361.125	0	($361.125)
Manufacturer drug rebates	$101.115	0	($101.115)
Revenue impact	**$462.24**	**0**	**($462.24)**
Net projected impact FY07 ( )=savings	**$260.01**	**$238.6**	**($21.41)**

There are several reasons for the positive net impact on MassHealth in 2006 and 2007. First, Massachusetts had already realized considerable savings in dual eligible beneficiaries' drug costs by 2003 as a result of cost containment programs, thus lowering the per-beneficiary drug cost in the clawback.[21] States that implemented cost containment provisions before 2003 fared better than those that implemented such measures after 2003. This worked to Massachusetts' advantage: by Fiscal Year 2003, Massachusetts had limited its drug spending growth to 4.1 percent, down from its prior year growth of 14.4 percent, resulting in lower than expected per-beneficiary drug costs.[22]

[20] Source: Data provided by MassHealth.

[21] The formula for monthly state clawback payments to CMS is based on: the product of a state's 2003 per capita drug spending for duals; estimated growth in national drug spending between 2003 and 2006 based on National Health Accounts; the number of full dual eligible beneficiaries in the previous month; and a percentage between 90 and 75 percent to phase down contributions over ten years.

[22] Massachusetts Medicaid Policy Institute/ Massachusetts Health Policy Forum *Issue Brief: Impact of Part D on Massachusetts Health Programs,* 2005.

According to MassHealth officials, the budget figures above reflect increased savings over earlier estimates that were projected in December 2005. Additional savings were realized because of: a greater than expected MassHealth dual eligible drug spending in the first six months of 2006; an increase in manufacturer drug rebate collection rate from 25% to 28%; and a change in the payment schedule in the first year of coverage, which reduced MassHealth Clawback payments by $20 million total for the year. Also, in February 2006, based on newly available National Health Estimates growth, CMS re-calculated Clawback payments for all states, lowering required Massachusetts 2006 payments by $10 Million.[23]

Massachusetts Emergency Legislation Related to Part D

Massachusetts passed legislation in December 2005, Chapter 175 of the Massachusetts Acts of 2005, to provide limited "wraparound coverage" for non-formulary Part D drugs and assistance with Part D copayments for dual eligible beneficiaries. Wraparound coverage provided supplemental drug coverage and lowered the cost sharing requirements of Part D to match that of MassHealth. The legislation also formalized wraparound coverage for Prescription Advantage members (discussed later in this report).

While the state was prepared to implement the assistance under Chapter 175 as of January 1, 2006, significant problems with the initial transition to Part D led Massachusetts, like most states, to provide emergency drug coverage to all dual eligible beneficiaries to ensure that they would continue to get needed drugs. In total, $17.6 million in drug claims for dual eligible beneficiaries was provided in emergency funding through March 15, 2006. Most of this initial emergency funding has been recovered from CMS, which agreed to cover these costs in full for most states through March 15, 2006.

Chapter 175 legislation required MassHealth to bring Part D copayments down to MassHealth levels. It also required MassHealth to pay for one-time 30-day supplies of medications -- followed by one-time 72-hour supplies -- for dual eligible beneficiaries when they were unable to get their medications through Medicare Part D. Initially the one-time 30-day supplies under Chapter 175 were set to expire by June 30, 2006, but the legislation was revised in July 2006, extending those supplies through December 2006. The 30-day supply provision has now expired, although there is currently no end date for the one-time 72-hour supplies or for the copayment assistance.

The July 2006 revision also clarified the circumstances in which one-time supplies are available. Initially the law was written to provide one-time supplies to dual eligible beneficiaries who were already enrolled in a Part D drug plan and whose prescriptions were denied. The July 2006 revision clarified that the one-time supplies should be provided in all situations in which dual eligible beneficiaries were unable to get their medications, whether enrolled in a Part D plan or not.

In 2006, Chapter 175 was critical in helping to maintain access to drugs, particularly for new dual eligible beneficiaries. Assistance under Chapter 175 is fully state-funded. Chapter 175 assistance to dual eligible MassHealth members from March 16, 2006 through December 31,

[23] Centers for Medicare and Medicaid Services, Medicare drug costs drop substantially. February 2, 2006 (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1766).

2006 totaled approximately $4.6 million for over 200,000 claims, including drug claims and required copayments. From July through October alone, the state spent an average of $375,000 (average of 4400 claims) per month for 30-day supplies.

Advocates voice concerns that 30-day supplies continue to be necessary in 2007, as new beneficiaries are continually aging into Medicare and Part D eligibility, as well as needing to requalify annually for LIS. They point to the considerable use of emergency funding throughout 2006. At the same time, MassHealth officials report that reliance on 72-hour supplies has been low in 2007, and suggest that Part D transition issues may be decreasing.

Prescription Advantage

Prescription Advantage (PA) is the state pharmacy assistance program for seniors and the low income disabled population, which was first implemented in 2001. Massachusetts made a commitment to wrap Prescription Advantage around Medicare Part D for its members who are Medicare beneficiaries. Part D is now the primary payer for prescription drug coverage for these members, and PA is now the secondary payer, covering Part D member cost sharing up to the PA benefit level. The goal of the PA wraparound program is to maintain the same level of benefits offered under the previous PA program. This arrangement was formalized through Chapter 175 (described earlier).

Of the 72,000 PA members who are Medicare beneficiaries, 20,000 stayed in their Medicare Advantage (MA) health plans with drug coverage. The 52,000 PA members who are not in MA plans were randomly assigned to basic Part D benchmark plans.[24] CMS allocated $6 Million over two years through a transition grant to Massachusetts for systems development and to assist in enrollment of PA members into Part D and application for LIS.

The extent of PA coverage depends upon member income, currently comprised of seven different income/ benefit levels. **Table 4** summarizes the design of Part D wraparound coverage into three income levels. For instance, Prescription Advantage covers members up to 188% of FPL ($18,424 for a single person and $24,816 for a couple), even if they do not qualify for the Part D low income subsidy, representing a considerable improvement over standard Part D. As income increases, the relative advantage of PA over Part D diminishes, although at all income levels (up to 500% FPL, the eligibility cap), there is a maximum out of pocket spending limit. Also, in contrast to Part D, PA copayment cost sharing is not indexed to increase each year.

[24] Basic plans are those that are actuarially equivalent to the standard Part D benefit. Enhanced plans offer additional benefits. PA members can join any plan, but PA premium subsidies are limited to the basic portion of the premium up to the regional benchmark.

Table 4: Prescription Advantage Table of Benefit Coverage Levels for Medicare Beneficiary Members

	Income		
	<188% FPL (n=53,125 members)	**188-300% FPL (n=14,866)**	**300-500% FPL (n=1730)** $200 annual fee to PA
Eligibility **(Must be in part D plan)**	• Divided into full, partial and no low income subsidy • Must apply for LIS or certify they exceed assets	Eligible, must be in Part D plan	500% FPL upper limit for Medicare beneficiaries to enroll in PA
Premiums	PA pays full basic premium up to basic benchmark	Up to 225% FPL, member pays first $20/month, program pays balance	Above 225% FPL, member pays entire premium
Copayments and deductibles	• No quarterly PA deductibles. • Copays no more than generic and preferred brand copays before Part D (no third tier copay) • PA pays difference between Part D and PA copay, including deductible and coverage gap • After member out of pocket reaches PA out of pocket limits ($1400-$2150), PA pays all Part D copays		• No quarterly PA deductibles • No copay assistance until total out of pocket reaches $2870; PA then pays all Part D copays
Coverage	• Benzodiazepines only uncovered class filled in • All formularies, prior authorization or limits through Medicare drug plans • Emergency one-time 72 hour supply		

In order to ensure that beneficiaries optimize their coverage through Part D before PA fills in gaps, PA members must be enrolled in a Part D plan, and any PA members who are also eligible for the low income subsidy must submit an application to SSA. Because PA does not require resource (asset) information on which Part D subsidies are based, when Part D began, PA contacted each member with incomes at or below 188% FPL and offered to facilitate application to SSA for the subsidy. Focused outreach began in the summer of 2005, and continues to date, although at a lower level of effort after the initial Part D enrollment year. Roughly 12,000 PA members were approved by SSA to be eligible for LIS, in addition to another 12,000 members who were deemed eligible by CMS.

Early data indicate that Prescription Advantage has met the goals of maintaining the level of cost sharing and access to prescriptions previously experienced by PA members. As **Table 5** indicates, the proportion of drug costs borne by PA for members was maintained at 20 percent during calendar year 2006. The proportion of drug costs borne by PA for members decreased from 32 percent prior to Part D (when there was no significant additional payer) to 28 percent in

2006. The higher rates of PA costs through March 2006 reflect the initial first payer status maintained during the early months of Part D implementation, and those in the period from October through December 2006 reflect the higher number of members in the Part D coverage gap.

Table 5: Prescription Advantage Drug Costs in 2006 and Member Share[25]

	Jan-Mar 2006	Apr-June 2006	July-Sept 2006	Oct-Dec 2006	CY 2006
Average eligible members	70,058	67,300	69,122	67,237	68,429
Average monthly utilizing members	38,705	38,628	41,361	41,907	40,150
Total drug cost[26]	$24,125,011	$25,479,711	$27,859,833	$29,553,939	$107,018,494
% PA cost	32.5%	18.7%	27.1%	31.9%	27.6%
% other payer cost	46.5%	61.3%	53.7%	49.6%	52.7%
% member cost	**21.1%**	**20.0%**	**19.2%**	**18.5%**	**19.6%**

Prescription Advantage Special Problems and Continued Challenges

Complexities involved in the process of enrolling PA members into Part D and applying for LIS include the following: finding the members eligible for the low income subsidy; coordinating with Social Security Administration to submit applications; matching across income categories that differed between the PA benefit categories and Part D benefit plans and income categories; and coordinating with CMS and health plans to see where members were enrolled. For instance, for some members who enrolled directly with drug plans, the CMS enrollment data provided to PA was incomplete or inaccurate, and PA did not know how much was owed to each drug plan for premiums. Additional PA activities included tracking down members who had no claims showing up after February 2006, to inquire whether this was due to access problems.

In spite of vast outreach efforts described above, as Part D was implemented, systems were unable, in many cases, to recognize PA as a secondary payer, as data transfers and LIS status were not available to pharmacies at point of service. On January 11, 2007, PA was reinstituted as primary payer and remained so through January and February, because numerous members had difficulties getting drugs due to the fact that their drug plans did not recognize them as members (as a result of a systemic data problem with Part D at its inception). PA is in the process of recovering this expenditure from Part D plans, as are other state programs where this occurred.

To a large extent, data system problems have been resolved, although changes in beneficiary status still pose an ongoing problem. PA still does not know directly from health plans which beneficiaries signed up into which plans, and it only learns from CMS after the fact. Additional

[25] Source: Prescription Advantage, February 2007.
[26] Total drug cost is estimated based on data in secondary claims, which may be incomplete.

systems problems include incorrect information on which members are approved for LIS, and miscalculation of true out-of-pocket (TROOP) spending to determine the point at which a member reaches catastrophic coverage. In early 2007, PA contacted 1147 members who were previously deemed eligible for LIS in calendar year 2006 but were not automatically eligible in 2007 due to a change in status, to assist them with applying for LIS.

Budgetary impact of Part D on Prescription Advantage:

As expected, total program spending for PA decreased as Part D became the primary payer. As **Table 6** shows, the budget for Prescription Advantage has gone from $115 million in 2005 to an estimated $64 million for the first full fiscal year after Part D implementation, part of which may reflect the ten percent decrease in enrollment.

Table 6: Prescription Advantage Estimated Budget Impact of Part D[27]

Fiscal Year	Enrollment	Estimated budget
2005	78,397	$115 million
2006	72,992	$96 million (1/2 year of Part D)
2007	71,003	$64 million

State Retiree Health Insurance Program (Group Insurance Commission)

Of the 267,000 state employees, retirees and dependents covered by the Group Insurance Commission (GIC), approximately 52,000 are Medicare beneficiaries, including 3,000 in three Medicare Advantage Part D (MAPD) plans. The GIC has traditionally provided drug coverage savings (approximately $80 million for Medicare beneficiaries in FY2006), and now Medicare provides a subsidy for each member. For the Commonwealth, MMA represents a savings, because the state now receives a subsidy for each Medicare beneficiary.

MMA provides several options for employer-sponsored retiree health plans for Medicare beneficiaries: 1) An employer can allow members to join a Part D plan and may pay premiums and wrap around benefits; 2) An employer can become a unique Part D plan and abide by Part D drug plan requirements; or 3) An employer can continue to provide drug benefits to beneficiaries through a non-Medicare Part D drug plan. As an incentive to maintain retiree coverage, employers taking this last option who provide drug coverage at least as generous as the standard Part D benefit are considered "creditable" and receive a subsidy from CMS for each covered member (28% of drug costs between $265 and $5451). In 2006, and continuing into 2007, GIC chose the last option -- to continue to provide drug coverage to retirees and take the subsidy. This choice was made in order to insure seamless prescription drug coverage, and to avoid having a prescription drug program for Medicare retirees that was different from that provided to employees and non-Medicare retirees. In addition, the GIC did not want retirees to bear the extra

[27] Source: Prescription Advantage, February 2007.

cost of purchasing Part D in addition to the health insurance and Part B premiums they already had to pay.

GIC took several important steps to insure that beneficiary drug coverage was seamless and that the program could take full advantage of Medicare Part D funding. Months prior to Part D implementation, GIC submitted applications to CMS to prove that drug coverage was actuarially equivalent to Part D and that the Commonwealth was therefore entitled to receive the employer subsidies. In order to make sure that no GIC members enrolled unnecessarily in Part D plans (thus eliminating the subsidy to the Commonwealth as well as resulting in increased costs to the retirees), the program sent out a series of letters to enrollees explaining that the retirees' drug coverage through the GIC was equivalent or better than that offered by Part D. Officials report that this successfully eliminated most retiree confusion during the initial Part D enrollment.

The major administrative burden for GIC has been the requirement to submit monthly membership reports to CMS for all covered members. CMS reviews these reports and determines which members listed are eligible for the Part D subsidy. The GIC must then transmit this subsidy-eligibility information to its health plans, so that only drug costs for those members are tracked for the purpose of the subsidy. There are additional issues due to particular MMA rules regarding subsidies for individual MAPD plan members. These included: identifying the small number of MAPD members who qualified for LIS, as CMS does not notify GIC in those cases; and administrative complexities involved in calculating and passing on premium reductions where applicable to those beneficiaries. This has been an administrative challenge, as savings are a varying range of small amounts distributed across members in a variety of plans. In terms of ongoing administrative tasks, the continued monthly feeds for subsidy eligibility to CMS and the health plans are a considerable burden. The GIC must also submit annual applications to CMS requesting approval to receive the employer subsidies. These applications require an attestation by an actuary that GIC prescription drug benefits for the year of the application are equivalent to the Part D drug benefit.

Special Problems / Challenges: Although CMS informs the GIC of all GIC retirees who enroll or attempt to enroll in Part D, CMS will not inform the GIC if a member joined because of LIS status (which likely means the enrollment is appropriate). This presents a problem in attempting to counsel members who join Part D, since the GIC cannot distinguish between members who joined due to LIS status from those who joined mistakenly thinking that they needed Part D coverage.

Budgetary Impact: It was initially estimated that the Commonwealth would save a total of approximately $23 million dollars in the first year of Part D. Since CMS will not reimburse employers for the costs of drugs covered by Part B, or for drugs in classes not covered by Part D, or for any amounts received as rebates, the GIC now estimates that the Commonwealth will save approximately $20 million dollars from the employer subsidies. The CMS subsidy is returned to the Commonwealth's General Funds rather than directly to the GIC, and therefore does not offset the GIC's budget.

In addition to the subsidy, Part D served to reduce the premiums for members enrolled in the GIC's three MAPD plans. Decreases in premiums saved the GIC approximately $1.5 million in calendar year 2006.

Other Massachusetts State Budgetary Impact of Part D

As a result of the statewide preparation for Medicare Part D, the state is able to centrally generate Medicare Part D revenue – approximately $10M annually for dual eligible and Medicare only clients at the various Department of Public Health, Department of Mental Health and Department of Mental Retardation institutions across the state. Massachusetts was one of a handful of states that was able to make all necessary contractual, operational and systematic changes to successfully claim and obtain reimbursement for pharmacy services covered by Medicare Part D, which is revenue that would have otherwise been lost.

IV. Conclusions and Future Concerns for Massachusetts

Because of the significant commitment of time and resources by Massachusetts health programs, insurers, advocates, pharmacists, and provider groups, 78 percent of eligible Medicare beneficiaries in Massachusetts are enrolled in Part D or other creditable plans, and nearly 90 percent of Medicare beneficiaries receive drug coverage from some source. Massachusetts state health programs have so far not been adversely affected in terms of direct budgets. Medicare Part D continues to evolve, making improvements to data sharing and enhancements, including publishing of basic plan quality indicators for use by beneficiaries in the areas of complaints, appeals, information sharing with pharmacists, and drug pricing. [28] National surveys indicate also that most beneficiaries are satisfied with their Part D drug benefit.[29]

At the same time, for those beneficiaries who have transition problems and difficulties accessing critical medications, outcomes can be devastating. Several issues, both for programs and beneficiaries, will be important to follow as the program evolves.

Beneficiaries: There is no doubt that Medicare Part D has improved access to drugs for many Medicare beneficiaries in Massachusetts, but several aspects related to drug coverage should be watched carefully into the future. Considering the design of Part D, beneficiaries will be faced every year with changing drug costs, formularies, and plan options. Reevaluation of plans is necessary for all beneficiaries each year, and transitions to different plans will be required for a portion of dual eligible beneficiaries, non-dual eligible low income beneficiaries, and higher income beneficiaries. Continued assistance with enrollment, appeals, grievances and troubleshooting at the community level will be critical in order ensure that beneficiaries maintain their best coverage options. No analyses have been conducted by CMS to determine whether most beneficiaries are in the drug plans that best fit their needs. Also, while some national surveys suggest broad satisfaction with Part D for the majority of enrolled beneficiaries, recent

[28] Individual plan performance data (assessments of Very Good, Acceptable or Poor) are available at: (http://www.medicare.gov/MPDPF/Shared/Include/Quality/QualityOverview.asp)

[29] Kaiser Family Foundation, *Voices of Beneficiaries: Medicare Part D Insights and Observations One Year Later* December 2006 (http://www.kff.org/medicare/upload/7605.pdf).

studies, discussed earlier, indicate that the most at-risk populations are having access problems. A direct independent assessment of beneficiaries' experiences through focus groups or surveys is warranted in order to determine the extent to which anecdotal evidence represents just a small number of beneficiaries, or whether it is the tip of the iceberg.

MMA has assigned accountability for prescription drug services to many Part D plans. CMS is no longer directly responsible for resolving specific plan decisions that are appealed. At this point, there have not been widespread difficulties reported within Massachusetts in terms of beneficiary grievances and appeals, but as the program evolves this must be watched.

For MassHealth dual eligible beneficiaries in particular, the absence of a coordinated drug and medical benefit increases the difficulties in managing the care of duals with disabilities and chronic disease. This is compounded by the fact that dual eligible beneficiaries are subject to numerous formularies that may differ in important drug coverage or management features.

Need for Additional Outreach: While enrollment in Medicare Part D has been considerable, over 125,000 beneficiaries may still be without coverage. Many of these beneficiaries are likely to be the most difficult to reach populations. Individuals involved in outreach and enrollment report that there are particular groups that have not enrolled into Part D, such as members of the Hispanic and Asian communities and others that are non-English speaking. Continued attention must be paid to these populations, as they may be going without needed prescription drugs.

Administrative, Data Systems and Communication: Some of the problems discussed above for MassHealth, Prescription Advantage, and the Group Insurance Commission regarding difficulties in data systems are likely to continue at least in the near term. This involves communication with CMS, such as time lags between enrollment and point of service recognition, communication between programs and member PDPs, and burdensome processes for submitting membership or drug claims. In particular, because continuous beneficiary status transitions are expected to occur into the future, lags in system communication will warrant continued emergency coverage.

CMS is making progress toward making drug plan data available to Medicaid programs. As noted at a recent national conference, specific steps were outlined that would facilitate sharing of drug data between health plans and state Medicaid agencies.[30] California, as an example, has a data exchange agreement with every PDP in the state, and is now able to share data. However helpful this is to the management of patients and integrated care, it is also reported to be quite burdensome to establish.

Massachusetts Health Programs: Analyses provided for this report by MassHealth, Prescription Advantage, and the Group Insurance Commission indicate a net positive budgetary impact for the first years of Medicare Part D. As long as Medicaid dual eligible beneficiaries receive their drug benefit through Part D market plans, there will always be a lack of flexibility for Mass Health in drug costs and management. States are also locked into a clawback formula, which at present is favorable to Massachusetts, but is also subject to overall health care inflation.

[30] National Health Policy Forum, Complexity, Coordination, and Compromise: States and the Medicare Drug Benefit. Forum session held August 4, 2006.

The Massachusetts Health Care Market: The sweeping changes created through MMA and implementation of Part D will affect the entire health care market in Massachusetts. A detailed analysis of health care market changes resulting from Part D implementation, and implications for providers, is beyond the scope of this paper. However, potential market effects will have implications for beneficiaries. One change in the market could be erosion of employer drug coverage. Currently, only a few employers in the state have decided to drop coverage in response to Part D, but as Part D becomes more established, more employers may drop coverage. Another potential change is in the managed care market in Massachusetts. Medicare Advantage plans are able to offer drugs at a lower cost than PDPs because they receive subsidies through MMA, and because they can use health plan strategies to manage care. According to Division of Insurance data, MA enrollment has not increased considerably in the Commonwealth between 2005 and 2006. However, a marketing strategy of plan sponsors is to enroll beneficiaries into PDP plans and then move them to more profitable MA-PD plans.[31] This could eventually change the structure of the health insurance market in the state.

Community pharmacies have experienced an additional and reportedly negative market effect of MMA. While larger chain drug stores are often partners in Medicare drug plans, smaller pharmacies must comply with PDP processes, which often have negative consequences. For instance, community pharmacies must essentially accept PDP pricing, are not in all PDP networks, and report greater lags in payments than with Medicaid. To the extent that these businesses are at risk, access for certain beneficiaries may be adversely affected.

Lessons for Enrollment Into Health Programs: Perhaps the most important lesson Massachusetts public and private programs can learn from implementation of Medicare Part D is what does and does not work in terms of design and enrollment into new health programs. First, partnering with a large network of public and private organizations that have familiarity with the target population is critical. A large workforce and volunteers to implement a program are critical, as the most successful tool for education and enrollment has been word of mouth and one-on-one assistance. The numerous choices that Medicare beneficiaries had to navigate in enrolling into Part D generated considerable confusion, and only increased the need for such intensive assistance. Customer service must be a critical part of enrollment and support, including round-the-clock phone assistance, interpreter services, and sufficient training to support these activities.

Second, data systems problems can thwart even the most effective education campaigns. In the case of Part D, because of data problems, large numbers of beneficiaries were unable to receive medications at pharmacies, copayments were higher than beneficiaries expected, and information was incorrect on websites. This created problems for beneficiaries at the point of service and may have led to mistrust of the program. The data systems problems were magnified by the fact that the program began for millions of beneficiaries across the country on one day, rather than a somewhat gradual ramp-up with data glitches being worked out as the program was phased in.

In any large-scale program like Part D, unintended consequences are to be expected. Effects of Part D in Massachusetts have been widespread across a broad number of health programs and

[31] "Plan A: Hook them with Part D," Business Week Online, January 30, 2006.

populations. Because of the nature of Medicare Part D, plan options and formularies will change each year. The effect on the most vulnerable and poor beneficiaries, and on programs that serve them, warrants continued monitoring. Legislation creating an emergency safety net was critical to maintain access for beneficiaries during the initial transition to Part D and after.

Acknowledgment

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Appendix

Prescription Drug Plan Options in Massachusetts, 2007

Massachusetts Drug Plans (PDPs), 2007[32]

Plan Name	Company Name	Monthly Premium	$0 Premium with Full Low Income Subsidy	Annual Deductible	Coverage in the Gap
WellCare Classic	WellCare	$13.40	Yes	$265	No gap coverage
Humana PDP Standard	Humana Insurance Company	$16.90	Yes	$265	No gap coverage
AARP MedicareRx Plan - Saver	UnitedHealthcare	$18.50	Yes	$265	No gap coverage
CIGNATURE Rx Value Plan	CIGNATURE Rx	$21.10	Yes	$265	No gap coverage
WellCare Signature	WellCare	$21.50	Yes	$0	No gap coverage
Blue MedicareRx Value	Blue Cross and Blue Shield of Massachusetts	$22.00	Yes	$265	No gap coverage
MedicareRx Rewards Value	Unicare	$22.10	Yes	$265	No gap coverage
Advantage Star Plan by RxAmerica	RxAmerica	$23.20	Yes	$265	No gap coverage
Prescription Pathway Gold Plan Reg 2	Pennsylvania Life Insurance Company	$23.20	No	$0	No gap coverage
AdvantraRx Value	Coventry AdvantraRx	$24.10	No	$0	No gap coverage
Health Net Orange Option 1	Health Net	$24.30	Yes	$265	No gap coverage
SilverScript	SilverScript Insurance Company	$24.40	Yes	$265	No gap coverage
HealthSpring Prescription Drug Plan - Reg 2	HealthSpring Prescription Drug Plan	$24.70	Yes	$265	No gap coverage
Prescription Pathway Bronze Plan Reg 2	Pennsylvania Life Insurance Company	$25.20	Yes	$265	No gap coverage
Humana PDP Enhanced S5884-002	Humana Insurance Company	$25.80	No	$0	No gap coverage
AARP MedicareRx Plan	UnitedHealthcare	$26.30	Yes	$0	No gap coverage
Sterling Rx	Sterling Life Insurance Company	$27.00	Yes	$100	No gap coverage
Community Care Rx BASIC	MEMBERHEALTH	$27.20	Yes	$265	No gap coverage

[32] Source: Centers for Medicare and Medicaid Services, 2007 http://www.medicare.gov/MPDPF/Public/Include/DataSection/Results/ListPlanByState.asp)

Plan Name	Company Name	Monthly Premium	$0 Premium with Full Low Income Subsidy	Annual Deductible	Coverage in the Gap
First Health Premier	First Health Part D	$27.40	Yes	$0	No gap coverage
Advantage Freedom Plan by RxAmerica	RxAmerica	$27.90	Yes	$265	No gap coverage
UnitedHealth Rx Basic	UnitedHealthcare	$28.00	Yes	$0	No gap coverage
Aetna Medicare Rx Essentials	Aetna Medicare	$28.30	Yes	$200	No gap coverage
Health Net Orange Option 2	Health Net	$29.00	Yes	$0	No gap coverage
CIGNATURE Rx Plus Plan	CIGNATURE Rx	$29.10	No	$0	No gap coverage
Blue MedicareRx Value Plus	Blue Cross and Blue Shield of Massachusetts	$30.30	No	$0	No gap coverage
UA Medicare Part D Rx Covg - Silver Plan	United American Insurance Company	$30.40	No	$265	No gap coverage
NMHC Medicare PDP Gold	NMHC Group Solutions	$30.50	No	$0	No gap coverage
SilverScript Plus	SilverScript Insurance Company	$33.00	No	$0	No gap coverage
AdvantraRx Premier	Coventry AdvantraRx	$35.00	No	$0	No gap coverage
Medco YOURx PLAN	Medco YOURx PLAN	$35.40	No	$100	No gap coverage
Community Care Rx CHOICE	MEMBERHEALTH	$35.60	No	$0	No gap coverage
WellCare Complete	WellCare	$36.80	No	$0	Generics
SilverScript Complete	SilverScript Insurance Company	$37.40	No	$0	Generics
CIGNATURE Rx Complete Plan	CIGNATURE Rx	$39.10	No	$0	Generics
First Health Select	First Health Part D	$39.80	No	$0	Generics
UA Medicare Part D Prescription Drug Cov	United American Insurance Company	$39.80	No	$0	No gap coverage
UnitedHealth Rx Extended	UnitedHealthcare	$41.10	No	$0	No gap coverage
EnvisionRxPlus Standard	EnvisionRx Plus	$42.00	No	$265	No gap coverage
MedicareRx Rewards Premier	Unicare	$42.20	No	$0	Generics
Aetna Medicare Rx Plus	Aetna Medicare	$42.60	No	$0	No gap coverage
Community Care Rx GOLD	MEMBERHEALTH	$43.10	No	$0	Generics
Prescription Pathway Platinum Plan Reg 2	Pennsylvania Life Insurance Company	$43.70	No	$0	Generics
AARP MedicareRx Plan - Enhanced	UnitedHealthcare	$43.80	No	$0	Generics
Health Net Orange Option 3	Health Net	$44.10	No	$0	Generics
SAMAscript	SAMAscript	$45.20	No	$265	No gap coverage
Blue MedicareRx Premier	Blue Cross and Blue Shield of	$45.80	No	$0	Generics

Plan Name	Company Name	Monthly Premium	$0 Premium with Full Low Income Subsidy	Annual Deductible	Coverage in the Gap
	Massachusetts				
AdvantraRx Premier Plus	Coventry AdvantraRx	$48.40	No	$0	Generics
Sterling Rx Plus	Sterling Life Insurance Company	$52.40	No	$100	Generics
EnvisionRxPlus Gold	EnvisionRx Plus	$60.50	No	$0	Generics
Aetna Medicare Rx Premier	Aetna Medicare	$71.80	No	$0	Generics
Humana PDP Complete S5884-031	Humana Insurance Company	$87.40	No	$0	Generics

Massachusetts Medicare Advantage (MA) Plans Offering Prescription Drug Coverage, 2007[33]

Plan Name	Company Name	Total Monthly Premium (including Drug Premium)	Drug Premium	Annual Drug Deductible	Coverage in the Gap
Freedom 5	Advantra® Freedom	$0	$0	$0	Generics
SecureHorizons MedicareDirect Rx Plan 55	SecureHorizons MedicareDirect	$10.30	$10.30	$265	No gap coverage
SecurityChoice Plus	Unicare Life & Health Ins. Company	$11.00	$11.00	$0	No gap coverage
Humana Gold Choice PFFS H1804-256	Humana Insurance Company	$89.00	$13.10	$265	No gap coverage
First Seniority Freedom (H7226-008-0)	Harvard Pilgrim Health Care Inc.	$26.00	$17.50	$0	No gap coverage
Medicare Preferred HMO Prime Rx	Tufts Health Plan	$78.00	$19.20	$0	No gap coverage
Medicare Preferred HMO Prime Rx	Tufts Health Plan	$125.00	$19.20	$0	No gap coverage
Medicare Preferred HMO Prime Rx	Tufts Health Plan	$118.00	$19.20	$0	No gap coverage
Medicare Preferred HMO Prime Rx	Tufts Health Plan	$98.00	$19.20	$0	No gap coverage
Medicare Preferred HMO Prime Rx	Tufts Health Plan	$88.00	$19.20	$0	No gap coverage
Medicare Preferred PPO Rx	Tufts Health Plan	$109.00	$19.20	$0	No gap coverage

[33] Source: Centers for Medicare and Medicare Services, 2007 (http://www.medicare.gov/MPDPF/Public/Include/DataSection/Results/ListPlanByState.asp). This table includes only those providing prescription drug coverage. Data are aggregated to the state level from county-level data to illustrate the range of plans offered in Massachusetts, so not all beneficiaries have access to all plans.

Plan Name	Company Name	Total Monthly Premium (including Drug Premium)	Drug Premium	Annual Drug Deductible	Coverage in the Gap
Medicare Preferred HMO Value Rx	Tufts Health Plan	$87.00	$20.20	$0	No gap coverage
Medicare Preferred HMO Value Rx	Tufts Health Plan	$80.00	$20.20	$0	No gap coverage
Medicare Preferred HMO Value Rx	Tufts Health Plan	$60.00	$20.20	$0	No gap coverage
Medicare Preferred HMO Value Rx	Tufts Health Plan	$70.00	$20.20	$0	No gap coverage
Medicare Preferred PPO Rx	Tufts Health Plan	$123.00	$20.20	$0	No gap coverage
Aetna Medicare Open Plan	Aetna Medicare	$80.00	$21.80	$265	No gap coverage
Humana Gold Choice PFFS	Humana Insurance Company	$99.00	$23.60	$0	No gap coverage
Humana Gold Choice PFFS	Humana Insurance Company	$129.00	$23.60	$0	No gap coverage
Medicare HMO Blue PlusRx	Blue Cross and Blue Shield of Massachusetts, Inc.	$103.00	$23.60	$0	No gap coverage
Medicare PPO Blue PlusRx	Blue Cross And Blue Shield Of Massachusetts, Inc.	$123.00	$23.60	$0	No gap coverage
Fallon Senior Plan Saver Basic Rx	Fallon Community Health Plan	$27.00	$27.00	$265	No gap coverage
Fallon Senior Plan Plus Basic Rx	Fallon Community Health Plan	$128.00	$27.50	$265	No gap coverage
Fallon Senior Plan Standard Basic Rx	Fallon Community Health Plan	$84.00	$27.50	$265	No gap coverage
SecurityChoice Enhanced Plus	Unicare Life & Health Ins. Company	$56.00	$28.70	$0	Generics
Medicare Preferred HMO Prime Rx Plus	Tufts Health Plan	$90.00	$30.70	$0	Generics
Medicare Preferred HMO Prime Rx Plus	Tufts Health Plan	$137.00	$30.70	$0	Generics
Medicare Preferred HMO Prime Rx Plus	Tufts Health Plan	$130.00	$30.70	$0	Generics
Medicare Preferred HMO Prime Rx Plus	Tufts Health Plan	$110.00	$30.70	$0	Generics
Medicare Preferred HMO Prime Rx Plus	Tufts Health Plan	$100.00	$30.70	$0	Generics
Medicare Preferred HMO Value Rx Plus	Tufts Health Plan	$99.00	$30.70	$0	Generics
Medicare Preferred HMO Value Rx Plus	Tufts Health Plan	$92.00	$30.70	$0	Generics
Medicare Preferred HMO Value Rx Plus	Tufts Health Plan	$72.00	$30.70	$0	Generics
Medicare Preferred HMO Value Rx Plus	Tufts Health Plan	$82.00	$30.70	$0	Generics
Medicare Preferred PPO Rx Plus	Tufts Health Plan	$134.00	$30.70	$0	Generics

Plan Name	Company Name	Total Monthly Premium (including Drug Premium)	Drug Premium	Annual Drug Deductible	Coverage in the Gap
Medicare Preferred PPO Rx Plus	Tufts Health Plan	$121.00	$30.70	$0	Generics
First Seniority Freedom Plus	Harvard Pilgrim Health Care Inc.	$78.00	$37.40	$0	Generics and Preferred Brands
Medicare HMO Blue PremierRx	Blue Cross and Blue Shield of Massachusetts, Inc.	$118.00	$41.40	$0	Generics
Medicare PPO Blue PremierRx	Blue Cross And Blue Shield Of Massachusetts, Inc.	$137.00	$41.40	$0	Generics
Fallon Senior Plan Saver Enhanced Rx	Fallon Community Health Plan	$47.00	$45.40	$0	No gap coverage
Fallon Senior Plan Standard Enhanced Rx	Fallon Community Health Plan	$102.00	$45.40	$0	No gap coverage
Fallon Senior Plan Preferred Enhanced Rx	Fallon Community Health Plan	$182.00	$52.40	$0	No gap coverage
Fallon Senior Plan Plus Advanced Rx	Fallon Community Health Plan	$159.00	$58.50	$0	Generics

Market Share of Plan Sponsors in Massachusetts, as of June 2006[34]

Sponsor	Enrollees	Percentage
United Healthcare	54,700	18.0%
Humana Insurance Company	48,700	16.1%
Blue Cross Blue Shield New England Alliance	47,300	15.6%
WellCare	28,600	9.4%
Health Net	26,400	8.7%
SilverScript	24,900	8.2%
PacifiCare Life and Health Insurance Company	24,700	8.1%
Pennsylvania Life Insurance Company	24,600	8.1%
Unicare	19,100	6.3%
Coventry AdvantraRx	4,300	1.4%
	303,300	**100.0%**

[34] Includes Prescription Drug Plans only. Source: Based on publicly available data provided by the Centers for Medicare and Medicaid Services, 2006.